WORKING WOMEN'S PERCEPTIONS OF POWER, GENDER-BASED VIOLENCE AND HIV-INFECTION RISKS: AN EXPLORATIVE STUDY AMONG FEMALE EMPLOYEES IN AN AIRLINE BUSINESS

by

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"Every successful learning initiative requires key people to allocate hours to new types of activities: reflection, planning, collaborative work and training." – Peter Senge

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Student number: 45610398

I declare that **WORKING WOMEN'S PERCEPTIONS OF POWER, GENDER-BASED VIOLENCE AND HIV-INFECTION RISKS: AN EXPLORATIVE STUDY AMONG FEMALE EMPLOYEES IN AN AIRLINE BUSINESS** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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SIGNATURE DATE

(MS R J FREEMAN)

SUMMARY

Power imbalances and gender-based violence (GBV) have increasingly been cited as important determinants putting women at risk of HIV infections. Studies have shown that globally one in every three women has been beaten, coerced into sex or otherwise abused in her lifetime. The study explored working women's perceptions of power, gender-based violence and HIV-infection risks. A qualitative, explorative study was conducted among female employees in an airline business in Namibia. Five women participated in in-depth, face-to-face interviews. The findings show that all of the participants experienced power imbalances and GBV in their intimate relationships. All of the women reported emotional or psychological abuse, whilst the majority were subjected to economic abuse, followed by physical abuse, and two alleged having been sexually abused. The study concludes with specific recommendations for the development and successful implementation of workplace policy and programmes to protect and promote women's rights.

KEYWORDS: Airline business, female employees, power imbalances, gender-based violence, HIV and AIDS, HIV-infection risks, and working women.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
EAP	Employee Assistance Programme
GBV	Gender-Based Violence
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IPV	Intimate Partner Violence
NDHS	Namibian Demographic and Health Survey
NPC	National Planning Commission
SADC	Southern African Development Community
SIAPAC	Social Impact Assessment and Policy Analysis Corporation
STDs	Sexually Transmitted Diseases
SRPS	Sexual Relationship Power Subscale
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNISA	University of South Africa
USAID	United States Agency for International Development
VAAW	Violence and Abuse Against Women
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

CHAPTER 1: ORIENTATION TO THE RESEARCH PROBLEM

1.1 INTRODUCTION

The World Health Organization (WHO 2004), together with other researchers and policy makers, has increasingly cited gender-based violence (GBV) and power imbalances as essential determinants of women's HIV-infection risks, globally and particularly in sub-Saharan Africa (Jewkes, Levin & Penn-Kekana 2003:1415). According to the United Nations Programme on HIV and AIDS (UNAIDS 2004), women are disproportionately affected by HIV and AIDS. Statistics have shown that women and girls make up almost 57% of the adult population with HIV and AIDS in sub-Saharan Africa (www.unaids.org). According to the WHO (2000), women in most parts of the world face particular risks of HIV infections, because of the interplay between their economic positions and social status. These realities form a social context in which women's abilities to make healthy choices is often diminished. When a woman is afraid of violent retaliation by her intimate partner, she is less likely to discuss the reduction of HIV risk with him (WHO 2000).

According to the United Nations Secretary General's *In-depth study on all forms of violence against women* (United Nations 2006), women's relative lack of control over their sexual lives and methods of preventing HIV and other sexually transmitted infections due to violence or fear of violence, is one of the main factors behind the spread of HIV. The lack of control is experienced not only by women who are sexually assaulted, but also by those women in relationships where they are unable to negotiate the use of condoms with their partners. Violence both exposes women to HIV infection and limits their ability to participate in and benefit from HIV and AIDS prevention methods and treatment (United Nations 2006:36). According to the WHO (2004), when women reveal that they are HIV-positive they may face real violence (or the threat of violence) and the risk of abandonment by their partners, families, friends and employees/colleagues.

The WHO (2004) reports that research findings in the United States and sub-Saharan Africa show an increased risk of HIV and AIDS among women victims of gender-based violence and that being HIV-positive is an added risk factor for gender-based violence against women. In this regard, the WHO (2004) identifies four areas in which women's vulnerability to gender-based violence and HIV and AIDS overlap, namely:

1) Forced sex may directly increase the risk of HIV transmission to women through physical trauma.
2) Violence and threats of violence may limit the ability to negotiate safer sex.
3) The experience of sexual abuse in childhood may lead to increased sexual risk-taking in adolescence and adulthood.
4) Sharing HIV test results with partners may increase the risk of violence.

