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The subjective experiences of violence after disclosure of HIV status among women

by

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DECLARATION

I hereby declare that this mini-dissertation submitted for the Master's degree in Counselling Psychology, at the University of Pretoria, is my own work and has not been submitted previously at another University or Faculty.

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ABSTRACT

There is a need for understanding the stories behind domestic violence and HIV/AIDS in women. Many research studies focus on the interaction between domestic violence and risky behaviours for HIV/AIDS infection and have ignored the experiences of women who are caught up in these situations. This study aims at exploring the experiences of HIV-positive women who are victims of domestic violence and tries to understand their feelings regarding their HIV status and the violence. Factors that contribute to the spread of HIV in women are also explored. It is argued that domestic violence and other socio-cultural factors are the driving forces behind the high incidence of HIV/AIDS in women. These factors also contribute to the continuation of dominant themes of domestic violence. The emerging stories further indicate that cultural factors situate women in positions that limit their ability to make decisions in the relationship, including sexual decisions. In the context of domestic violence, it not only becomes difficult for women to cope with their HIV diagnosis, but their positive HIV status also leads to the continuation of domestic violence.

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CHAPTER 1

ORIENTATION

1.1 INTRODUCTION

Although violence against women is a challenging problem all over the world, South Africa appears to be the country with the highest rate of statistics in this area. In most African countries, women are unable to take a stand against abuse and violence due to the prevailing economic and socio-cultural factors. These factors situate women at the lowest ladder of the social hierarchy and put men in more dominant positions that enable them to exercise control and power over women. Women are therefore often forced to endure abusive and violent relationships as a result of their social positioning and economic dependency. This situation exposes them to a wide range of risk-related behaviours that render them prone to contracting HIV, such as transactional sex, having multiple partners and/or substance abuse. (Current HIV/AIDS statistics show that the prevalence rate of this epidemic is higher in women that it is in men.)

In some instances, a woman's HIV-positive status has led to the emergence of violence in the relationship. Although a number of research studies have been conducted in this area, they seem to focus on the interaction between HIV/AIDS risk infection behaviours and domestic violence (Dunkle, Jewkes, Brown, McIntyre, Gray & Harlow, 2003; Maman, Mbwambo, Hogan, Kilonzo, Sweat & Weiss, 2001a) and have ignored the women's experiences before and after disclosure of their status. This study was therefore conducted to gain an in-depth understanding of the women's experiences of violence after disclosing their HIV status. The study also focused on finding out whether the onset of domestic violence followed or preceded the disclosure of the HIV status.

The qualitative research method was used to achieve the objectives of the study. Semi-structured interviews were conducted in two African languages, namely Northern Sotho and Southern Sotho. The interviews were audio-taped and then transcribed verbatim by the researcher. Some of the main themes uncovered during the study were the following:

- Violence had already existed in the relationship before HIV was discovered, but women stayed in their abusive marriages due to cultural factors.
- Women could not cope with the violence emotionally but often suppressed their feelings.
- Financial dependency often contributed to the continued existence of a violent relationship.

The findings of this study also indicated that some women struggle to disclose their HIV status in fear of their partners' reactions, whereas others have the courage to tell their partners immediately after testing. However, generalising the findings of this study should be done with utmost caution, as it was carried out using a very small sample, that is, two participants. Nevertheless, in both cases the results indicated that violence accelerated after disclosure of the women's HIV status.

The Serithi project, this study's recruitment point, was drawing to a close when the invitation posters for participation in this study were put up. Most clients had already completed their follow-up visits and only a few were coming for last interviews. Hence only two women came forward to participate in this study. However, the research design was adjusted to include the case studies of the two participants so as to provide an in-depth analysis of the results. A decision was made to include data relating to domestic violence *prior* to HIV disclosure as well, and not only *after* disclosure as had originally been planned.

1.2 THE RESEARCH PROBLEM

HIV/AIDS (Human Immune Virus/ Acquired Immune Deficiency Syndrome) and domestic violence are the two major health problems facing women worldwide (Berry, 2007; Dunkle et al., 2003; Kometsi, 2004; Maman et al., 2001a; Suich, 2006; The Norwegian Organisations, 2001; World AIDS Campaign, 2004). It has been indicated that one in five women has experienced some form of violence from their intimate partners and the common forms of violence include physical, sexual and psychological or mental violence. Violence and abuse towards women often have a negative impact on their physical and psychological wellbeing. A detailed discussion of this impact will be provided in the following chapter (World Health Organization, 1997).

A large body of research has been conducted on domestic violence and the findings indicate that women are exposed to different types of violence and abuse in their relationships on a daily basis. They are often subjected to emotional, sexual, psychological and physical abuse (Roy, 1997). The research findings by Dunkle et al. (2003) on the association between gender-based violence and HIV infection indicate that the types of violence experienced by women include emotional (67,5%), financial (13,7%), sexual (20,1%) and physical violence (45%). The study was conducted on a sample of pregnant women attending antenatal clinics in Soweto and revealed that women who are in violent relationships find it difficult to negotiate the use of safer sex methods as they fear that their partners will physically abuse them (Dunkle et al., 2003). This obviously exposes them to the risk of HIV infection. It has also been indicated that some women engage in transactional sex as a result of domestic violence, which is also a high risk factor for HIV infection.

It appears that in every country, between 10 and 50% of women have reported having experienced an incident of physical violence by the intimate partners in their lives (WHO, 2007; World AIDS Campaign, 2004). In many cases, women sustain serious injuries for which they have to seek hospital treatment. For example, research conducted in Papua New Guinea shows that 18% of married women who experienced physical violence had to go for hospital treatment. In Canada, out of the 45% of women who reported incidents of wife beating, 40% of victims went out to seek medical treatment. On average, 50% of women who reported incidents of violence had sustained injuries (WHO, 1997). This study focused solely on violence against women in families. Furthermore, the report of the meeting held in Geneva on issues concerning domestic violence and HIV/AIDS indicated that 20,5% of women in the Unites States were physically abused by their partners after they had been diagnosed with HIV. In another study involving 324 HIV-positive women conducted in Kenya, 19% of them reported having experienced violence from their partners (WHO, 2000).

Rape is a well-known type of violence directed towards women in intimate relationships. Some women believe that their partners have the right to sex at any time and do not even regard forced sex as rape when they are married to or cohabitating with their partner (WHO, 1997). Others indeed regard forced sex as rape in spite of the fact that they are married to the perpetrator. Surveys conducted by the World

Health Organization (1997) in a number of countries showed that between 10 and 15% of women reported forced sex by their intimate partners as rape. In other population-based studies, it was found that between 12 and 25% of women had at some stage experienced forced sex by their intimate partners (WHO, 2000). Rape seems to be more prevalent in violent relationships as women who are exposed to physical violence are more likely to report incidents of forced or coerced sex by their partners. Furthermore, women who are physically or sexually abused by their partners also tend to be psychologically and mentally abused. That is, the physical or sexual assault is often accompanied by harassment and verbal abuse (WHO, 1997).

A study conducted in East London by Foster (1999), which focused on the experiences of women reporting rape and domestic violence, indicated that although domestic violence seems to be highly prevalent in South Africa, there are only a few studies that accurately reflect the incidence of this situation. Foster's study (1999) provided statistics of cases of domestic violence that had been reported to three East London police stations (189 cases) and the area court (624 cases) in April 1999. An in-depth discussion of domestic violence follows in Chapter 2.

Domestic violence exposes women to the risk of HIV infection in a number of ways that will be discussed in detail in the following chapter. For example, women are often afraid to raise the issue of adopting safer sex practices in an abusive relationship in order to avoid conflict (Dunkle et al., 2003; Kometsi, 2004; Maman et al., 2001a). A growing body of research shows that the HIV infection rate is disproportionately high among women and young girls between the ages of 15 and 24 years (Berry, 2007; Gray, 2002; Pembrey, 2007a; Suich, 2006; WHO, 2007; World AIDS Campaign, 2004). Global statistics also indicate that women constitute 59% of those infected with HIV/AIDS (Suich, 2006). A more detailed account of HIV statistics will be given in the following chapter.

Based on the above scenario, it is clear that domestic violence and HIV/AIDS remain problems faced by women in society, regardless of where in the world they are. Women face the challenge of coping not only with domestic violence, but also with HIV/AIDS. The latter receives lots of attention from health workers, hospitals, non-governmental organisations, the government and community activists. Awareness campaigns are raised throughout the country in an attempt to reduce the number of

new infections and alleviate the spread of the HI virus. Television dramas such as Soul City and community campaigns such as Love Life are major campaigns used to raise HIV/AIDS awareness and to also promote healthy sexual behaviour among youths and adults (Pembrey, 2007b). An outline of each of these campaigns appears in Chapter 2.

In spite of the countless efforts of the South African government to reduce the spread of HIV/AIDS and alleviate violence against women, these two issues continue to be major problems in the country. Scores of women between 15 and 49 years of age are caught up in the vicious cycle of domestic violence and HIV/AIDS (Pembrey, 2007a). Although domestic violence seems to be contributing to HIV/AIDS infection among women, it also appears to have a negative impact on their disclosure of HIV test results. The majority of women find it difficult to tell their partners about their own positive HIV status, mainly because they are uncertain about the reaction they will get (Dunkle et al., 2003; Kometsi, 2004; Maman et al., 2001a).

1.3 MOTIVATION FOR THE STUDY

The researcher has been involved in the Serithi project for five years as a research assistant, collecting data through structured interviews. Some screening questions in the Serithi questionnaire were meant to check if the client had experienced violence or any kind of stigma from the community (see Appendix B). A number of clients mentioned that they had been treated badly within their households. The current study of violence towards women followed from the Serithi project, which revealed that several women were experiencing some form of discrimination from family members and relatives. Others reported suffering negative treatment from their intimate partners. Of those who mentioned violent behaviour from their partners, a few indicated that violence started after they had divulged their HIV status. For example, one woman actually mentioned during the data collection interview that her husband became emotionally and financially abusive after learning about her HIV status. Other research assistants in the project indicated that they had also come across women who mentioned that they had suffered violent and abusive times in their relationships due to their HIV status. It was easier for Serithi clients to share their experiences with us, the research assistants, as we have established rapport with them over time. As

mentioned earlier, some background will be provided about the Serithi project later on in this section so as to give a clear picture of the researcher's clinical experiences within this project.

While the Serithi project was in its final year of operation in December 2007, a tragic incident happened. One morning as the researcher was entering the gates of the Kalafong Hospital, she saw the face of one of the Serithi clients on the front page of the newspaper, bold headlines reading: *Woman stabbed to death for "disclosing HIV status"* (Mashego, 2008). According to the newspaper reporter, a 24-year-old woman disclosed her HIV status to her partner. It was alleged that the partner became violent, slit her throat and stabbed her to death with a knife after learning about the HIV diagnosis (Mashego, 2008). The newspaper report also hinted at the possibility that disclosing one's HIV status could lead to the onset of violence in intimate relationships.

The experiences of Serithi clients evoked the researcher's curiosity, interest and sympathy about the situation in which these women found themselves when they also had HIV. She therefore felt urged to explore the experiences of these women. In addition to her own clinical experience, external empirical evidence also showed that women experienced various forms of violence and abuse from their partners and were, in some instances, even killed (Gordon & Crehan, 1999; Roy, 1997). In fact, a large body of research shows that there is a connection between domestic violence and HIV/AIDS (Berry, 2007; Dunkle et al., 2003; Gordon & Crehan, 1999; Kometsi, 2004; Maman et al., 2001a; Miller & Steinberg, 1993; Suich, 2006; The Norwegian Organisations, 2001; World Health Organization, 1997; World AIDS Campaign, 2004).

While qualitative research findings indicating that domestic violence follows the disclosure of HIV status are not readily available, there is general consensus that domestic violence contributes to the high HIV infection rate in women (Dunkle et al., 2003). It has in fact been indicated that domestic violence puts women at risk of getting infected with HIV – a matter that will be explored further in Chapter 2 (Dunkle et al., 2003; Kometsi, 2004; Maman et al., 2001a). However, although a number of studies have investigated the link between HIV infection and domestic

violence, there has been no indication as to whether violence surfaced before or after the disclosure of the positive HIV status (Dunkle et al., 2003).

Results of the study by Dunkle et al. (2003) indicate that many studies focused on the association between violence and HIV risk behaviours and ignored the women's experiences following disclosure of an HIV test or their confirmed HIV status to their partners. Qualitative information on how women feel about this issue and what abused women want from health services has not been given much attention. Therefore, the current research study focused on this area and explored the experiences of women in relation to violence in their relationships before after disclosure of their HIV-positive status. The objective to understand women's experiences of violence before discovery of their HIV status was also explored, seeing that this matter was pointed out by Maman et al. (2001a). These researchers indicated that qualitative research on domestic violence and HIV disclosure was incomplete as other women reported having experienced incidents of violence before they went for HIV testing.

This study was conducted with a view to understanding the complexities and intricacies of domestic violence, HIV/AIDS and disclosure of HIV status in intimate relationships. The results should therefore provide some insights into the nature of relationship dynamics in which women are caught up after disclosing their HIV status to their partners. Hopefully, the findings will help and inform other researchers to empower women who are in violent and abusive relationships. Maybe this will help them to assist these women to alleviate the crisis of domestic violence and increase their chances of safety once they have tested positive for HIV.

1.4 SERITHI PROJECT

The Serithi project is a community project that operated in two townships around Pretoria, namely Mamelodi and Atteridgeville. It was carried out under the auspices of the University of Pretoria and co-facilitated by Professor Maretha Visser, one of the lecturers in Psychology. The principal investigator in this project was Professor B. Jeffrey, a gynaecologist and obstetrician. The offices of the Serithi project were located at the Kalafong Hospital in Atteridgeville.

The research project focused on understanding HIV-related stigma and its effects on choices of infant feeding and disclosure of status. It also aimed at understanding how women feel when they have HIV and to use this information to develop an intervention programme to support women in dealing with their HIV status. The related support programmes will be discussed in Chapter 2 (Mundell, 2006; Visser, Mundell, de Villiers, Sikkema & Jeffrey, 2004). Participants in the Serithi project were pregnant women who tested positive for HIV. They started to participate in the study when they were 28 weeks pregnant and made regular follow-up visits until their babies were 36 months old. They came at specific intervals starting from when their babies were three days old. During these visits, research assistants conducted structured interviews that lasted for approximately one hour. Most women became more confident to talk about their personal problems during the interviews as most questions elicited such information (Visser et al., 2004).