This relationship is seen as having grave consequences for global health and development, especially with regard to adult women, adolescents and girls who are most affected by sexual violence and are susceptible to HIV infection. The WHO's (2004) multi-country study on gender-based violence includes estimates from Namibia and Tanzania where the proportion of women who had ever experienced physical or sexual violence was 36% in Namibia (capital), 41% in Tanzania (capital), and 56% in Tanzania (district). The study shows that one in every three women is subjected to violence in a relationship (Namibia Ministry of Health and Social Services 2004:ix). Among countries such as Botswana, Zimbabwe and Swaziland, Namibia ranks as having one of the highest sexual violence and HIV-prevalence rates in the world (LaFont & Hubbard 2007:234).

Violence against women is a complex and multidimensional problem, and as Heise, Pitanguy and Germain (1994, as quoted in Namibia Ministry of Health and Social Services 2004:xi) indicate: *"Male violence against adult women is a public problem of enormous magnitude"*.

Strauss *et al.* (1980, as quoted in Namibia Ministry of Health and Social Services 2004:xi) state that Namibia's political history, combined with social values and practices within which inequality between men and women are embedded and condoned, has created an environment where violence against women has flourished. This type of violence has therefore evolved to become the embodiment of unequal power relations between men and women (Namibia Ministry of Health and Social Services 2004:xi).

Brown, Dunkle, Gray, Harlow, Jewkes & McIntyre (2004) demonstrate that women who had less power in their sexual relationship were at elevated risk of HIV infection. Researchers have argued that the high prevalence rates of HIV among females are the results of gender power inequities and violence against women (Brown *et al.* 2004), not forgetting the biological nature of women's reproduction system which also puts them at risk. Jacobs (2003) has argued that violence against women is both a cause and a consequence of HIV infection (Jacobs 2003). Researchers have consistently found high prevalence rates of gender-based violence among South African women (Brown, Dunkle, Gray, Harlow, Jewkes, & McIntryre *et al.* 2003).

It is generally known that human societies make social distinctions based on gender and virtually allocate more power and higher status to men. This research sought to draw on existing knowledge of and research findings on women's perceptions of power, gender-based violence and HIV-infection risks within their intimate relationships. Such insights formed the backdrop to the data gathering, which used a narrative approach in which a sample of volunteer women were asked to retell their experiences of power, gender-based violence and HIV-infection risks within their intimate relationships.

In this regard, the proposed study sought to uncover their experience of the *"web of abuse and the personal and external resources from which they can draw to shift the balance of control within such relationships",* as explained by Kirkwood (1995, as quoted in LaFont & Hubbard 2007:86). Gender-based violence and its consequences for women's health has long been an interest of the researcher.

In 2008, the researcher launched the "*I"-stories* booklet which chronicled real life stories of Namibian women who spoke out against gender-based violence during the *Sixteen Days of Activism Campaign against Violence against Women.* The theme of the *"I"-stories* booklet was: *"Healing through the Power of the Pen".* This was a series of first-hand accounts of women who have experienced gender-based violence, and included themes such as domestic violence, rape, child abuse, poverty and HIV infection after sexual assault. The aim was to create a safe and supportive platform where women could gain emotional healing in the telling and writing of their personal accounts. For the writers it was empowering to tell their stories, because it formed part of a transition from victim to survivor (Namibian Voices for Development 2008:3).

It was during the Sixteen Days of Activism campaign and after receiving copies of the *"I"-stories* booklet, that five women employed in an airline business in Namibia approached the researcher and voiced their need to be given an opportunity to share their perceptions of gender power, gender-based violence and HIV-infection risks both in their intimate relationships and at the workplace. For the purpose of this research, the researcher approached these five working women to form part of the study. Three of them continued with their voluntary participation, and two of them withdrew. The researcher continued and recruited two more women to form part of the study voluntarily.

1.2 THE RESEARCH PROBLEM

The central research problem of this study was to explore from the narratives of working women, what their perceptions are of power, gender-based violence and HIV-infection risks within intimate relationships. This problem was dealt with as warranting an explorative, qualitative approach, working with volunteer interviewees employed at an airline business. The details of and the reasons for selecting such an approach, are discussed in Chapter 3 of this dissertation.

Namibia is frequently applauded for being signatory to the United Nation's Conventions and the Southern African Development Community (SADC) *Protocol on Gender and Development* (2008) with no reservations – a wholehearted degree of commitment which is rare amongst the countries of the world (LaFont & Hubbard 2007:100-101). According to LaFont and Hubbard (2007:4,100), Namibia in its 19 years of independence, has made remarkable progress in fighting gender-based violence and HIV and AIDS by establishing enabling environments through well-defined laws and policies. The researchers LaFont and Hubbard (2007:4,104) state that there is a legal framework for gender-based violence which includes the *Married Persons Equality Act* (Act No. 1 of 1996, as quoted in LaFont & Hubbard 2007:104), which eliminated the discriminatory Roman-Dutch Law concept of marital power previously applicable to civil marriages in Namibia, and which grants women equal legal status in their household. Yet in reality, most women do not seem to enjoy equality in their domestic spheres. *The Combating of Rape Act* (Act No. 8 of 2000, as quoted in LaFont & Hubbard 2007:106) outlaws rape within the marriage and is one of the most progressive laws on rape in the world; yet, most men still believe that their wives are under an obligation to provide them with sex whenever they demand it.

The Combating of Domestic Violence Act (Act No. 4 of 2003, as quoted in LaFont & Hubbard 2007:106) covers a range of different forms of domestic violence, including sexual violence, harassment, intimidation, economic violence and psychological violence. It covers violence between husbands and wives, parents and children, boyfriends and girlfriends, and close family members (LaFont & Hubbard 2007:106). Moreover, amendments made to the *Criminal Procedure Act* (Act No. 24 of 2003, as quoted in Legal Assistance Centre 2009:144) amended the *Criminal Procedure Act* (Act No. 51 of 1977, as quoted in Legal Assistance Centre 2009:144), to provide special measures for vulnerable witnesses (Legal Assistance Centre 2009:144). *The Labour Act* (Act No. 11 of 2007, as quoted in Legal Assistance Centre 2009:6) and *The National Code on HIV* and *AIDS in Employment (*as quoted in Legal Assistance Centre 2009:6) aim to protect the rights of workers and prohibits discrimination in any aspect of employment on the basis of sex, marital status and family responsibilities, as well as forbid harassment on the same grounds (Legal Assistance Centre 2009:4).

These are all progressive pieces of legislation that sought to outlaw and discourage gender-based violence and HIV and AIDS, but lags behind in implementation. In this regard, LaFont and Hubbard (2007:108) report that Namibia has one of the highest rates of sexual violence in the world, with the vast majority of rapes in Namibia – at least 67% involve persons known to the victim, about one fourth (25%) involve spouses or intimate partners, including past partners. Furthermore, the country's HIV prevalence rate ranks fifth in the world (LaFont & Hubbard 2007). The situation of women in Namibia can partly be equated with what Ipinge and Le Beau (1997, as quoted in LaFont & Hubbard 2007:108) suggest about women in Southern Africa, namely that they remain a vulnerable, marginalised group that does not yet enjoy equal status with men or have equitable access to services and resources.

According to the Namibia Ministry of Health & Social Services (2008c:1), women are found to disproportionally account for those living in poverty, those who are illiterate and those who are landless or living in rural areas where facilities are scarce (Namibia Ministry of Health & Social Services 2008c). The researcher argues that there are still many challenges in achieving gender equality in Namibia, especially in the view of persistent gender stereotypes among communities.

The SADC Protocol on Gender and Development (2008) defines gender stereotypes as *"beliefs held about characteristics, traits and activity domains that are deemed appropriate for women, men, girls and boys based on their conventional roles both domestic and socially"*. The researcher simplified the definition of gender stereotypes to denote the way men, women, girls and boys are, behave and think as a result of socialisation. From birth, gender stereotypes influence boys and girls to become what society wants them to be. It is through this socialisation process that men, women, girls and boys learn what is appropriate and improper for both genders. For example, stereotypically women are regarded as naturally submissive and domesticated, whereas men are regarded as natural leaders.