1.5 THE OBJECTIVES OF THE STUDY

The current study sought to provide an in-depth understanding of the women's experiences of violence before and after disclosing their positive HIV status to their partners. The study focused more specifically on exploring the following objectives:

- The preliminary status of participants in order to understand whether the violence started before or followed the disclosure of HIV status.
- The subjective experiences of women in relation to violence in their relationships before disclosing their HIV status to their partners.
- The women's experiences of violence following disclosure of their HIV status and also the patterns of violence before and after HIV were discovered.

The current health challenges of HIV/AIDS and domestic violence that are faced by women around the world, especially in Africa, are closely related to gender inequalities and domestic violence that have been fuelled by poverty and poor economic conditions. These factors will be discussed in detail in the next chapter. Therefore, when addressing HIV/AIDS in women and domestic violence, we should realise that we are dealing with a continuum or problems and with a range of factors that cut across the gender segment.

1.6 RESEARCH QUESTION AND EMERGING INTENTIONS

The question that will be answered in this study involves women's experiences of violence before and after disclosure of their HIV status. The researcher set out to uncover the patterns of violence that preceded the disclosure as well as the violence before HIV was discovered, in order to understand the dynamics of violent relationships when HIV is also involved.

In summary, this study was conducted with a view to understanding the complexities of the link between domestic violence and the disclosure of the HIV status. Attempts are therefore made to provide insight into the nature of the circumstances in which women in violent relationships are caught up with regard to the disclosure of their positive HIV status. Furthermore, insights are provided about how women feel about the violence in their relationships, as this area has not yet been thoroughly investigated (Dunkle et al., 2003). It is hoped that the findings that will be added to the existing body of knowledge will benefit other researchers in as far as further research in the area of HIV/AIDS and domestic violence is concerned.

1.7 CONCLUSION

This chapter introduced the research problem as well as the motivation for undertaking the research study. This was followed by a description of the background of the Serithi project so as to provide a clear picture of the researcher's clinical experiences. She also listed the aims of the study and finally provided a description of the research process and the emerging intentions.

In Chapter 2, the focus is on prior work that was done by other researchers on domestic violence and HIV/AIDS. Firstly, worldwide statistics of HIV/AIDS are provided, followed by the trends of this epidemic. This is followed by a discussion of the factors that contribute to the high prevalence rate of HIV in women, the statistics of domestic violence, as well its impact on women. Methods that have been utilised in

an attempt to prevent HIV infection and the spread of this epidemic are also discussed.

Chapter 3 is dedicated to a discussion of the theoretical approach used in this study. Firstly, the narrative perspective is discussed, after which the assumptions of this theory are outlined. The narrative theory in therapeutic situations receives some attention next, followed by a discussion of the motivation for using narrative theory together with the qualitative research method.

Chapter 4 focuses on the research methodologies employed in this research study – the research paradigm, the research procedures, the ethical issues that the study abided by and finally the method of data analysis that was used in this study.

Chapter 5 presents the results of the study and finally, drawing on insights gained from the above, highlights key issues relating to experiences of domestic violence, disclosure of HIV/AIDS status, as well as ways of coping with the violence.

Chapter 6 is dedicated to some conclusions drawn on the basis of this study and recommendations for future action and research.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

HIV/AIDS is indiscriminately affecting the lives of millions of people across the globe. The HIV prevalence rate also seems to be higher in women than it is in men due to social, cultural and biological factors. Domestic violence, in particular, plays a role in the high infection rate in women, as it limits their ability to adopt safer sex practices. Some women are exposed to domestic violence after disclosing their HIV status. Sub-Saharan Africa has the worst HIV/AIDS epidemic and the number of new infections is rising drastically on a daily basis. This chapter looks at the dynamics of HIV/AIDS, which include the current trends in HIV/AIDS, factors that contribute to the spread of this epidemic in women, as well as domestic violence and its impact. Finally, prevention measures are explored, including community-based HIV/AIDS projects and campaigns.

2.2 GLOBAL TRENDS IN HIV/AIDS

The statistics of HIV/AIDS are fluctuating every year as a result of the constant death and infection rates due to this epidemic. However, research findings have shown that the prevalence and incidence of HIV is shockingly high across the world. More than 25 million people have died of AIDS since it was discovered in 1981 (WHO, 2007). The HIV prevalence rate increased rapidly across the globe from approximately eight million people living with HIV in 1990 to more than 33 million at the end of 2007. More than two million people died of AIDS during 2007 and the number of new infections is still on the rise (WHO, 2007).

Research findings by Barnett and Whiteside (2006) indicate that 39,4 million people were living with HIV at the end of 2004. Of this number, 37,2 million were adults, while women accounted for approximately half of those living with HIV. During 2004, 4.9 million people were infected, of which 4.3 million were adults. Furthermore, 3.1 million people died of AIDS during the same year, with adults making up 2.6 million of those who died. Sub-Saharan Africa is the hardest hit region and accounted for approximately 25.4 million people who were living with HIV at the

end of 2005. The region's death rate also appears to be high, for example, 2 million people died of HIV/AIDS in Sub-Saharan Africa in 2004 alone (Berry, 2007).

South Africa, on the other hand, is currently worst affected in the world by the HIV epidemic. HIV infection rates and death rates are increasing and both are currently extremely high in South Africa. Approximately 1000 people die of AIDS every day and 71% of deaths are said to occur in young people between the ages of 15 and 49 years (Pembrey, 2007b). The 2004 survey of the South African Department of Health estimated that 6.29 million people were living with HIV at that stage (Barnett & Whiteside, 2006).

European countries as well as other American countries are also affected by the HIV epidemic. The infection rate is high in some parts of these countries and the situation is exacerbated by factors such as drug use and unsafe sex practices. For example, in Russia it was found that more than 80% of HIV cases occurred among drug injectors (Barnett & Whiteside, 2006). Many American countries report a high infection rate, whereas Asia seems to have quite a low rate of HIV infection. However, due to its huge population figures, even a small percentage of HIV-infected people implies an enormous number of cases. Although the infection rates differ from region to region, millions of people are also losing their lives to HIV in America as a whole (Barnett & Whiteside, 2006).

Despite the fact that HIV/AIDS affects both males and females, the prevalence rate worldwide appears to be higher in women than in men (Barnett & Whiteside, 2006; Suich, 2006). According to Kometsi (2004), this situation can be partially attributed to the biological make-up of women as the recipients of men's semen. Brouard, Maritz, Van Wyk and Zuberi (2004) believe that for the infection to occur there should be larger quantities of the virus in the blood and fluids, and exposure to the virus should last for a longer period. This biological factor interacts with socio-cultural factors, which will be discussed later on in this chapter when the focus will be on the rapid spread of HIV in women (Kometsi, 2004).

When we look at the statistics of HIV prevalence among women, results of studies by Barnett and Whiteside (2006) indicate that the female sex accounts for about 57% of adults living with HIV. Globally, these statistics are even higher among young women

between the ages of 15 and 24. The situation is worse in Sub-Saharan Africa as women account for more than half of those infected with HIV. Research results of Pembrey (2007b) indicate that one in every four young people living with HIV is a female. It was also found that among this 15-24-year-old group, there are 36 young women living with HIV for every ten young men (Barnett & Whiteside, 2006). Despite the already high HIV prevalence in Sub-Saharan Africa in both men and women, the infection rate is still on the rise. Trends in the HIV/AIDS epidemic indicate the gravity of this epidemic across different regions.

According to WHO (2007) statistics there were approximately 33,2 million people living with HIV worldwide at the end of 2007. Adults between 15 and 49 years of age accounted for a larger proportion of those living with HIV, and in Sub-Saharan Africa this age group accounted for 61%, that is, an estimation of 30.8 million people. Women were found to make up approximately 50% of those living with HIV worldwide, whereas people younger than 25 years of age accounted for half of the new infections worldwide. In 2007 there were 2.5 million newly infected people worldwide and 2.1 million died during the same year (WHO, 2007).

In Sub-Saharan Africa, approximately 22.5 million people were living with HIV during 2007 and the number of new infections skyrocketed to 1.7 million. This region accounted for 69% of all the people living with HIV around the world (WHO, 2007). There were 11.4 million orphans in 2007 and women accounted for 61% of those infected (Pembrey, 2007a). Although the infection rate in South Africa started to rise in the mid 1980s, we are currently experiencing the worst episodes of the HIV/AIDS epidemic (Pembrey, 2007b).

In Southern African countries such as Botswana, Lesotho, Swaziland and Zimbabwe, the HIV prevalence rate is currently higher than 20%. However, the corresponding rate seems to be less in West African countries such as Cameroon. Despite the fact that infection rates are lower in this region, there was a drastic increase in the prevalence rate in pregnant women between the ages of 20-24 during 1998-2000 (Pembrey, 2007b). The above statistics suggest that the infection rate is increasing faster in women and this state of affairs requires the examination of factors that contribute to the rapid spread of HIV in women.

2.3 FACTORS THAT CONTRIBUTE TO THE HIGH PREVALENCE RATE OF HIV/AIDS IN WOMEN

Research results indicate that women have been overlooked due to the fact that HIV was initially perceived as a gay man's illness (Barnett & Whiteside, 2006; Brouard et al., 2004; Centres for Disease Control and Prevention (CDC), 2007). It was never thought that women would acquire this disease and the focus was therefore on men. Moreover, certain social norms and expectations promote inferiority in women and encourage men to disregard risk behaviours that cause them to become infected or infect their partners (Brouard et al., 2004). Even when it was confirmed that HIV also affects women, the infection rate continued to rise due to social and cultural factors such as substance abuse, poverty, biological vulnerability and power relations, and violence against women. These factors place women in a subordinate position and give men the power to have control over women and make decisions in a relationship, including sexual decisions (Kometsi, 2004; The Norwegian Organisations, 2001). The CDC (2007) also highlighted multiple risk factors that are similar to the above mentioned which contribute to the rapid spread of HIV, for example, inequality in relationships, socioeconomic stress, substance abuse and psychological issues. A discussion about these factors will be given below.

2.3.1 SUBSTANCE ABUSE

Research by the CDC (2007) shows that an estimated one in five new female HIV cases is related to the use of drugs. Women who share syringes and needles when doing drugs are vulnerable to HIV infection as the needles are sometimes contaminated with HIV. Even those who do not inject drugs could also be exposed to the risks of getting infected when they sell sex in return for drugs. Basically, women who use drugs or alcohol are at high risk of getting infected because they may engage in unprotected sex while under the influence of such substances.

2.3.2 POVERTY

Financial dependency appears to be the main reason for risky behaviour. According to Kometsi (2004) and the Norwegian Organisations (2001), unemployed women are often economically dependent on men in most African societies. They depend on their

husbands for food and other necessities for their children. As was stated earlier, this economic dependency puts women in a position where men hold all the power and are able to decide their fate by making all (even sexual) decisions. Since they fear that their partners might neglect them, women often find it difficult to raise the issue of using condoms, even when they are aware of their partner's extramarital relationships (Kometsi, 2004; The Norwegian Organisations, 2001).

It seems that poverty also encourages risky livelihoods such as prostitution or transactional sex. Research findings have indicated that women end up engaging in prostitution in order to get money to care for their children (Dunkle et al., 2003; The Norwegian Organisations, 2001). It is often difficult for these women to tell their customers to use condoms, partly because they are in desperate need of money. Furthermore, since men usually also dominate in these situations, women are again in a subordinate position and unable to insist with their customers on the use of a condom (Berry, 2007; The Norwegian Organisations, 2001).

In some instances, women who have lost their partners to AIDS and are already HIV positive may go on to infect others in their attempts to escape poverty. They could engage in prostitution or transactional sex to make a living and survive, and in the process pass the virus on to their customers, who will in turn take the virus home to their wives (Berry, 2007). Apart from engaging in risky sexual behaviour, poverty could also force women to endure abusive relationships that will expose them to the risks of getting infected with HIV (Dunkle et al., 2003; Maman et al., 2001a; Pembrey, 2007b; The Norwegian Organisations, 2001; World AIDS Campaign, 2004). A discussion on the relationship between domestic violence and HIV/AIDS follows later on in this chapter.

Long and Ankrah (1996) indicated that women from all walks of life and different backgrounds are at risk of getting infected with HIV because of economic dependence and other social factors. When considering the factor of economic dependence, young women and teenagers, for example, are exposed to the risk of infection as a result of peer pressure and their parents' financial struggle. Due to the fact that they want to look glamorous, some of these young women end up dating older men (45 years old or even older) so that they can manage to get money and buy the latest fashion clothing. These men are often infected by their younger partners and spread the virus

further through unprotected sex with their wives. The exact opposite is also true. Research findings of the Norwegian Organisations (2001) show that women who are dating older men are usually unable to initiate the use of a condom. Thus, it appears that younger women are at equal risk of acquiring HIV from older men.

Long and Ankrah (1996) further argue that financial dependency puts married or single matured women at risk of HIV infection as they lack the ability to negotiate safe sex methods. This financial dependency places women in a subordinate position where they have limited ability to initiate the use of condoms. Although financial instability puts women at risk of HIV infection, their situation is the exact opposite of what it is for men. Research findings show that education and economic stability give men the opportunity to afford more than one sexual partner and therefore, ironically, it is their financial security that causes their increased risk of infection (Long & Ankrah, 1996).

Long and Ankrah (1996) also posit that social factors expose educated and financially independent women to the risk of HIV infection as a result of their partners' non-caring behaviour. According to Kometsi (2004) and Long and Ankrah (1996), men are seen as being responsible for the spread of HIV. These researchers suggest that it is socially acceptable for men to have more than one sexual partner while, at the same time, it is expected of their stable partners or wives to give them sex. Long and Ankrah (1996) hypothesise that women dare not deny their partners sexual pleasure for fear of losing them or failing to keep them at home.

2.3.3 DOMESTIC VIOLENCE

Domestic violence is another factor that contributes to the high HIV infection rate in women because their partner's violent behaviour causes women to be afraid of negotiating the use of safer sex methods or making any sexual decisions (Dunkle et al., 2003; Maman et al., 2001a; The Norwegian Organisations, 2001). Furthermore, violence has an impact on women's ability to take care of their health once they are infected with HIV as they are afraid to disclose their serostatus results. When they tell their partners about their positive HIV results, they are often physically abused or abandoned (Kometsi, 2004; The Norwegian Organisations, 2001). The interactive relationship between domestic violence and HIV/AIDS has received much attention in

a number of research studies as will be discussed in another section below in this chapter.

Domestic violence is experienced by the majority of women across the globe and is even more common in intimate relationships (WHO, 2000). This view is supported by Kapoor (2000) who indicates that domestic violence is often committed by men against women within the domestic sphere. It is defined as any act of violent behaviour directed towards women, which often results in physical or psychological suffering. This violence often takes the form of sexual, psychological or physical abuse (WHO, 1997).

Although domestic violence appears to be rife worldwide, its prevalence cannot be accurately estimated because, for various reasons, many cases are not reported to the police and other formal institutions. For example, some women refuse to report the violence that they are experiencing from their partners as they believe that they have done something wrong and therefore deserve to be beaten. Others fear that this could make their partners angry and inadvertently exacerbate the abuse. Still, other women are plainly ashamed of their situation and thus keep the abuse secret. Coerced sexual intercourse also occurs in intimate relationships and marriages, but most women are reluctant to report sexual abuse as they believe that their husbands have the right to unlimited sexual access (WHO, 1997).

In addition to the underreporting of domestic violence, available data in this area is also not reliable due to variations in sample sizes of women participants in different research studies. Moreover, researchers use different parameters when researching this issue. For example, one researcher could focus on physical abuse only, while another could be interested in a combination of physical and sexual or emotional abuse. Researchers could for instance ask if women had experienced any form of violence from their partners and then concentrate on responses that were in line with their area of focus (Kapoor, 2000; WHO, 2000). Although the statistics in this area of research are not reliable, available estimates will be provided on the prevalence of domestic violence in order to shed some light on the magnitude of this problem.

Findings of research reported on by WHO in 1997 indicate that one in every five women worldwide were experiencing some form of violence from their partners. In

countries where reliable surveys were conducted, it appeared that 16 to 52% of women had been physically assaulted by an intimate partner and 10 to 15% had been sexually abused. Women who were experiencing physical abuse and violence tended to suffer sexual violence more frequently than those who experienced other forms of abuse (WHO, 1997). In his book, AIDS Review, Kometsi (2004) indicated that the majority of men use physical violence as a way of resolving problems in relationships and as a means of showing their manhood. This form of abuse inevitably has negative consequences for their victims' physical and mental wellbeing as will be discussed below (Kapoor, 2000; WHO, 1997).

2.3.3.1 THE IMPACT OF DOMESTIC VIOLENCE

2.3.3.1.1 Physical impact

Although most domestic violence cases remain unrevealed and silent, women who are exposed to this problem are left with visible physical scars (Kapoor, 2000; WHO, 1997). Those who are physically abused often sustain bodily injuries such as bruises, minor cuts, fractures or permanent disability. In some instances, the abuse could lead to death when the woman incurs serious injury – this is often referred to as unintentional culpable homicide. Furthermore, due to the fact that some women keep the abuse secret, they are eventually overwhelmed by the situation and commit suicide in order to escape the violence (WHO, 1997).

If these women are not murdered by their partners or if they don't decide to end it all by committing suicide, they could well die from sexually transmitted diseases. This could happen because their partners' violent behaviour frightens them so much that they fear to raise the issue of adopting safer sex practices. This situation puts women at risk of contracting a sexually transmitted disease like HIV/AIDS that could cause their death (Kapoor, 2000; WHO, 1997). As indicated earlier by WHO (1997) and Kapoor (2000), the consequences of domestic violence are often concealed from the outside world, with the result that abused women also suffer from psychological and emotional harm.

2.3.3.1.2 Psychological and emotional impact

Women who are in abusive relationships often experience mental health problems as they endure the emotional and psychological abuse over a long time. In the long run, they sometimes develop effects like chronic fatigue, eating disorders, and appear to be depressed most of the time. Others may be anxious or display symptoms of posttraumatic disorder (WHO, 1997).

The emotional impact of violence could also be detrimental to the health of these abused women because they often have high levels of stress and suffer stress-related illnesses (Kapoor, 2000). However, there are women who, from the outset, find it difficult to cope with the emotional stress resulting from domestic violence in general and thus resort to high-risk behaviours.

Results of the study conducted by El-Bassel et al. (2006) show that both the physical and emotional abuse could drive women to engage in high-risk behaviours such as abusing alcohol or using drugs. They often use these substances in order to numb the emotional pain they are going through and this in turn exposes them to the risks of getting infected with HIV (El-Bassel et al., 2006) and eventually death due to high levels of stress (Kapoor, 2000). It has been found that even when abused women are aware of the violence in their relationships, they find it difficult to leave such relationships due to cultural and economic factors (El-Bassel et al., 2006).

2.3.4 SOCIO-CULTURAL FACTORS AND POWER RELATIONS

Women who are in abusive relationships often do not make an effort to find a job due to threats or fear of violence whereas others are forced to take low-paying, exploitative jobs as a result of the violence in their families. That is, they are I obliged to take such jobs as their partners put pressure on them to find a job and threaten them with violence if they fail to do so (Kapoor, 2000). These circumstances force women to stay dependent on their partner and also to endure all the abuse and violence that occur in their relationship. On the other hand, the fact that a woman is independent could also expose her to domestic violence. When she has a better-paying job and the partner is unemployed, she becomes a threat to him and this exposes her to the risk of violence (Kapoor, 2000).

Cultural factors put women in a subordinate position and give men the power to have control over women (CDC, 2007; Kometsi, 2004; The Norwegian Organisations, 2001; World AIDS campaign, 2004). Certain cultural constructions tend to legitimise violence against women and promote male dominance in other circumstances. For example, wife beating is accepted due to the fact that it is believed that men have ownership of their wives. This ownership furthermore gives men the power to make decisions within the relationship, the power to control women's sexuality and the power to make sexual decisions. These traditional customs seem to be indigenous as they evolve and continue through generations (Kapoor, 2000).

The findings of studies conducted by Maman et al. (2001a) also indicate that there are situations in which the beating of women is accepted. For example, when a woman refuses to have sex with her partner or has been unfaithful to him, or even when she is disobedient, physical punishment is warranted. However, punishment is considered normal and accepted if it does not leave any visible injuries or marks. Although other research studies did not focus much on punishment of women, they also confirmed that women occupy a subordinate position in marriage and relationships. Thus, they are more susceptible to domestic violence, which it turn enhances their risk of contracting HIV (Dunkle et al., 2003; Kometsi, 2004; Long & Ankrah, 1996; Maman et al., 2001a; Maman et al., 2001b; The Norwegian Organisations, 2001).

The social discourses about being a woman and the concept of masculinity place men and women in different positions on the social ladder. Women are given a subordinate position in marriage and relationships and are expected to leave the authority to make decisions in the hands of men. This situation obviously limits their own ability to make decisions, and their power to determine the circumstances surrounding sexual matters. On the other hand, men traditionally occupy a powerful position and bear the responsibility to make decisions (Kometsi, 2004; The Norwegian Organisations, 2001). Due to their position of power and expectations based on the concept of masculinity, men are under social pressure to behave in a domineering and sexually aggressive way – a behaviour that, ironically, enhances their risk of acquiring HIV. Unfortunately they also put their partners at risks of HIV infection and at the same time fuel the spread of this epidemic (Kometsi, 2004).

Sexually aggressive ways of displaying masculinity include behaviours such as having multiple partners, violence and exercising control over women. Furthermore, men are also expected to act out their masculinity by putting sperm into a woman's body and this prevents them from adopting safe sex methods even if they have more than one sexual partner (Kometsi, 2004; The Norwegian Organisations, 2001). This is an instance where the biological vulnerability of women is intensified by the common view of power relations in society.

Due to the social pressure on men to prove their manhood by engaging in multiple, unprotected sexual relationships, women are more predisposed to HIV infection. Their biological design causes them to carry the men's deposits for a long time (Kometsi, 2004; The Norwegian Organisations, 2001), thus making the odds much greater of being infected, than of infecting their partners. Furthermore, as a social expectation, women might even decide not to use condoms so that they can prove their fertility by falling pregnant.

Above and beyond this need to prove their worth as women, women tend to accept male domination in sexual relationships in many African cultures despite the fact that it places them at a disadvantage and makes it difficult for them to negotiate the use of safer sex methods (Berry, 2007; CDC, 2007; Kometsi, 2004; The Norwegian Organisation, 2001; World AIDS Campaign, 2004). According to research findings by Kometsi (2004), men interact with women mainly through sex and it is through this method that they come to show their manhood. As has been discussed above, this reputation of strength and domination is often obtained in an aggressive manner.

Furthermore, polygamous marriages are accepted and practised in various racial groups. This type of marriage greatly exposes women to the risk of HIV infection and at the same time fuels the spread of the epidemic. For example, if the husband has another sexual partner outside of the polygamous marriage, he exposes his wives to the risk of infection. This is equally true when any of the wives has an extramarital affair (The Norwegian Organisations, 2001). However, according to research findings of the World AIDS Campaign (2004) women do not have adequate knowledge of anti-HIV behaviour and their protection against infection therefore depends on the men. Also, prevention methods that can be controlled by women, such as

microbicides, are currently not available and thus women rely on men's assistance and understanding for condom use.

2.3.5 BIOLOGICAL VULNERABILITY AND POWER RELATIONS

As it has already been indicated in the section above, women are more likely to get infected with HIV during a single session of unprotected sexual intercourse than are their male counterparts due to their biological makeup (CDC, 2007; World AIDS Campaign, 2004). Empirical evidence shows that this vulnerability interacts with a number of socio-cultural factors (including power relations between men and women) and this interplay increases the risk of HIV infection on the part of women (CDC, 2007; Kometsi, 2004; Long & Ankrah, 1996; The Norwegian Organisations, 2001). Moreover, men seem to have different perceptions regarding the use of condoms and sexual habits that could limit the rate of HIV infection, such as masturbation (Kometsi, 2004).

2.4 DOMESTIC VIOLENCE AND HIV/AIDS

There appears to be a relationship between HIV and domestic violence in a wide range of dimensions, inter alia violence and disclosure of the HIV status (Gielen, McDonnel, Burke & O'Campo, 2000; Kometsi, 2004; Maman et al., 2001a; Maman et al., 2001b). These researchers found that, due to violence within the domestic sphere, women are often afraid to disclose their HIV status to their partners. They are even more afraid of their partner's reaction when there is a history of violence in the relationship. The violence also acts as a barrier for women to go for HIV testing as they fear an escalation of violence or the outbreak of renewed violence in the relationship.

In their study that focused on the barriers to HIV testing and disclosure of HIV status, Maman et al. (2001b) report that women often had to ask for permission from their partners to go for HIV testing. It was found that due to fear of their husband's reaction, especially possible abandonment and violence, some women were reluctant to discuss the issue of testing with their partners. They would do anything to avoid conflict, especially if there was some history of violence. However, circumstances eventually forced them to go for testing, even without the consent of their partners.

This usually happened when they started suspecting that they themselves could be HIV positive, for example, when the partner or child fell sick, or when she lost either of the two (Maman et al., 2001b).

In those cases where the decision to test was not due to the partner's death, women are faced with the difficulty of disclosing their test results to their partners, especially when they tested positive. This situation is greatly exacerbated if the partner reacted negatively when the woman asked permission to get tested. For example, in some instances the partner would discourage the idea of testing and even become violent. Therefore, this negative and violent behaviour compels women to keep quiet about their serostatus results in order to avoid conflict and, most of all, abandonment (Maman et al., 2001b). Some of those who decide to tell their partners about the results are often physically abused or abandoned (Kometsi, 2004; Maman et al., 2001b). Quite the opposite is true for the men. According to Maman et al. (2001b), men need not ask for permission from their partners before going for testing. Moreover, they do not experience any difficulty in telling their partners about their test results, even if the results were positive.

In some instances, women may simply decide to go for testing without discussing this issue with their partners beforehand. However, they still become afraid to tell their partners about the HIV positive results. Results from studies by Maman et al. (2001a) focusing on HIV and partner violence have indicated that fear of a partner's reaction is a barrier to disclosing HIV status. In most cases, women fear that their partners will abandon or physically abuse them. This situation appears to be more prevalent among women who are already experiencing physical violence in their relationship. Maman et al. (2001a) nevertheless found that a number of women who have disclosed their positive HIV status to their partners were actually physically abused or abandoned or chased out of the house.

The study by Dunkle et al. (2003) aimed to describe the association between gender violence and HIV infection for women attending antenatal clinics in Soweto. Dunkle's team reached findings which indicated that power inequalities cause women to adopt a subordinate position where they are unable to make sexual decisions. Even when they know that their partners have other sexual partners, they are still not in a position to insist on the use of condom. Thus, the high-risk behaviour of their partners

puts them at risk of getting infected (World AIDS Campaign, 2004). In some instances, women end up engaging in transactional sex in order to gain material things and money from men (CDC, 2007; Dunkle et al., 2003; El-Bassel et al., 2006; World AIDS Campaign, 2004). In most cases, they are forced to submit to whatever decisions made in any relationship because of their subordinate positioning (Kometsi, 2004). To crown it all, they are at risk of being physically abused by their intimate partners, abandoned or divorced should they be diagnosed with HIV – regardless of whether their partner actually caused the infection.

Although the cure and treatment of HIV and prevention methods fall outside the scope of this study, they are important to note and will therefore be discussed very briefly in the following section.

2.5 THE CURE AND TREATMENT OF HIV

Antiretroviral drugs (ARVs) were developed around 1996 to reduce the viral load and thus prolong the life of the infected person. These drugs were initially used especially in the economically developed countries of the world (Brouard et al., 2004; Pembrey, 2007a). In 2002 Botswana was the first African country to provide ARV treatment and South Africa followed in 2004. The South African government was reluctant to start providing ARV treatment, partially as the result of the statement made by the former President, Mr Thabo Mbeki, as to his uncertainty about whether HIV really caused AIDS. The situation was perpetuated by the advice of the then Health Minister (Dr Manto Chabalala-Msimang) to HIV-infected persons to simply eat good food and nutrition rather than take ARV drugs for the treatment of HIV (Pembrey, 2007b). Even though the cure for HIV is not available, deliberate efforts are made to prevent new infections and the spread of HIV/AIDS (Brouard et al., 2004).

2.6 METHODS FOR PREVENTING HIV/AIDS

Condoms are regarded as a reliable means of preventing HIV infection and have been distributed in many countries in Sub-Saharan Africa (Pembrey, 2007a). However, it is not always possible to use condoms due to social, cultural and practical factors. For example, it is difficult to suggest that a condom be used in a stable relationship where both partners are still planning to have children (Pembrey, 2007a). Furthermore,

women are sometimes afraid to ask their partners to wear condoms due to their inferior positioning in a marriage and their fear of being physically abused (Dunkle et al., 2003; Maman et al., 2001a; The Norwegian Organisations, 2001). Therefore, efforts are being made to reduce the infection rate and also to empower women to protect themselves against infection (Brouard et al., 2004). Scientists around the world are trying to develop an AIDS vaccine that will fight the HI virus and kill it when it enters the human body. Unfortunately it is still going to take a long time before such a vaccine will be available (Brouard et al., 2004).