The lack of gender-sensitive (here meaning inclusive definitions of gender roles, sexuality and relationships), workplace policies and programmes to address power imbalances, warrants further research into gender-based violence and HIV-infection risks. The SADC Protocol on Gender and Development (2008) defines gender equality, *"as the equal enjoyment of rights and the access to opportunities and outcomes, including resources by women, men, girls and boys"* (SADC 2008). In this regard, equality does not imply for men and women to become the same or to be treated in exactly the same way, but that individuals' rights, responsibilities and opportunities will not depend on whether they are born male or female (LaFont & Hubbard 2007:91). Gender equality means treating people who are in similar situations in a similar way (LaFont & Hubbard 2007:91).

It implies that the interests, needs and priorities of both men and women are taken into consideration, recognising the diversity of different groups of women and men. The *Commonwealth Plan of Action for Gender Equality (2005-2015)*, sees equality between women and men as both a human rights issue and as a precondition for sustainable people-centred development (Commonwealth Secretariat 2005:18).

According to the Namibian National Planning Commission's *Report on the Millennium Development Goals* (2004:13), gender equality is about extending freedoms, choices and opportunities to both women and men. The Namibian National Planning Commission (2004:13) states that, although Namibian women are doing relatively well in terms of educational achievement, the picture is less encouraging when it comes to translating education into good jobs and overall changes in society. While Namibian women hold more than half of all professional jobs in general, they account for just one third of higher level positions such as legislators, senior officials and managers. Moreover, only nine per cent of seats in the Namibian National Assembly were occupied by women in 1990. This has gradually increased since, but is still only at 19 per cent. The SADC (2008) recommends that the number of women politicians and decision-makers should be at least 30 per cent by 2005.

Edwards (2007, as quoted in Cupido, Edwards & Jauch 2009:32) states that the disparities in income, employment and access to resources according to gender in Namibia are glaringly obvious. Of the economically inactive sector in the Namibian population, 43,1 per cent is classified as homemakers, with women accounting for 70 per cent of this figure (Edwards 2007, quoted in Cupido *et al.* 2009). Women form the bulk of caregivers, yet are considerably under-represented in the formal economy, especially at managerial level. Female-headed households, which are some 40 per cent of the total, have a *per capita* income of N$7528, in contrast to male-headed households with a *per capita* income of N$12 248.

According to the Namibian National Planning Commission (Namibian National Planning Commission 2004), these figures point to a large number of single mothers and to the continued economic marginalisation of women in the Namibian society. Edwards (2007, as quoted in Cupido *et al.* 2009:32) states that under conditions of poverty there is a demographic transition towards older and female household heads. This partially explains why there are so many poor, matrifocal families in Namibia (Cupido *et al.* 2009:32).

1.3 THE PURPOSE OF THE STUDY

The purpose of the study was to explore working women's perceptions of power, gender-based violence and HIV-infection risks within their intimate relationships. The interviewees were female employees in an airline business, because the researcher wanted to understand the challenges women experience in both their intimate relationships and at the workplace.

The rationale for the study was supported by the recommendation of the Beijing Platform for Action for the promotion of *"research and data collection on the prevalence of different forms of violence against women, especially domestic violence and research into the causes, nature and consequences of violence against women"* (Namibia Ministry of Health and Social Services 2004:1).

1.4 RESEARCH QUESTIONS

The following are the research questions that this study sought to answer:

1.4.1 What are working women's perceptions and past experiences of power imbalances and gender-based violence?

1.4.2 What challenges do working women experience in the workplace regarding power imbalances and gender-based violence?

1.4.3 How, in the perceptions and experiences of the research participants, do power imbalances and gender-based violence put women at risk of HIV infection?