Efforts are also made to refine a product called Microbicide, which will help prevent HIV infection specifically in women. This product will be in the form of a gel or cream that has to be applied to the female genitals. It would be extremely helpful for women because it will put them in the position to protect themselves. However, Microbicide will only be available in a period of five to seven years (Brouard et al., 2004). According to the CDC (2007), there is much support for developing Microbicide, and laboratory tests and animal studies are performed to test the effectiveness and safety of these products before approval of their use on human beings.

There is as yet no cure or vaccine available for HIV, but sustained efforts are being made in many countries to encourage healthy and safer sex methods and to promote public awareness with regard to HIV/AIDS (Brouard et al., 2004).

2.7 HIV/AIDS PREVENTION CAMPAIGNS

Already in 1988, the World Health Organisation declared 1 December as the first World AIDS Day – a special day on which people and organisations across the globe came together in an effort to raise awareness on HIV/AIDS.

According to research by Pembrey (2007a), HIV prevention campaigns are being carried out across the globe to curb the spread of the HIV epidemic. These campaigns led, for example, to a decline in the HIV prevalence rate among adults in Senegal. The campaigns also had a positive impact in Uganda, where the HIV prevalence rate dropped from around 15% in the early 1990s to approximately 5% in 2001. Some of these campaigns include the World Aids Campaign, Love Life, Soul City, the

Khomanani project (Caring together), the Beyond Awareness campaign and the Serithi project. A description of each of these awareness campaigns or projects follows below:

2.7.1 World AIDS Campaign

The World AIDS Campaign, an international initiative that was launched in 1997 by UNAIDS, focuses on issues concerning HIV/AIDS and raising awareness about it. The focus of the campaigns changed every year. For example, in 2002 and 2003 it was on general issues surrounding HIV/AIDS, while in 2004 it was on women and young girls.

2.7.2 LoveLife

This project was started in South Africa in 1999. Its main focus is on the youth and it aims at reducing the rate of teenage pregnancies, sexually transmitted diseases and HIV infection. It uses the media to convey the message of sexual responsibility to young people and provides youth centres that provide sexual health facilities, especially at clinics. The LoveLife campaign aims at increasing the adoption of safer sex methods and promotes knowledge and awareness about HIV/AIDS. It also conducts outreaches to rural areas where young people are not part of the educational system (Pembrey, 2007b).

2.7.3 Soul City

This is another nationwide campaign that uses the mass media to raise HIV/AIDS awareness. The Soul City project started in 1994 in South Africa and educates people about AIDS through the radio, the printed media and television. Its message is conveyed by means of entertainment, such as dramas and ‘soapies’ (Pembrey, 2007b).

2.7.4 Khomanani Campaign (Caring together for life)

This is a SA Government mass media and communications initiative that aims to reduce new HIV infections and increase treatment, care and support for those infected and affected by HIV and AIDS. It involves wide-ranging use of mass media and

conveys messages through the use of the mass media and the involvement of celebrities (Pembrey, 2007b). The campaign was launched in 2001 and is managed by the Khomanani Communication Consortium (KCC) on behalf of the national Department of Health.

2.7.5 Beyond Awareness Campaign

This was a project of the HIV/AIDS and STD Directorate of the South African Department of Health, which ran between 1998 and 2000. It focused on educating young people about HIV through the media (Pembrey, 2007b).

2.7.6 Serithi Project

The Serithi project is explained in detail as it constitutes the context of the current study. (Other research studies emerging from the Serithi project will also be touched on.) As mentioned in Chapter 1, the Serithi project is a community project that operated in Atteridgeville and Mamelodi between 2003 and 2007. The project focused on HIV-positive pregnant women and aimed at promoting healthy lifestyles. This included infant feeding methods, adopting healthy ways of living with the HI virus and condom use. The Serithi project comprised two cohort groups. A support programme was developed during the second phase of the project in order to empower women and help them cope with their HIV-positive status **(**Jeffery et al., 2005,). This support programme involved structured support groups meeting for twelve sessions that were facilitated once a week in Mamelodi as well as in Atteridgeville. The facilitators of the support groups were well trained, especially in ethical issues focusing on research conducted with human beings (Jeffery et al., 2005).

The topics that were discussed in the support groups were the following:

- Week 1: Introduction and Orientation
- Week 2: HIV and access to treatment
- Week 3: HIV, pregnancy and birth
- Week 4: The emotional experience of having HIV
- Week 5: The emotional experience of having HIV (continued)

- Week 6: HIV, disclosure and stigma
- Week 7: Coping, problem solving and stress management
- Week 8: HIV and relationships
- Week 9: HIV and relationships (continued)
- Week 10: HIV, human rights and stigma
- Week 11: Socio-economic survival and decision making
- Week 12: Life planning and goal setting

Another research study that emerged from the Serithi project based its focus on evaluating the impact of the above structured support groups on HIV-positive women. Mundell (2006) indicates that most HIV-positive women find it difficult to disclose their HIV status for fear of the negative reactions of others and the stigma associated with the disease. This silence makes it hard for them to cope with their positive status. They do not have anyone to talk to about it and this in turn prevents them from getting social support. Mundell (2006) argues that the structured support groups of the Serithi project had a significant impact on the participants and enabled them to cope better with their status.

According to Mundell (2006), the support group also provided participants with a non-judgemental environment where they were able to talk freely about their status and share with one another their experiences of living with HIV. The participants supported each other and this environment uplifted their self-esteem, enabled them to accept their status and also to disclose their positive status to others. Moreover, they were able to focus on positive and healthy lifestyles such as seeking medical help, using condoms and following a nutritious diet.

2.8 CONCLUSION

This chapter gave an overview of the current situation with regard to the statistics of the HIV/AIDS epidemic worldwide. It explored factors that contribute to the spread of HIV, especially in women. The complexities of HIV testing, disclosure of the HIV status and domestic violence were also touched on. Treatment for HIV and prevention measures were discussed, including community-based projects and campaigns. The various AIDS campaigns were briefly discussed with a more in-depth discussion of

the Serithi project as the context of the study. The following chapter will focus on the theoretical approach that was used in this study.

CHAPTER 3

THEORETICAL POINT OF DEPARTURE

3.1 INTRODUCTION

The narrative approach was decided on in order to achieve the objectives of this study. The narrative perspective will therefore be discussed next, followed by the assumptions of this point of view. The application of the narrative theory in therapeutic situations will be considered, as well as how this theoretical approach was relevant for the qualitative research method chosen for the study.

3.2 THE NARRATIVE PERSPECTIVE

The narrative approach is interested in the subjective meanings that participants give to the events and social interactions that have constituted their lives (Lieblich & Josselson, 1997). It is embedded in the views of constructivism and social constructionism (Drewery & Winslade, 1997; Freedman & Combs, 1996; Minuchin, 1991; Weingarten, 1995). The central tenet of constructivism is that objectivity is impossible. According to this view, meaning is actively constructed through language, by all parties involved, rather than being simply transferred. For example, in therapeutic situations, both the therapist and the client become actively involved in the process of creating meaning in the client's life (Minuchin, 1991). The social constructionist view claims that meaning is constructed within a social context through language (Drewery & Winslade, 1997; Freedman & Combs, 1996; Weingarten, 1995).

Gergen (1991, as cited in Weingarten, 1995, pp. 1-2) list the following assumptions of social constructionism:

- The terms by which we understand the world are a product of historically situated interchange between people, not reflections of an objective reality outside of us that can be known through ever more accurate empirical investigations.
- The degree to which a given understanding prevails is not fundamentally dependent on its objective validity, but on its use by a community of speakers, listeners, writers and readers.

- What we know and understand is shared with others and these negotiated meanings influence the actions we take.

In both the constructivism and social constructionist views of narrative theory, language is regarded as the main tool for creating meaning. It enables participants to speak from their subjective point of view about their lived narratives and experiences (Drewery & Winslade, 1997; Freedman & Combs, 1996; Minuchin, 1991; Weingarten, 1995). Furthermore, participants are free to "talk in their own words about events and experiences and to describe their feelings and thoughts they have about them" (Lieblich & Josselson, 1997, p. 121). According to Freedman and Combs (1996, p. 28), "language is an interactive process, not a passive receiving of pre-existing truths". The definition of a narrative is provided below in order to illustrate the significance of language in this perspective.

A narrative is defined as the "recounting…of one or more real or fictitious EVENTS communicated by one, two or several (more or less overt) NARRATORS to one, two or several (more or less overt) NARRATEES…" (Abbott, 2002, p. 13). According to Abbott (2002), this definition shows that for a narrative to occur, there should be a person who tells the story and others listening to the story being told. He goes on to say that the most distinctive feature of a narrative is that events are represented in a sequence as they have occurred. Such narratives are characterised by constituent events that drive the story. According to Freedman and Combs (1996, p. 33), narrative therapy "is about the telling and reliving of stories". The stories include the past, present, future and culture.

The context in which meaning arises is also important in the narrative approach (Drewery & Winslade, 1997; Freedman & Combs, 1996; Weingarten, 1995).According to Freedman and Combs (1996), when people talk about their problems, they construct and create meaning in relation to the context they find themselves in. For example, the cultural context plays a very important role in people's lives and some of the narratives that are constructed during social interaction become dominant. Therefore, when individuals talk about their experiences, they often create meaning on the basis of these dominant cultural narratives, as well as on the basis of the personal stories where they position themselves. According to

Drewery and Winslade (1997), dominant stories about how things should be, often shape the stories people tell about their lives and they therefore create meaning on the basis of such dominant discourses.

Drewery and Winslade (1997) also argue that discourses can situate people in particular positions in their relationship with others. For example, a person can be situated in a dominant or subordinate position, depending on the prevailing discourses about how that particular person is expected to be positioned in relation to others of the opposite gender, younger or older age, or different race . Drewery and Winslade (1997) gave an example of family discourses as an example to clarify the issue of positioning. According to that example, a wife is expected to behave in a certain way in relation to her husband and the same applies to a position given to a mother in relation to a father. In this study, socio-cultural factors situate women in a difficult position where they lack the ability to make decisions.

3.3 THE ASSUMPTIONS OF THE NARRATIVE THEORY

According to Drewery and Winslade (1997), Freedman and Combs (1996), Minuchin (1991), Waldegrave (1990) and White and Epston (1990), assumptions of narrative theory include the following:

3.3.1 Realities are socially constructed

According to this view, people interact with one another in social situations to construct meaning. The construction of realities involves three processes, namely typification, institutionalisation and legitimation (Freedman & Combs, 1996).

- Through the process of typification, perceptions are sorted into types and these typifications are learnt and adopted from interactions with certain social groups such as families, friends or other social groups.
- The process of institutionalisation gives rise to the emergence of institutions on the basis of classes or types of typifications that have been socially constructed. For example; women who have children are classified as mothers and the institution that arises around this class of mother is called motherhood.

- Legitimation is the process of legitimising the type and institution that have been socially constructed. When people often talk about the institutions and typifications that have been socially constructed, they legitimise such terms. For example, children always address their mothers as mother and in doing so, they legitimise the type or class of mother.

3.3.2 Realities are constituted through language

As mentioned earlier, language is regarded as the main tool for constructing meaning. People construct realities during social interaction with others and use language in relation to the context. However, language is ever changing and therefore allows for the construction of new meanings for problem situations (Drewery & Winslade, 1997; Freedman & Combs, 1996; White & Epston, 1990).

3.3.3 Realities are organised and maintained through stories

People construct the meaning of their lives through telling stories (Waldegrave, 1990; White & Epston, 1990). Freedman and Combs (1996, p. 33) put it this way: “So, narrative therapy is about the retelling and reliving of stories. As people retell their stories in therapy, they often notice that they have already experienced participating in an alternative story.” They also remark that people pass on the realities they have lived to others through language and in the form of stories. McLeod (2001, p. 104), is of the opinion that “the key idea in narrative analysis is that people largely make sense of their experience, and communicate their experience to others in the form of stories”. Drewery and Winslade (1997) also suggest that people construct the meaning of their lives in social interaction through telling stories.

3.3.4 There are no essential truths

Experiences are interpreted in different ways from the narrative point of view and this suggests different meanings or truths (Freedman & Combs, 1996). According to this view, there is no essential truth when it comes to interpreting people’s experiences. When people talk about their experiences, they often tell and retell their stories from different points of view and this gives new and different meaning to their experiences. The stories change because the problems are talked about from different contexts. At

the same time, people view themselves differently in different contexts and such descriptions are not regarded as essentially true. Therefore, in narrative, therapists help clients to present themselves in the manner they prefer within the relevant context (Freedman & Combs, 1996). According to White and Epston (1990), the definition of a person's problem evolves because people often struggle to find appropriate words that could help in providing a clear representation of their experiences.

3.3.5 Narrative theory in therapeutic situations

The narrative theory is often used in therapy sessions with clients. Language remains the main tool for constructing meaning, even in therapeutic situations. Both the client and the therapist become actively involved in the creation of the client's meaning of life. However, the client is allowed or given the opportunity to be an expert when talking about his or her experiences, while the therapist speaks less. At the same time, the therapist shows curiosity about and interest in the client's stories through probing. The therapist also helps the client to externalise the problem and thus enables him or her to reconstruct a positive meaning of his or her life. The assumptions of narrative therapy are briefly listed as follows (Drewery & Winslade, 1997; Freedman & Combs, 1996; Waldegrave, 1990; White & Epston, 1990):

- The client's language is important in creating meaning.
- Clients are experts in talking about their problems. This instils a sense of hope in the client and also brings confidence. People are given the freedom and enough time to talk about their experiences.
- Narrative therapists adopt a curious stance and show interest in listening to the client's stories.
- Meaning emerges from context. Meaning arises in the context of our social histories and the histories that we tell about our lives give meaning and coherence to our lives.
- The therapist helps the client to externalise the problem.
- The problem has to be externalised. The problem is the problem and it is separated from the person and dealt with as an entity. The therapist helps the client to externalise the problem and also helps in deconstructing problem-saturated stories

through asking questions. Through externalisation of the problem, people are able to identify lived experiences that do not form part of and contradict dominant stories. This enables the person to experience a sense of personal agency and to realise his or her competency in taking a stand against the problem. Through this process, people are able to re-author their lives and interactions with others.