1.5 THE CHOSEN RESEARCH APPROACH

A narrative approach was chosen for the study. According to Overcash (2003:179), a narrative approach can be defined as collecting and analysing the accounts people tell to describe experiences and offer interpretations (or make sense) thereof. Narrative research provides an option to explore personal experiences beyond the boundaries of a questionnaire, providing insight into decisions taken (Overcash 2003). The following are some characteristics of narrative which make it appropriate for a study such as this:

1) Narrative is used to describe a variety of ways on how humans perform the "telling of events". Carr (1986, as quoted by Overcash 2003:180) suggests that narrative is not just a way of describing events, but is a part of the events. The retelling merges events with reality, however "true or accurate" they may be.
2) Narrative accounts detail unique experiences and perceptions pertaining to various aspects of humanity and culture.
3) Narrative can provide insight into human interaction, social-moral conduct, perceived role responsibility and other perspectives.
4) Narrative can be the analysis of telling an experience in its entirety with great detail.

Narrative research is not only the stories or accounts contributed by the participant itself, but also entails evaluating and analysing those accounts (Overcash 2003:180).

The reasons why the researcher followed a narrative approach in her study were because she wished to examine the central issues from the perspective of women, to access their stories, to *"tap into their usual ways of expressing themselves",* and *"to incorporate the context and chronology of events while imparting meaning and relaying larger cultural themes and values"* (Ismail, Berman & Ward-Griffin 2007:461).

In her experience of women's talk about abuse and violence, the researcher has become familiar with the potential of narration to, in the voices of the narrators, contextualise unique experiences and to offer insights into the dynamics of gender-based violence and vulnerability to HIV. Furthermore a narrative approach enabled the research participants to provide their own definitions of violence, abuse, gender-based power dynamics and vulnerability to disease. In conclusion, as far as this study was concerned, in-depth interviewing proved to be critical in the data collection process, while narratives served to complete them. Both methods were therefore equally necessary to obtain the data needed to answer the research questions.

1.6 THE CHOSEN STUDY SITE

This study was conducted in an airline business in Namibia. For this study, the target population consisted of working women between the ages of 36 and 44, who experienced power imbalances, gender-based violence and HIV-infection risks. Participants of this study were selected in accordance with the following criteria:

- Participants were working women in an airline business.
- Participants had all experienced some form of gender power, gender-based violence and HIV-infection risks.
- Participants were all over 18 years of age.

- Participants were all voluntarily willing to participate in this study and to be interviewed and tape-recorded.

Primary data was collected mainly through in-depth, face-to-face interviews with a volunteer sample of five women. Recruitment of the participants was done on a volunteer basis. The researcher approached those women who had indicated in 2008 that they would like to participate in a study where they could share their personal perceptions and experiences of power and gender-based violence and HIV-infection risks on an individual basis. All of these women were willing to participate in the study. The researcher scheduled individual appointments with the participants, and the details of the study were explained to them verbally and in writing. Further details of the chosen research design are given in Chapter 3 of this dissertation.

1.7 DEFINITIONS OF KEY TERMS

A number of working definitions about power, gender-based violence and HIV infections were given in alphabetical order in this chapter. At this stage, it is important to note that the theory of gender and power is a structural theory and one of the most integrative theories of gender which focuses primarily on power imbalances (Connell 1987, as quoted in Wingood & DiClemente 1998). The central emphasis of this theory is that the analysis of gender involves three overlapping, but distinct concepts proposed to explain the roles and behaviours of men and women, namely:

a) Economic inequality – referred to as the sexual division of labour;
b) Male partner control within relationships – referred to as sexual division of power; and
c) Social norms related to gender roles – referred to as the structure of cathexis (Wingood & DiClemente 1998).

These three structural models exist at different levels, for example, at family level, societal level and institutional level condoned by social mechanisms.

Furthermore, each of these three structures (the structure of labour, the structure of power and the structure of cathexis), exists at two different levels: the societal and the institutional. The following key concepts draw on the theory of gender and power, but other theoretical perspectives are also considered.

1.7.1 Gender-based violence

SADC (2008) defines gender-based violence as, *"all acts perpetrated against women, men, girls and boys on the basis of their sex which cause or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict".*

The notion of gender-based violence conjures up the image of physical violence against women, despite the fact that it was intended as a gender-neutral term to include the all-pervasive scourge of violence committed against both males and females. Heise, Pitanguy and Germain (1994) acknowledge that in the overwhelming majority of incidents of violence, women are the victims (Namibia Ministry of Health and Social Services 2004:xi). According to the United Nations (2006), there is no single or universal definition of gender-based violence. Understandings differ according to country/culture, community and legal context. The term *'gender-based violence'* in its widest sense, refers to the physical, emotional or sexual abuse of a survivor. Despite this inclusive definition, the term *'gender-based violence'* is widely used as a synonym for violence against women (United Nations 2006).

Gender-based violence may be experienced at separate and multiple stages of the life cycle: Bott, Morrison & Ellsberg (2004:3) define violence against women as *"any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. It encompasses, but is not limited to physical, sexual and psychological violence occurring in the family".* As described by the World Bank (2006), gender-based violence can include, but is not limited to:

1. Physical violence (slapping, kicking, hitting or the use of weapons);
2. Emotional violence (systematic humiliation, controlling behaviour, degrading treatment, threats);
3. Sexual violence (coerced sex, forced into sexual activities considered degrading or humiliating);
4. Economic violence (restricting access to financial or other resources with the purpose of controlling a person).

In the table below, the types of violence commonly experienced at various phases of the life cycle are displayed (Heise *et al.* 1994).

TABLE 1.1: TYPES OF VIOLENCE COMMONLY EXPERIENCED AT VARIOUS PHASES OF THE LIFE CYCLE

Phase	Type of Violence
Prenatal	Prenatal sex selection, battering during pregnancy, coerced pregnancy (rape)
Infancy	Female infancy, emotional and physical abuse, differential access to food & medical care
Childhood	Genital cutting, incest & sexual abuse, differential access to food & medical care & education, child prostitution
Adolescence	Dating & courtship violence, economically coerced, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Reproductive	Abuse of women by intimate partners, marital rape, psychological abuse, sexual abuse in the workplace, sexual harassment, rape
Old Age	Abuse of widows, elder abuse (which affects mostly women)

(Source: Heise *et al.* 1994)

1.7.2 HIV-infection risks

According to Kalichman, Williams, Cherry, Belcher and Nachimson (1998), the risk of HIV infection includes any behaviour that results in exposure to body fluids (blood, semen and vaginal fluids) carrying significant amounts of HIV that could, theoretically, result in HIV transmission. Risks for HIV infection are also determined by co-occurring biological factors such as the viral load of the seropositive partner, co-occurring sexually transmitted infections (STIs) and integrity of genital mucosa (Kalichman *et al.* 1998).

1.7.3 Power

Social psychologists define '*power*' as the capacity to influence the action of others. The application of the sexual division of power at the societal level is where the society assigns women and men unequal powers. In this regard the ability resides primarily at the interpersonal level and occasionally at the institutional level (Wingood & DiClemente 1998).

Empowerment literature defines *'power'* as the ability to act so that change happens in a desired direction. If one person has power over another it means that the 'other' will be powerless. For example, because of many societal expectations that men have control over women in all aspects of relationships, women become powerless. The researcher argues that male power involves decision-making on when and how women will have sexual relations, and on when and how many children women will have. This type of male power is condoned by tradition and social norms. For example, women are being socialised that their first loyalty must be to their next of kin and families, which causes them to act in ways that reinforce rather than challenge female disempowerment.

The socially-structured theory of gender and power developed by Connell (1987), and reworked by DiClemente and Wingood (1997) defines the sexual division of power as maintaining inequalities between men and women. This theory states that the sexual division of power continues to encourage male abuse of power and control over women in relationships. According to Wingood and DiClemente (1998:543), the sexual division of power manifests as behavioural risks and inequities. Furthermore, Wingood and DiClemente (1998) argue that as the power between men and women increases in favour of men, women are more likely to experience adverse health outcomes (Wingood & DiClemente 1998:543).

In this study, the researcher used the theory of gender and power by Connell (1987), as reworked by Wingood and DiClemente (1998), as the guiding theoretical framework. In line with Wingood and DiClemente (1998), the researcher argues that women's lack of power in decision-making at the national level, at household levels, at personal levels as well as in their marriages, negatively affects their sexual autonomy and causes them to be more vulnerable to unwanted pregnancies, sexual violence and infection with HIV. The researcher argues that the sexual division of power sustained at family level, encourages male domination. In this respect, women's bargaining powers within the family are weakened. Women are expected to be passive – which means that they are usually unable to discuss, negotiate or decide on sexual and reproduction issues. When it comes to decision-making in relationships in Namibia, there are important power differences which are based on gender inequality. In other words, unequal parties are not in a position to negotiate when they have sex, they cannot decide how often they want to have sex and how they can protect themselves from STIs and HIV. Men's high-risk behaviour of having multiple sexual partners and the expectation that men have to know more about sex also put them and their partners at risk. These high-risk behaviours also prevent men from seeking information about sexual health.