3.4 MOTIVATION FOR UTILISING THE NARRATIVE APPROACH

The narrative approach assists in obtaining valuable data for this study as language is used as the main tool for constructing meaning. In this study, the data was collected by means of individual, semi-structured interviews and language was used as a tool for talking and understanding participants' experiences of violence in their relationships. The researcher was the main instrument for collecting data and the stories that participants told were treated as primary sources of data. Since Freedman and Combs (1996, p. 28) mention that "language is an interactive process, not a passive receiving of pre-existing truths", the researcher worked in collaboration with the research participants to help each of them to create meaning of their lives.

During the interviewing process, the researcher adopted a 'not-knowing' position (McNamee & Gergen, 1992). In other words, she allowed participants the opportunity to talk about their experiences at length, since they themselves are viewed as the experts on their lives and subsequent situation. She also approached the interviews from the angle of some of the assumptions of narrative therapy that were mentioned above, such as showing curiosity, treating participants as experts and also attending to contextual stories (Drewery & Winslade, 1997).

3.5 NARRATIVE THEORY AND THE QUALITATIVE RESEARCH METHOD

The narrative approach was preferred for this study because the concepts of constructivism and social constructionist on which this approach is based, relate to the definition of qualitative research method, which will be discussed in detail in the following chapter. These concepts emphasise the importance of understanding meaning in the client's context, whereas the qualitative research method also argues that a phenomenon should be studied holistically in its natural setting (Newman,

1997; Newman, 2000). The current study was conducted in the natural setting of women and the data was derived directly from the women who were caught up in the context of domestic violence and cultural discourses.

Both the narrative theory and qualitative research method are flexible and spontaneous in nature and allow for the emergence of new stories. The conversational style of the narrative approach and the spontaneity of qualitative research gave the participants the opportunity to tell their stories in an unrestricted fashion (Drewery & Winslade, 1997; Freedman & Combs, 1996; Minuchin, 1991; Newman, 1997; Newman, 2000; Weingarten, 1995). In the current study, the problem involves domestic violence among women who are HIV positive and the narrative therapy approach was used to observe this problem from the view of the women's own context and experiences.

In the qualitative research paradigm (to be discussed in Chapter 4), the researcher is the primary instrument for data collection and analysis. In the present study, the researcher interacted with participants, collecting data from them mainly though semi-structured interviews, subjectively interpreting it and presenting it as a narrative. Thus, she did not intend to gather information for the sake of quantifying what is out there because, as argued above, no singular account constitutes the truth. Instead, this study acknowledges the qualitative researcher as being interested in understanding the meaning people have constructed and not the explanation given. Moreover, there are many possibilities of interpreting any experience (Freedman & Combs, 1996). In this study, the researcher's aim was to understand domestic violence within a particular context, thus generating the subjective meaning of data.

3.6 CONCLUSION

Chapter 3 focused on the theoretical approach, namely narrative theory, which was used in carrying out this study. The narrative approach is interested in the subjective meaning that people give to events in their lives. The definition of a narrative was given, followed by a detailed discussion of the constructivism and constructionism viewpoints on which the narrative theory is grounded. According to these viewpoints, meaning is actively constructed in social situations through language. The assumptions on which the narrative theory is based were discussed, as well as the

application of this theory in therapeutic situations. In the current study, the narrative approach was used together with the qualitative research method, as they are both flexible and spontaneous. Language is regarded as the main tool for collecting data and for understanding the experiences of women. The qualitative research method that was utilised in this current study will be discussed in detail in the following chapter.

CHAPTER 4

RESEARCH PARADIGM AND METHODOLOGY

4.1 INTRODUCTION

The focus of this chapter is on exploring the research methods and tools utilised by the researcher to achieve the aim of this study. Firstly, the qualitative research paradigm is discussed, followed by the research procedures which include the sampling method, data collection procedures and the setting. Ethical issues that the study abided by will also be discussed, namely informed consent, harm to participants and privacy/confidentiality.

Finally, the data analysis method will be discussed.

4.2 QUALITATIVE RESEARCH PARADIGM

This study was conducted within a qualitative paradigm, using an interpretive design in a purposeful sample selection. Although the qualitative research method is defined differently by different researchers, there is general consensus that this method of research is flexible and interested in the subjective meaning of a phenomenon in its natural setting (Black, 1999; Terre Blanche, Durrheim & Painter, 1999; Newman, 1997; Newman, 2000; Silverman, 2000; Witley, 2002). According to Terre Blanche et al. (1999), the qualitative research paradigm is an inquiry that focuses on understanding phenomena in their natural setting as they unfold. Since this research method allows for the exploration of emerging issues, it provides an in-depth description of the phenomena.

Newman (1997) sees qualitative research as an inquiry that focuses on meaning in context and that pays attention to the sequence of events. He argues that it allows the researcher to document real events in their natural settings and record what people say. According to this definition, the researcher focuses on the subjective experiences of participants and the meanings they attribute to their experiences. The current study of domestic violence and HIV/AIDS aims to understand the subjective experiences of women with regard to the situation at home.

According to McLeod (2001, p. 1), “qualitative inquiry offers a set of flexible and sensitive methods for opening up the meanings of areas of social life that were previously not well understood” and language is therefore used as a tool to construct and convey a new understanding in social situations. Witley (2002) maintains that qualitative research focuses on the subjective experiences of people about events in their lives. He goes on to say that this approach allows for the emergence of new issues where the researcher becomes inseparable from the research process. Silverman (2000) defines qualitative research as the inquiry that seeks to provide an in-depth understanding of social phenomena. He goes on to say that it is a flexible method of doing research that bases its interest in subjectivity, which allows meaning to unfold in its natural setting.

These definitions illustrated to the researcher that meaning is constructed by individuals and shaped within their society or context. She therefore adopted the interpretive qualitative design in order to achieve the objectives of this study and understand the experiences and stories of women in depth. The research design maintains that “reality to be studied consists of people’s subjective experiences of the external world” and that the researcher becomes a primary tool for both collecting and analysing data (Terre Blanche et al., 1999, p. 6). Although the participants share their lived experiences from their own subjective experiences, the researcher interacts with them and empathetically interprets the meaning of what was said.

According to Newman (2000), interpretive researchers are interested in how people subjectively experience their lives and they explore these experiences in order to understand what is happening to people who are directly involved. In the current research study, the interpretive research design allowed the researcher to gain insight into the phenomena of domestic violence and HIV disclosure by means of exploration and intersubjectivity (Terre Blanche et al., 1999).

Women’s experiences of domestic violence and their positive HIV status was understood from the perspective of their subjective experiences through the narrative theoretical point of view that was discussed in Chapter 3. The data collection process took place in the natural setting of these women, namely through the Serithi project office at Kalafong Hospital. The hospital seemed to be more of a home to most of the Serithi clients, as participants indicated that they relaxed and felt free to talk about

their personal issues when they were at Serithi. The research procedures that were followed in the collection of data are explained in the following section.

4.3 RESEARCH PROCEDURES

4.3.1 Sampling method

According to Newman (1997), sampling is a practical process of selecting a case for participation in a research project. The sampling procedure employed for this study was a non-probability type of sampling, namely purposive sampling (Black, 1999; Newman, 1997; Newman, 2000; Silverman, 2000; Witley, 2002). According to Newman (2000) and Newman (1997), purposive sampling is often used in exploratory research whereby the researcher uses his or her own judgement in selecting participants. Silverman (2000) and Black (1999) also suggest that purposive sampling allows the researcher to choose participants on the basis of features or characteristics that are relevant for participation and meet the criteria of the research.

When using the purposive sampling technique, the researcher selects participants through identifying those who possess most of the characteristics or attributes that are required for the research study. This helps to ensure that the characteristics of the participants who are judged are relevant to and appropriate for answering the research question (Black, 1999; Silverman, 2000; Witley, 2002). In this research study, participants had to meet the following criteria:

- The woman must be HIV positive.
- She must be married or living with a partner.
- Her relationship with this partner has to be characterised by some form of violence.
- She must be between 20 and 35 years of age.

Because it is a method that is recommended in exploratory studies (Newman, 1997), the purposive sampling method was used to select research participants from the Serithi project and gain an in-depth understanding of the life stories of participants. Although the researcher was able to identify women who were relevant for participating in this current study, participants were provided with an opportunity to make voluntary choices regarding participation by putting up invitation posters at the

Serithi consulting offices. That is why only two women stepped forward to participate as mentioned and discussed in Chapter 1. Moreover, the Serithi project was nearing its end when the invitation posters for participation in this study were put up and most of the clients did not get the opportunity to see them as they had already come for their last interviews. The researcher therefore examined the data in a case study manner and provided an in-depth analysis of the results.

4.3.2 Data collection procedure

Semi-structured one-on-one interviews during which open-ended questions were asked, were used as the data collection method (Terre Blanche et al., 1999). According to Rubin and Babbie (1997), this method makes the interview flexible as the researcher "is able to follow up particular interesting avenues that emerge in the interview, and the participant is able to give a fuller picture" (Strydom, Fouche & Delport, 2002, p. 302). A couple of questions with which to begin the conversation were prepared in order to elicit information that would most probably answer the research question (Strydom et al., 2002; Terre Blanche et al., 1999). (See Appendix C.) The researcher was the data collector in this study and thus conducted the interviews in Northern Sotho as most of the Serithi participants are fluent in this language.

The interviews were recorded on a mini audiotape and transcribed verbatim. Since the researcher is fluent in both the Nothern Sotho and English languages, she then translated each Sotho transcript into English prior to data analysis. Once the transcripts had been completed, each of the participants was invited to read through them to ensure that their specific interview had been captured correctly according to their recollection/perception of it. During this session, the researcher also indicated that they were free to add to the transcript any further information that they felt would be relevant (Newman, 2000). Since the session also provided a platform for further discussion on the topic, detailed notes were taken of it.

To avoid disturbing the flow of the interviewing process, notes were made immediately after each interview to ensure accuracy and confirmation of the transcripts (Terre Blanche et al., 1999; Newman, 1997). Moreover, pseudonyms were used to keep the participants' identity confidential (Newman, 2000). The researcher's

personal feelings, impressions, and thoughts were recorded after each interview as well as her reflections on and thinking about the data and coding (Rubin & Babbie, 1997).

4.3.3 Setting

Interviews were conducted at the Serithi project offices at Kalafong Hospital. In this quiet environment and safe setting, the participants felt comfortable to reveal their personal stories. Although the offices are located on the premises of the hospital, they are at the back, far from the hospital wards, with no frequent movement or noise. However, they are easily accessible and provided maximum privacy for the two participants (Strydom et al., 2002). Ethical issues were adhered to throughout the research process.

4.3.4 Ethical issues

Informed consent

The researcher discussed the consent form (see Appendix A) with each participant before starting with the interviewing process. She gave them the opportunity to ask questions, and then answered the questions they had about this research study. A detailed description of the nature and objectives of the study was given to participants to enable them to make a voluntary decision regarding participation. She also asked their permission to record the interview and the process only commenced after a consent form had been signed (Strydom et al., 2002).

Harm to participants

The researcher ensured that participants were protected against physical, psychological or emotional harm by keeping all the information gathered during the data collection process confidential (Rubin & Babbie, 1997). Moreover, she informed them about the potential impact of the investigation in terms of unearthing painful experiences that might arouse emotional hurt and thus offered them the opportunity to withdraw from the study if they so wished.

Privacy / confidentiality

Strict confidentiality was adhered to throughout the research process. Verbal assurance was given to the participants that any information obtained from them during the data collection process would be kept confidential (Strydom et al., 2002). Care was taken not to reveal the identity of participants in documents and pseudonyms were used (Newman, 2000; Terre Blanche et al., 1999). Permission to use audiotapes was obtained from the participants (Newman, 1997).

4.3.5 Data analysis

This research study used the immersion/ crystallisation style in analysing the data obtained from the participants. In terms of this method, the researcher looked at all the data material and read them thoroughly as many times as possible so as to develop themes. She subsequently reviewed these themes again, elaborated on them and classified pieces of information that seemed to belong together under relevant themes (Terre Blanche et al., 1999).

McLeod (2001, p. 104) argues that "the key idea in narrative analysis is that people largely make sense of their experience, and communicate their experience to others in the form of stories". While analysing data in this study, the researcher took all her field notes and the interview transcripts and immersed herself in those again. That is, she read the material over and over again, reflecting on the interviews in order to get a clear understanding of the women's stories. She then developed main themes from those stories that were most relevant for answering the research question and that correlated with the literature review. The main themes in this study included the women's experiences of violence and abuse (physical, emotional, sexual and financial) before and after they were diagnosed with HIV. Sub-themes were also developed from the main themes, for example socio-cultural factors, participants' reactions to the positive HIV results, disclosure of the HIV status as well as the partner's reactions to the HIV results.

After developing the themes, the researcher started coding the data. During this stage, she classified pieces of data that belonged together under relevant themes in order to make sense of them. To ensure that data had been coded meticulously under

appropriate themes, she read the themes through once again. Finally, she interpreted the findings by using the themes that were developed during the data analysis process as sub-headings. She then considered her own behaviour during the data collection process to see if this could have influenced either the collected data or the analysis (Terre Blanche et al., 1999).

As mentioned earlier, the participants were invited to read through the interview transcripts and to voice their comments about the transcripts.

4.4 CONCLUSION

Chapter 4 was devoted to the research methods that had been utilised in the study. The qualitative research method was used to achieve the objectives of the study as it is flexible and focuses on the subjective meaning of a phenomenon in its natural setting. The qualitative research method was used following a purposive sampling method in the selection of participants. Attention was also given to ethical issues and the data collection procedures that were followed in this study. Lastly, the immersion/ crystallisation data analysis method was discussed. The findings of this current study will be presented in the following chapter.

CHAPTER 5

WEAVING THE STORIES TOGETHER

5.1 INTRODUCTION

This chapter presents the findings of the qualitative data that were collected from participants using the immersion/ crystallisation style (Terre Blanche et al., 1999). The data concerns the preliminary HIV status of participants when they first got married, the stories of domestic violence prior to being diagnosed with HIV, the participants' reactions to the positive HIV results, disclosure of the HIV status, the partners' reaction to HIV positive results, the stories of domestic violence after disclosure of HIV status, socio-cultural factors contributing to domestic violence, and the participants' experiences of coping with HIV/AIDS. More attention was given to the participants' dominant and recurring stories. These stories were therefore gathered and put together in a sequence so as to produce a meaningful narrative.

5.2 THE PRELIMINARY HIV STATUS OF PARTICIPANTS

As was indicated in Chapter 1, numerous research studies have been conducted on the relationship between HIV/AIDS and domestic violence but there is still a lack of qualitative data to show whether domestic violence prevailed before a positive diagnosis of HIV or whether it surfaced after the diagnosis (Dunkle et al., 2003). In this study, participants were encouraged to talk about their experiences of domestic violence in their own language. They were helped to externalise their lived experiences and to map the influence of their problems through asking questions (Drewery & Winslade, 1997; Freeman & Combs, 1996; Minuchin, 1991; Weingarten, 1995; White & Epston, 1990). Participants were therefore asked about the time when their partners started abusing them. The findings indicated that violence had started a long time before HIV was discovered. Both participants were diagnosed with HIV after they had been married for a number of years. For example, participant 1, a 34-year-old mother of three children tested positive for HIV when she was pregnant with her second child in her marriage. Even though Participant 1 already had one child when she got married, she had two other children with her husband. The same thing happened to participant 2, a 27-year-old mother of three children. Participant 2 also

tested positive for HIV when she was pregnant with her second child. Participants shared more stories about their experiences of domestic violence before HIV surfaced in their marriages.

Due to the emerging narratives in the study, the researcher decided to include the experiences of domestic violence prior to HIV diagnosis. This is partly due to the fact that participant response, in terms of being part of the sample, was poor – only two participants stepped forward to be part of the study. Thus, the inclusion of their discussion of domestic violence before as well as after HIV disclosure enables a better in-depth look into the two participants' narratives. Both periods are also included because the onset of violence in the lives of the participants actually occurred before the disclosure of their HIV status. The researcher therefore deemed it necessary to discuss both so as to make a comparative analysis. Without acknowledging prior violence, the study's findings would be tainted. Thus, the findings led to a discussion on how the violence had been before HIV disclosure and how it changed after that.

5.3 EXPERIENCES OF DOMESTIC VIOLENCE PRIOR TO HIV DIAGNOSIS

In narrative theory, the problem is seen as separate from the individual and is dealt with as an entity on its own. This is achieved through working in collaboration with the client and helping him or her to externalise the dominant problem stories in his or her life (Drewery & Winslade, 1997; Freedman & Combs, 1996; Waldegrave; 1990; White & Epston, 1990). In this study, the dominant stories of domestic violence prior to HIV diagnosis were explored. In order to map the influence of violence and understand their experiences of domestic violence, participants were asked how the violence in their marriages had been before they were diagnosed with HIV. Four main themes were identified in this area, namely physical abuse, emotional abuse, sexual abuse and financial abuse. The experiences of the participants were therefore considered from the angle of these four aspects of abuse.

5.3.1 The early stories of physical abuse

Participants talked about their experiences of physical abuse and described how they had started experiencing violence in their relationships. For Participant 1, physical

abuse started at a very early stage before she even got married. Thus the tone was set for violence to persist and often filled with serious physical abuse as illustrated in the extract below:

"Yes! He hit me with a fist. I said to him, why are you beating me now? Wahlaaa, with a slap! People of God! He threw a fist in, and…, you know he fought with…, you know, he beat me, beat me, beat me! You know, I did not even know what to do. I was embarrassed you know!"

Participant 1 also mentioned that the physical abuse kept on recurring, and her story was saturated with many incidents of violence as is clear from the following quotation:

"*… So he pulled the drawer, took out a knife and tried to stab me with it. I said, you, a knife! Do you want to kill me? I said that means you are used to it, you are a murderer. Okay fine, right there I ran to the bedroom."*

Although Participant 2 was already married when physical violence first occurred in her relationship, she indicated that the violence started at a very early stage, just after the birth of the couple's first child.

"*After having a child, he developed some changes... and was fighting. I mean he was really fighting, not just talking, he was fighting…with his hands, he used to beat with his hands*". Participant 2 mentioned that the physical violence became routine: "*It went on, it went on, it went on, and this became a lifestyle.*" Thus the violence and abuse became a dominant discourse in both participants' lives.

As their stories unfolded, participants mentioned that they often suffered visible physical injury as a result of the beatings. The injuries included bruises and swelling as participants were beaten with fists and even slapped. Although participants did not sustain any serious injuries, they indicated that their partners attacked them with weapons at times.

5.3.2 The dominant stories of emotional abuse

Participants' stories were also filled with the emotional impacts of physical violence and stories of direct emotional abuse. The stories of emotional abuse left them feeling gagged in terms of expressing their feelings or showing their emotions about the situation they were caught up in. Participants did not dare voice their concerns and dissatisfaction in the marriage as they tried to avoid conflict by all means. For example, Participant 1 said:

"I was angry because it was not nice anymore in the house. He was impatient with me and then, should I speak out, he would start to…he would beat me up, you understand."

The other participant suppressed her emotions in the presence of her husband in order to give him a false impression. For example, she wanted to pretend that she was strong enough to cope with the violence, as is illustrated in the following extract:

"When he was finished fighting like that, when he was finished, finished, it would be just quiet. After he has gone out when I am alone, I would then take out all that pain and cry. It's like, I did not like crying when he was around. That is, I was thinking that he will take too much advantage and say that I will beat her everyday, I know that she cries."

Besides suffering the emotional consequences of physical abuse, the stories showed that participants were in fact abused emotionally. The abuse included insults and sharp words uttered by the participants' partners. According to narrative theory, the power of language provides people with the agency to talk about their lived experiences; it enables them to construct their views of reality and also to express their thoughts and feelings. Through using language, people are accorded the expert position to talk about their own stories (Drewery & Winslade, 1997; Freedman & Combs, 1996; White & Epston, 1990). Participants in this study were consequently seen as experts in representing their stories of emotional abuse in their own language.

Participants mentioned that their partners were verbally aggressive and vulgar towards them. When Participant 1 talked about her stories of emotional abuse, she said: *"You*

know what? He is vulgar, he is vulgar! You know when it comes to vulgar words, you cannot beat him." Moreover, she said that she had initially tried to ignore the insults by leaving her partner alone, but eventually she started to retaliate as the emotional abuse continued. As her story unfolded, participant 1 said: "*Hey, he insulted me, insulted me. He insulted me with my mother and I said you too, your mother."* This illustrates how the participant desperately tried to change the story by bringing herself into the script as a co-author. However, her co-authorship further confirmed the dominant discourse in that her response was 'more of the same' and did not create an alternative reality/story.

The findings also indicated that the dominant discourse presented itself at a societal level within the communities where these women stayed. For example, the extramarital affairs of both participants' husbands were another form of emotional abuse directed towards these women. They mentioned that it was apparent that their partners were having affairs with other women and it was hard for them to cope with this situation. Even though one of the participants confronted her husband about the extramarital affair, she eventually identified a unique outcome which was to give him the silent treatment as he continued with the affair. In her opinion, this enabled her to cope better with the situation: *"I said no, let me leave him alone. I left him alone. He saw that I did not ask anything… being quiet while he kept on going and coming back, going and coming back, going and coming back. That is, I did not care you know, nothing was even happening in my heart.*"

According to White and Epston (1990), people often seek therapy about their problems when the narratives of their experiences do not accurately represent their lived experiences. However, participants in this study mentioned not having anyone with whom to share their stories and the emotional pain resulting from their husbands' extramarital affairs, even though they were battling to cope with the situation. Participant 1 said: "*I did not feel okay about it but I just kept it to myself… died inside*." She felt that it was inappropriate to discuss marital problems with people who are not married as this could give rise to negative views of her marriage. "*This will somehow degrade the dignity of my marriage. After a while, hey, it would seem as if I am not happy, so, I did not want to talk about it.*" This remark indicates that dominant cultural discourses about marriage prohibited Participant 1 from talking about her

marital problems. White and Epston (1990) argue that cultural discourses enable people to talk about other aspects of their lived experiences and also determine how people construct their view of reality. Hence participants in this study remained silent about their marital problems due to the prevailing dominant discourses about such matters.

Based on the findings of this study, it appears that the dominant stories of emotional abuse harmed participants emotionally as they were obliged to remain submissive to the power held by their partners. This actually legitimised the powerful position held by men in intimate relationships. The stories showed that participants used to suppress their feelings and emotions about the abuse that was prevailing in their relationships. Moreover, participants were psychologically affected by the ongoing violence in their relationships. It seems that their thinking processes were hampered as they could not take precautionary measures to look after their own physical health. The findings indicated that even though participants were aware of the fact that their partners had other sexual partners, they could not think of using a condom in order to protect themselves from sexually transmitted diseases.

For example, Participant 1 said that she was aware of her husband's affairs but did not suggest that they use a condom: "*It was a problem there but, well, I never thought of using a condom, you understand?"* The same was true for Participant 2, who also did not think about the health consequences of her husband's extramarital affairs: "*I did not think about it and I never even thought of using a condom…*" The above statements indicate that domestic violence and the resulting emotional abuse – the dominant discourse in the participants' lives – had a powerful influence and blinded them from discovering alternative outcomes that would have enabled them to experience a sense of personal agency and become proactive in dealing with the prevention of HIV infection.

5.3.3 The stories of sexual abuse and power relations

The interviews revealed that participants experienced sexual abuse even though it was not violent in nature. It emerged from the study's findings that the status of participants in relation to their respective partners did not allow them to voice their concerns in their relationships (Drewery & Winslade, 1997). This status or

positioning is largely due to the African culture from which these women come. Cultural traditions of African women prevent them from exercising their rights in terms of sexual relations. Their stories illustrate how they were not given a say in making sexual decisions and deciding on family planning and the spacing of children. Due to power relations and positioning, participants were coerced by their partners into falling pregnant against their own will – as is clear from the following extracts:

Participant 1: *"He insisted that he wanted a boy as there were already three women in the house."*
Participant 2: *"That is, he was complaining about the fact that Matjeka has grown up and now I am able to go out jolling while he is at work."* The participant was simply forced to fall pregnant again.

The discourses prevailing about sexual relations prevented the participants from having any control over sexual decisions in their marriages.

5.3.4 The dominant stories of financial abuse

It emerged in the narratives of this study that participants were denied financial support by their partners. The financial abuse occurred in two ways. Firstly, the men did not buy food for the family and also stopped giving their wives money to buy some basic requirements such as food and toiletries. Participant 2: "*Money! No, I bought soap, I bought stuff for the baby, I bought… He would say: that is my money, I am the one who is working neh*"! She explained that when she used the money for basic needs, a fight would ensue.

Participant 1 stated that "*he was not giving me money anymore*".

Research findings by Dunkle et al. (2003) and the Norwegian Organisations (2001) indicat e that poverty and financial dependency may well lead to risky livelihoods such as prostitution or transactional sex. However, participants in this study did not engage in risky behaviour but rather tolerated the abuse. In narrative theory, depressing dominant stories tend to affect the lives of individuals in a negative way. These stories prevent the individual from seeing any positive way out and from developing a new meaning of life (Drewery & Winslade, 1997; Freedman & Combs,

1996; White & Epston, 1990). Due to the intensity of their dominant story, participants were unable to seek any other means of getting financial help.

The dominant stories of domestic violence in general evolved and grew into the narratives about how the participants came to learn about and reacted to their own HIV diagnosis. This discussion was seen as relevant for this study as it led to the crux of the dominant story, thus illustrating how the story changed from this point. To provide an in-depth analysis of the dominant stories, it seemed necessary to include not only the stories of the disclosure of HIV status, but also the way in which the women's partners reacted to the HIV results.

5.4 CONFLICT AND THE PARTICIPANTS' REACTION TO POSITIVE HIV RESULTS

The common thread in this story is that the participants discovered their HIV status when they were pregnant. Although both were very much hurt by the results, their reactions were different. For example, Participant 1 was shocked by the results and worried about her children:

*"I… I tested positive. (*Silence*). Uhm… I do not know how to put it but, yeah, it hurt me! It hurt me and… I cried, and… uhm, I accepted and I said yeah! (*Silence*). Now I started thinking about everything, that he used to go and doing stuff, doing stuff, and I said; you see… what it has caused me! It means he is also HIV positive."*

"It scared me! Am I going to die? What if I die and leave my children behind?"

Although Participant 2 was also worried about her positive HIV test results, she managed to accept her status after a short while. However, she was also concerned about her children as she explains in the following extract:

"It's like I don't know how I felt in my heart or may be it hardened or… it's like, I got worried for a short while but I was alright when I arrived at home."

"I had accepted! That is, I told myself that it is true… it is true because I have a husband, it is true. I cannot say that I do not have it, it is really there. If I was single I would say that I do not have it or go and test again or do something."

"It is that I wish that one could at least die when Matjeka would be old enough to look after the children because I have not yet started to get sick yet, I don't know."

The statements above indicate that participants experienced emotional conflict between dealing with their positive HIV results and finding a solution about the care of their children. Even though they were willing to accept their HIV status, it was difficult for them to cope as they expressed a desire to live and take care of their children.

5.5 THE TURNING POINT IN THE STORY: DISCLOSURE OF HIV STATUS

Both participants eventually disclosed their HIV status to their partners, though at different times. Participant 1 had some difficulty in telling her husband about the HIV diagnosis. The dominant stories of abuse immediately came to haunt the participant as she was afraid of her husband's reaction, thinking that he might become violent and beat her up. She was therefore silent about her status for the whole duration of her pregnancy. Her fear of disclosing her status is shown in the following extracts:

"Hey, now it became difficult for me to tell him that… that I am HIV positive."

"I did not know how he was going to behave because, for many people, when they hear about HIV it's like you are pointing a gun at them and you want to shoot them."

"It was like, if I could tell him, is he going to beat me… he is now going to start…, uhm…, you know what? Will he tell people? What is he going to do, such things."

Participant 2 faced the situation and thereby negated the power of the dominant story to some degree when she did not hesitate to tell her partner about her status: *"After that I then discovered that I was HIV positive. I told him when I got home."*

5.6 SURPRISE AND SUSPENSE FOLLOWING THE PARTNERS' REACTION TO HIV POSITIVE RESULTS

The partners' reaction to the disclosure of the HIV results emerged as important to this study. It presents a clear picture of the patterns of violence that succeeded the disclosure, as well as illustrates how the dominant narrative became further entrenched. The reaction by the two husbands and their subsequent behaviour also confirmed the powerful influence of dominant discourses. The two men reacted quite oppositely when they were told about the positive HIV results.

Participant 1's husband was hurt by the results and this came as a surprise to her – she did not expect it from him: "*Yeah! I saw the tears trickling down his face…Then, after telling him there, after he had cried…, he cried and went out and I was sitting on the bed…He came back. When he came back he said: mama, I am asking for forgiveness, forgive me my wife, forgive me mama, forgive me.*"

Participant 1 experienced what narrative theory calls a unique outcome. The unique outcome was that the dominant discourse, which strives to cause further destruction and violence, was humbled by the participant's husband asking for forgiveness. This unique outcome set the stage for the researcher searching to uncover more examples of when the dominant narrative lost its power.

Although Participant 2's husband did not say anything or show any emotion when he was told about the HIV test results, his behaviour in the house changed immediately after that. "*He did not say anything but sometimes, when he was drunk, said I gave him AIDS.*" The dominant narrative used guilt and blame as a way of further gaining power over the participant. It also used denial of the reality of the participant's HIV status. Participant 2 thought that "*maybe he did not take it seriously or he took it somehow or it was already eating at him… but then he started showing some changes again*".

Her partner's reaction to the disclosure left Participant 2 in suspense about whether he had actually internalised the HIV diagnosis or not. Unfortunately, the dominant story of abuse and violence eventually re-emerged in both participants' relationships after the disclosure of their HIV status.

5.7 EXPERIENCES OF VIOLENCE AFTER DISCLOSURE OF HIV STATUS

In this study it was found that the dominant story of abuse continued and reached a climax after participants had disclosed their HIV status to their partners. In order to understand the women's subsequent experiences of violence and to map the influence of the dominant story in their relationships, participants were asked about the way in which their stories of violence changed after disclosure of their HIV status. The same four main aspects were identified, namely physical abuse, emotional abuse, sexual abuse and financial abuse.

5.7.1 More stories of physical abuse

The stories indicated that the dominant discourse became more established and gained strength from the use of substances such as alcohol. Both participants mentioned that the beatings occurred more frequently, especially when their partners were under the influence of alcohol. Participant 1's husband initially seemed to be calm about the HIV diagnosis but changed later on and started fighting about it: "*Yes, with the HIV status… Now afterwards… Yes, now he was fighting.*" She mentioned that her husband became more outrageous and even disregarded the safety of their baby when he was beating her. *"I remember one time when he was beating me; I was breastfeeding the child."* She said that the beatings escalated so much that she even sustained visible physical injuries. "*One day he beat me, I got swollen, my mouth…, even my eyes were swollen. My mouth was swollen on this side and this eye.*"

However, Participant 1 mentioned a change in the story, a unique outcome, when her husband started insulting her again. Because his aggression was about the HIV status and not directly towards her, she decided to literally fight back. "*When I went to the bedroom he was still insulting me… There is this thing here, next to the door; there is a shoe bag there. I pulled out the Andreoli shoe and I held it properly... Hey, I beat him with that shoe, I beat him…, I beat him, I beat him and fast!"* She further explained how she lost control: *"I cracked his head open, you know, I beat him and beat him!... You know what, I was angry, I was angry. You know I had beaten him until I realised that he was losing strength… I took him and threw him out there.*" According to narrative theory, unique outcomes are usually positive lived experiences

that people tend to neglect due to dominant problematic stories in their lives (White & Epston, 1990). However, Participant 1 regarded her violent actions as a unique outcome as this had helped to lessen the strong feelings of anger she had towards her husband.

In the case of Participant 2, the physical violence started again after her partner had learnt about her HIV status: "*Yes, that is, he changed after I told him … starting again with those old things of fighting with me.*" She agreed that the physical violence escalated so much that her partner once attacked her with objects in the house. However, Participant 2 also mentioned a unique outcome that enabled her to bring about a positive change in connection with the violence in her marriage. She said that she got so frightened that she tried to defend herself and her unborn child: "*Yes! Now… that is, at that time he was beating me with everything, do you see? That is… when we were fighting you would find that whether it's a chair or anything, he would beat me with it. I realised that he might end up hurting the child. I then stood up and fought for myself. It happened that I also took an iron and beat him with it."*

Sadly neither of these outcomes produced a change in the dominant story, the story of violence, as it simply perpetuated the violence. The only change was in the role of perpetrator and victim.

5.7.2 The stories of emotional violence and their intensification

The story of emotional and verbal abuse emerged again, and was characterised by even more disrespect and intent to cause intense emotional pain. Both women mentioned that their partners continued with their extramarital affairs, which obviously affected the participants emotionally. Although the participants struggled to cope with their husbands' extramarital affairs, they suppressed their feelings in order to avoid further conflict. This method of dealing with the violence and abuse situation emerged as a unique outcome which enabled participants to keep the dominant story stable. However, the story did not stabilise but actually escalated to a point where the husbands not merely insulted and shouted at the participants, but also called them bad names and blamed them for having brought AIDS into the marriage.

Participant 1 said that after she had disclosed her status, her husband started accusing her of having extramarital affairs and insulted her about the fact that she was HIV positive:

"Yeah! You are a prostitute! You are a prostitute! Now you even have AIDS, heey, what-what. You know, he insulted me, insulted me, insulted me. When I was going to work, it meant I was going to see other men. When I come back… eh… When I go to church, I went to see other men. That is, I could not go anywhere, you understand."

Participant 1's husband even shouted at her about her status in front of the children and the children got worried about what their father said. They started asksing her a lot of questions like "*Mama, why is papa saying that you have AIDS? Mama, do you have AIDS? Mama…"*

"Mama? Why? Are you also HIV positive? Mama, do you also have AIDS?"

Participant 2, on the other hand, did not talk much about the HIV status with her husband. However, every time the subject came up, he attacked her verbally and accused her of having brought HIV into their marriage. This is another example of how the dominant story used guilt and blame to strengthen its position. As in the case of Participant 1, Participant 2's husband also accused her of having extramarital affairs. Her husband simply shifted the blame of their HIV status onto her, as is clear from her response to his insults: *"Because now that you have heard that we are like this, you start thinking that I am jollying. He said yes, you must have brought this thing if it really exists."*

5.7.3 The sexual abuse stories continue

The common theme in this area is that both participants continued to experience sexual abuse after they had disclosed their HIV status to their partners and did not have the ability to make sexual decisions. Although the abuse revolved around making sexual decisions such as condom use, it occurred in different ways. In the case of Participant 1, her husband always used a condom. However, he was sometimes aggressive regarding other sexual decisions such as when sexual intercourse should occur. The interview revealed that her husband sometimes became verbally abusive

and chased her out of their bedroom when he did not feel like sleeping with her: "*Just imagine, it is winter, you are sleeping, you are fast asleep with the child in your bed, he arrives and pull you, you with fat thighs, get off my bed! You understand. He would take the blankets off you and throw them there! I have to go and sleep in the children's bed. When - when, if he wants to, he would tell me to come back to our bed, things like that.*"

In the case of Participant 2, her husband often refused to use a condom until she fell pregnant. Her husband made her feel guilty about the fact that she insisted that he should use a condom. He often accused her of having other sexual partners with whom she did not use a condom: "*He said when you sleep with me… Yes, you really have other men outside whom you are sleeping with and when you come to the house you want to sleep with me with a condom.*" Thus, the dominant story of violence and abuse continued and used guilt and blame to gain its power and control over the participants. Due to the participants' domination by and inferior positioning in relation to their partners, participants were neither allowed nor expected to make any sexual decisions. In narrative theory, dominant discourses determine how people are expected to behave in relation to others and also place them in particular positions in such social interactions (Drewery & Winslade, 1997; Weingarten, 1995). In this study, dominant family discourses therefore placed the participants in a subordinate position and accorded their partners a powerful position which legitimised their dominance and power to make decisions. The participants also perpetuated these dominant discourses by being submissive and behaving in the way expected of women – thus living up to expectations.

5.7.4 Stories of financial abuse persisted

The stories of financial abuse continued in the same way as before the participants' disclosure of their HIV status, but suddenly took a steep turn. For example, after Participant 1 had disclosed that she was HIV positive, her husband stopped buying food completely. She mentioned that she confronted her husband about his sudden refusal to buy food for the house but this created conflict between the couple. "*We were fighting because he was not buying food lately at home and now I… (*Silence*). I had HIV but… uhm, he did not buy anything.*" The extent of financial abuse also

escalated in Participant 2's marriage and her husband completely stopped buying food for the house: "*Then he stopped buying food for the house*." These extracts illustrate that the dominant story continued and gained strength from using its power and dominance over the participant.

Although the domestic violence and abuse escalated after disclosure of their HIV status, the participants stayed in their marriages. Many readers would ask why. In an attempt to answer their question, the researcher next discusses the socio-cultural factors that surfaced in the context of the participants' experiences of violence.

5.8 DOMESTIC VIOLENCE AND SOCIO-CULTURAL FACTORS

Cultural discourses assisted the participants in this study to represent other aspects of their experiences of violence (White & Epston, 1990). White (1991, as cited in Freedman & Combs, 1996, p. 32) mentioned that cultural stories determine the shape of our individual life narratives and the way in which people construct their meaning of life. In this study, participants related their stories on the basis of the cultural context in which they were living and re-authored their experiences according to dominant cultural discourses. The findings therefore pointed to a number of socio-cultural factors that prevailed in the marriages of both participants and interfered with their ability to make decisions. The main themes in this area include power relations, cultural factors and economic conditions.

5.8.1 Dominant stories of power relations

Power relations in the narrative approach received much attention from theorists such as Drewery and Winslade (1997) and White and Epston (1990). Thus there are dominant stories about how particular people are expected to be positioned in relation to others in society and conflict often arises if the individuals do not live up to society's expectations. Therefore, as the stories evolved in this study, it emerged that dominant discourses regarding power relations strengthened the prevailing stories of violence and abuse. The common theme here was that cultural rules place the participants in this study in a subordinate position in relation to their partners and thus the women do not have the power to make any decisions in their marriages.

As was mentioned earlier, participants could not make any decisions regarding sexual matters – their partners had all the responsibility to do so because society expected of them to be "a man" in marriage. In this study both participants were even forced by their partners to fall pregnant and they had no right to refuse. Furthermore, the male partners had the power to decide about the spacing of children in the family. Participant 1 said that she fell pregnant for the second time because "*I was doing it for him because he wanted a boy and he was stressing the fact that he married me, what-what*". While still discussing power relations and the right to make sexual decisions, Participant 2 mentioned that she fell pregnant with her second child because her husband insisted as on it: "*He wanted another child! That is, he was complaining about the fact that Matjeka has grown up.*"

Due to the overriding discourses of power relations, participants often could not strike back when they were physically assaulted by their partners. It emerged from their stories that participants regarded such behaviour as disrespectful towards their partners, hence they tolerated the physical violence for a long time. Participant 1 mentioned that she was not afraid of her husband but avoided fighting with him – "*to grant him that dignity because now if you can slap him once, really, even tomorrow should he try to raise his hand again, I will kick him and throw him, far away there, you understand it*". Participant 2 also felt that it was not a good thing to fight with her husband: "*It is that I was just respecting him as my husband.*"

The above statements indicate that the dominant discourses perpetuated the stories of abuse. Both participants were determined to live up to the expectations of the society in which they lived by behaving in the way expected of them.

5.8.2 Stories of cultural factors

The narrative approach comments on culture by saying that cultural narratives play a crucial role in determining how people construct their view of reality. They often base their stories on the dominant discourses of the culture in which they find themselves. Dominant cultural discourses therefore shape the stories people compose about their lived experiences (White & Epston, 1990). The emerging narratives in this study indicated that the cultural context apparently also played a major role in the way that participants responded to the violence in their marriages. The stories indicated that

both participants stayed in their abusive relationships due to the prevailing cultural discourses about marriage in their society. According to the participants, a woman has to be strong and tolerate the hardships she encounters in a marriage, as it has been socially constructed that marriage is a tough institution that needs tolerance. The following extracts are examples of what Participant 1 has learnt about marriage:

"No, I just told myself that… but now we often hear older people saying, eh… Such things are home builders, a home, a woman has to tolerate, hey my child, and we have also passed there."
"Even when I explain to his family, they also say no my child, we are also staying like this, it is not because it is nice…"
"She said you know what; marriage! Don't hear people saying they are married, it is tough."
"You understand? I also told myself that I need to be like other women and tolerate."
"They said tolerate, tolerate my child, these are the home builders."

The study also revealed that the way in which marital problems were dealt with in families compelled participants to endure abusive relationships. Participant 2 mentioned that she was forced to stay in her abusive marriage as a result of the Southern Sotho cultural rules and norms. She said that according to these norms, a woman has to tolerate hardship in a marriage and would not be allowed to return back home at all. Participant 2 was therefore left with no other option but to stay with her abusive husband: "*What should I do? Go back to my home? Moreover, I know about the Sotho norms and I just had to stay.*"

"The lobola was paid, everything was issued out. When I arrive home, they will say that…. They will call him and talk again… because they will send me back to him again."

These findings indicate that certain cultural discourses virtually legitimise domestic violence and give men the power to dominate and exercise control over women. Such dominant discourses often interact with power relations, whereby women are accorded a subordinate position and are expected to legitimise the powerful position held by men. The dominant stories of abuse in this study were therefore perpetuated and strengthened by the dominant cultural discourses of the people involved.

5.8.3 Stories of economic conditions and a predisposition to domestic violence

As indicated earlier, the narrative theory states that power relations determine how people are expected to be positioned in relation to others in their relationships. Furthermore, past research has shown that the socio-cultural factor of power relations interacts with economic conditions (Kometsi, 2004; The Norwegian Organisations, 2001). The stories in this study also indicated that participants were financially dependent on their partners. This economic dependency situated the two women in a subordinate position and forced them to endure the abusive relationships, whereas their male partners occupied a position of power. For example, Participant 1 said that she overheard her husband talking to another woman about being employed and the power to have extramarital affairs. "*So I thought and said; ooh; now he is able to jola, having affairs because now he is working*", indicating that money and financial stability put her husband in a powerful position and enabled him to have other women because he could afford to give them money. Even though Participant 1 was working and able to pay for some things by herself, she still depended on her husband financially.

Participant 2 was unemployed and totally dependent on her husband. She said that most of their physical fights started around the issue of money: "*That is, if he had… if he had given me money, he would fight every day. He even fought when I refused it.*" The dominant story of abuse and violence was therefore perpetuated by the participant's economic dependence on her husband. Even though the violence in her marriage revolved around money, Participant 2 could not leave as she was dependent on her husband for the child's support. "*But I cannot leave because I have a child, this child has the things he needs, so, what should I do.*" This statement shows that the dominant story of abuse was reinforced by this woman's economic dependence on her husband.

As the narratives of this study unfolded, a discussion followed on the participants' stories of coping with HIV. The experiences of participants were included as they formed part of the dominant stories of domestic violence and abuse which constitute the core of the study. Furthermore, participants were caught up in the dilemma of

dealing with both domestic violence and living with HIV. It was therefore necessary to discuss the stories of coping with HIV in order to provide an in-depth analysis of participants' experiences in the context of domestic violence.

5.9 UNIQUE OUTCOMES: COPING WITH HIV/AIDS

As indicated earlier on, the narrative theory states that when people are experiencing problems in life, they become fused with the dominant problem. This makes it difficult for them to identify alternative stories that would empower them to narrate their lived experiences in a positive way (Drewery & Winslade, 1997; White & Epston, 1990). In this study, participants perceived the HIV diagnosis as part of themselves and their narratives centred increasingly on living with HIV. Through deconstructing and externalising the problem, participants were asked how they managed to cope with their HIV status.

The emerging narratives indicated that participants were hurt by the positive HIV diagnosis and emotionally struggled to cope with their status. The dominant story created a fear (and reality) of dying from AIDS, especially when participants thought about the future care of their children. Participant 1 struggled to accept her HIV status for a while and also did not tell anyone about it. She said that *"So, uhm…, it…, it, it was hard for me. I felt so bad about it whereby…, I don't know… It was something I did not believe I could talk to anyone about."* However, Participant 1 remarked on the unique result of support from others when she said that she was comforted by the research assistants of the Serithi project: "*But really, the people of Serithi have… they, they… they made me…, they comforted me."* This finding indicates that through the support of the workers on the Serithi project, the participant was able to identify an external audience and witness the performance of new stories. It emerged from her story that this support brought about a sense of personal agency in the participant and enhanced the survival of her new stories – namely to accept her HIV status and live positively with it.

In narrative theory, once people have identified alternative stories in their narratives, they come to realise and talk about significant aspects of their lives which they had not been aware of. In order to enhance the survival of these new stories, the person is invited to be an audience to his or her own performance of new alternative stories

(White & Epston, 1990). Thus, Participant 2 was able to identify other important aspects about her HIV diagnosis and invited herself to be an audience in the performance of those alternative stories. Participant 2 did not struggle much to accept her HIV status – she could well believe that it was possible since there was a man in her life. She accepted her status and said *"it is true because I have a husband, it is true"*.

In this discourse – the context of domestic violence – it became more difficult for participants to cope with their HIV status. As indicated in the discussion above, the positive HIV results activated the dominant stories of abuse and helped them to unfold and reach a climax. The participants continued to experience domestic violence – which was actually increasing considerably – and were at the same time learning to live with HIV. Although the stories indicated that participants were able to cope better with their HIV status, the stories of domestic violence and abuse did not reach closure.

According to Weingarten (1995), dominant cultural discourses seem to constrain people's lives and influence the way they interact with others and the decisions they make. The emerging narratives in this study indicated that dominant discourses about marriage and what it means to be a wife constrained the participants as they had to behave in accordance with social expectations. Moreover, the dominant discourse was perpetuated by the participants' culture as they were encouraged by family members to tolerate their abusive marriage. Despite constantly living in the violent and abusive relationships, participants developed the strength to resist the hold that cultural constraints have on their lives. Participants became stronger and more resilient as the dominant discourse rendered them powerful to cope with the dominant stories of abuse and violence. Participant 1 said: *"I just have to tolerate, as they say, you have to tolerate in order to build a home, you see!"* This indicates that the prevailing cultural discourses in the participant's community gave her the courage to stay and prove her worth as a woman who can build a home. Participant 2 also gained strength from the dominant cultural discourses and managed to cope with the domestic violence situation :*"We could have separated a long, long, long time ago, but according to the Sotho culture I have to be strong and stay at my house."*

5.10 CONCLUSION

This chapter presented the findings and stories that emerged in the study. The stories revealed that participants had experienced domestic violence before they were diagnosed with HIV and that this violence escalated after the participants had disclosed their positive HIV status to their partners. The main themes that were identified included physical, emotional, sexual and financial abuse. As the women's stories evolved, they led to a discussion of the participants' reaction to the positive HIV results, which constitute the crux of the study. It became clear that participants were hurt and also shocked by their HIV results. The socio-cultural factors that had led to the continuation of the dominant stories of domestic violence were discussed next, and the stories revealed that these factors tended to legitimise domestic violence and the powerful position held by men in intimate relationships.

Finally, Chapter 5 presented the stories of the women's coping with HIV. The research methods that were employed, as well as the limitations of the study are discussed in Chapter 6.

CHAPTER 6

LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter concludes the discussion by providing an account of the limitations the study encountered, as well as suggestions for future research. It became clear from the study's findings that the growing problem of domestic violence in South Africa and globally necessitates further research, especially when this is compounded by HIV/AIDS. It is hoped that future research can be guided by the limitations of this study.

6.2 REVIEW OF THE RESEARCH

6.2.1 Narrative theory approach

As explained in Chapter 3, this study utilised the narrative approach. This means that participants were able to talk about their lived experiences freely and at length in their own language. Women were able to articulate themselves clearly using the terms they understand as they were using the language they are fluent in. Language was therefore the main tool for narrating their experiences and enabled the researcher to collaborate with participants in making sense of the experiences.

The participants' description of their experiences of violence included contents, emotions, thoughts and coping methods that they developed in an attempt to deal with the violence situation. Although participants did not focus much on their emotions and feelings about their experiences, the narrative theory approach enabled the researcher to ask questions that guided the participants to reflect on the influence of violence in their lives. This led the women to identify and realise the impact of violence in their lives. Furthermore, the narrative theory approach situates people in the expert position when they talk about their own experiences and therefore, as the conversations evolved, other important aspects of women's experiences of violence emerged. Some of these aspects did not form part of the research question, but seemed relevant for inclusion in this study as they provided a deeper understanding of the

women's experiences of domestic violence and their HIV diagnosis. The stories that emerged from these 'neglected areas' provided a clearer picture of the onset of violence after the participants' disclosure of their HIV status, as well as the patterns of violence that followed. As mentioned in the previous chapter, the researcher translated the transcripts herself in order to avoid losing important narratives for this study during the translation process.

Socio-cultural factors that played a role in the participants' experiences of violence were also discussed during the interview. The narrative theory states that cultural factors play a crucial role in determining how people make sense of their lives. Therefore, this approach enabled the researcher to also listen to cultural stories. Since the narrative theory is flexible and allows people enough time to relate their stories, it promoted the collection of richer data for this study and provided an in-depth understanding of the participants' experiences of domestic violence.

6.2.2 Research methods

The qualitative research method that was used in this study was effective for collecting valid data and allowed an in-depth analysis of the results. Semi-structured interviews were used to collect data and thus gave participants the opportunity to explore their experiences of violence without any limits. Participants in this study were able to talk about their experiences from their subjective point of view, while the researcher also became involved and asked questions for clarification in an attempt to obtain relevant data for the research question.

The purposive selection sampling method that was used in the recruitment of participants was effective in that it drew the attention of the women involved in the Serithi project. Women got a chance to make their own decisions regarding participation in this study before contacting the researcher. This sampling method encouraged voluntary participation in the study as invitation posters were put up at the Serithi consulting rooms. Participants in the study came forward to share their experiences of domestic violence without any coercion from the researcher.

The setting in which the interviews were conducted provided participants with a sense of confidence and confidentiality as it was considered to be a private environment.

Most of the Serithi clients were comfortable with talking about their personal problems at this venue (also the Serithi offices) and interviews for the current study were conducted there. Participants felt free to talk about their experiences of violence within this setting.

This study abided by the ethical rules designed to protect participants against any harm. All relevant ethical issues were set out in the consent form, which was read with the participants and translated into their language so that they were able to understand fully and make an informed decision.

The researcher translated the Sotho transcripts into English before the data analysis process as she is fluent in both languages. This provided an opportunity for capturing all the stories and experiences that participants talked about.

6.3 LIMITATIONS OF THE STUDY

The following were identified as limitations of this study:

- Although this study provides an in-depth understanding of the women's experiences of violence, the data was collected from only two participants. This is obviously not a sufficient number and therefore the results cannot be generalised. As remarked earlier, the Serithi project was reaching its final stage when the invitation posters for participation in this study were put up – thus most of its clients had already completed their follow-up visits and did not see the posters. Only two women came forward and volunteered for participation. However, this number of participants was sufficient for a study aimed at providing an in-depth 'case study' analysis of the results.
- Seeing that both participants in this study also took part in the Serithi project, they probably had a chance to talk about their domestic problems with the project's research assistants and perhaps also received support and comfort. Thus, the data collected in the current study may have been influenced by prior intervention. However, in order to guarantee the richness of the data and to provide an in-depth analysis of the results, the researcher included pre and post disclosure narratives.
- Although the sampling method that was proposed for the recruitment of participants was effective in drawing the attention of potential respondents, it took

approximately six months to get two voluntary participants. This delay is blamed on the fact that only a small number of Serithi clients still had to come for their final visit when posters for participation in this study were put up.

- The data was collected by means of semi-structured interviews in which strictly open-ended questions were asked. Even though participants struggled to answer the open-ended questions at times, the researcher avoided asking leading questions. Through re-phrasing, participants were sometimes helped to understand the questions better, but basically the scope of the answers was left undefined. This method of interviewing might have caused participants to omit other important descriptions of their experiences.

6.4 CONCLUSION

This final chapter reviewed the qualitative research methods and the narrative theoretical approach that were used in this study. Firstly, the qualitative research method was used because it is flexible and interested in the subjective meaning of a phenomenon. Secondly, semi-structured interviews both served to gain an understanding of the women's experiences and provided the participants enough space to talk about their experiences. Thirdly, the purposive selection sampling method encouraged voluntary participation from participants. Finally, the narrative theory approach gave participants the freedom to talk about their experiences of violence in their own language, while the combined use of the qualitative research method and the narrative theory enabled an in-depth understanding of the participants' experiences.

In conclusion, the findings of this study provided some insight into understanding the women's experiences of violence before and after the disclosure of their HIV status. It was found that participants experienced domestic violence before they tested positive for HIV and that the violence escalated after the diagnosis and disclosure of their HIV status. Other important aspects of the participants' experiences of domestic violence emerged during the data analysis. This included the influence of socio-cultural factors on domestic violence, which also caused participants to remain in their abusive marriages. The findings indicated that, besides struggling to accept their HIV status, both participants also had great difficulty dealing with domestic violence and abuse.

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Appendix A

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MAMELODI CAMPUS

Serithi Project
Kalafong Hospital
Clinikala Building
University of Pretoria
Tel. no: 012-373 1077
Researcher: Jeanette Ramodike

Re: Consent for participation in a research project

1.1 Title of the study

An exploration of the experiences of violence and abuse towards women in relationships after disclosure of their HIV status to their partners.

1.2 Purpose of the study

Although violence and abuse towards women has been prioritised in South Africa, some women still experience it in their relationships and HIV seems to have an influence on this aspect. In some relationships, violence escalates after the revelation of HIV status, whereas in others it arises for the first time following the disclosure their HIV status. Therefore, this study aims to explore the experiences of violence in relationships and focuses on physical, emotional, sexual and financial abuse once the HIV status was discovered. The focus will also be on determining how the patterns of violence and abuse changed after the revelation of the HIV status. Lastly, the study will explore the intervention measures that would increase the women's safety in their relationships.

1.3 What to expect in this study

If you agree to participate in this study, you will be asked to attend a one-on-one interview/discussion only, which will be tape-recorded. This interview will take approximately one hour and you will be asked to share your experience of violence in your relationship before and after disclosing your HIV status.

1.4 Risks and discomforts

The only risks to you in this study relate to the unearthing of issues that may arouse emotional pain. However, you will be referred to the relevant professionals within the Serithi project to help you deal with those emotions immediately.

1.5 Benefits

Participants will not be paid for their participation but can still benefit from the study. It is anticipated that exploring violence and abuse within relationships could uncover some emotional hurts and thus referral will be made to relevant professionals immediately after the interview. Participants will not be expected to pay for the counselling services that they will receive.

1.6 Participant's rights

Your participation in this study is entirely voluntary. You will not be forced to disclose any information that you do not feel comfortable to talk about. Furthermore, you can refuse to participate or withdraw from the study at any time and this will not affect your involvement with the Serithi project.

1.7 Confidentiality

Information obtained from participants will be kept strictly confidential. Once information is collected, your name will be replaced by a false name and the documents will be kept safe in the filing cabinets at the Serithi offices. The filing room is always locked and only senior researchers of the Serithi project have access to that room. The identity of participants will also not be revealed in the publication of the research results.

Consent for participation

I_____, voluntarily agree, without being coerced or pressured, to participate in this study and feel comfortable to share my experiences of violence with the interviewer. I understand that the information that I will provide for this study will be disseminated and shared with other researchers and that my identity will not, under any circumstances, be disclosed during publication without my consent.

Name and surname of participant_____
Signature of participant_____
Signature of researcher_____

If you have any further questions about this study or if you have a problem, you can call Jeanette at 012-373 1077 or come past Serithi offices to talk to me about this research study.

Appendix B

Screening questions for women's subjective experiences of violence after disclosure of HIV status. Participants are expected to choose from the following three options:

1 No experience of this.

2 I have experienced this a little.

3 I have experienced this a lot.

1. I have lost friends because I'm HIV+.
2. I have felt hurt by how people have reacted to learning about my HIV.
3. People have avoided touching me because of my HIV.
4. People don't want me around their children because of my HIV.
5. People act as though it is my fault I am HIV+.
6. People don't want me to come to their houses because I am HIV+.
7. I have been shouted at because I am HIV+.
8. I have been called bad names because I am HIV+.
9. I have been hit or physically hurt because I am HIV+.
10. People have threatened to kill me because I am HIV+.

Appendix C.

Questions used to facilitate the conversation during interviews are as follows:

1. What is your deepest concern about your experience of violence in your relationship?
2. How was the violence in your relationship before you disclosed your HIV status?
3. In which ways has it changed after disclosing your HIV status?
4. How did you manage to cope with your HIV status?
5. How are you going to deal with this situation?
6. Which safety methods could be used to alleviate violence and increase your safety in your relationship?

Appendix D

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INVITATION TO PARTICIPATE IN A RESEARCH PROJECT.

You are invited to participate in a research project that is about to start at our offices at Kalafong Hospital. This study focuses on **Violence Against Women and HIV/AIDS.** If interested in the study, please contact JEANETTE at 012 - 373 1077 or come past the Serithi project offices to talk to me about the study. **All information gathered is strictly confidential!!**