In Namibia, countless men still refuse to use condoms and women, in particular young women and rural women, are disempowered to decline unprotected sex. HIV and AIDS are not only driven by inequality – it entrenches gender inequality, putting more women, men and children further at danger (Namibia Ministry of Health and Social Services 2008b: xiv).

1.8 CONCLUSION

This chapter established that there is an increasing recognition of power imbalances and GBV as related to the increased risk of HIV infections. This means that power imbalances and GBV should be regarded as public health problems to be addressed in the public health sphere as well as in the sphere of workplace programmes and policies at all levels. Power imbalances and GBV are not only risk factors for HIV infection alone, but also give rise to a host of other health-related problems, which can accumulate in the risk for HIV infection (Brown *et al.* 2003).

Dunkle, Jewkes, Brown, Gray, McIntyre and Harlow (2004) argue that power imbalances and GBV have long-term impacts on women's health, including chronic pain, gynaecological problems, sexually transmitted diseases, depression, post-traumatic stress disorders and suicide (Dunkle *et al.* 2004). It is also true that gender-based violence can occur as a result of an HIV-positive diagnosis. A number of workplace policies that already cover aspects of either HIV/AIDS or gender-based violence or both, are lagging behind in terms of programme implementation. In most workplace programmes gender-based violence and HIV/AIDS are seen as separate issues and are therefore also handled separately, but several studies argue that gender-based violence is an important cause of HIV infection and that an integrated gender-sensitive approach through policy review and programme actions is therefore needed (ILO 2001).

The ILO's (2001) *Code of Practice on HIV* and *AIDS* emphasises that each part of a comprehensive workplace programme on HIV and AIDS needs to be gender-sensitive and needs to include activities for women and men separately as well as together to cover prevention, care and the protection of rights. The researcher, through this qualitative study based on in-depth interviews and narratives with five working women in an airline business, was able to look closely at the perceptions, experiences, beliefs, thoughts and wishes, which allowed her to gain a better understanding of what women experience in abusive situations.

1.9 OUTLINE OF CHAPTERS

The rest of the dissertation is organised in the following way:

Chapter 2 introduces a discussion of the available literature and the theory of gender and power upon which this study was based. In this chapter, three overlapping but distinct concepts are proposed to explain the roles and behaviours of men and women, namely:

a) Economic inequality – referred to as the sexual division of labour;
b) Male partner control within relationships – referred to as sexual division of power; and
c) Social norms related to gender roles – referred to as the structure of cathexis (Wingood & DiClemente 1998).

Chapter 3 outlines the research methodology adopted for this study. In this chapter a description is given of the methods used to answer the main research questions detailed above. Emphasis is placed on the research design and sampling. Data collection methods are discussed where attention is placed on qualitative interviews and narratives. Information is also provided on data analysis and interpretation.

A discussion of ethical considerations is provided where the researcher shows how she observed the ethical principles and protocols during the study. The last part of the chapter concludes with a reflection on the researcher's role.

Chapter 4 provides the findings and an analysis of the research results. In this chapter the researcher analyses the findings of the study in accordance with the research questions and the objectives, and provides an interpretation and summary of the findings.

In the last chapter (Chapter 5), the researcher discusses the general research conclusions and recommendations. In this chapter the focus is on the limitations of the study, suggestions for further research, a summary of the findings, as well as on some recommendations for policy and programmes, and the conclusion.

CHAPTER 2: REVIEW OF LITERATURE

2.1 INTRODUCTION

There is a huge amount of published work in the area of power, gender-based violence and HIV-infection risks among women (see for example Brown, Dunkle, Gray, Harlow, Jewkes and McIntyre 2003; Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow 2004; Manfrin-Ledet & Porche 2003). Whereas this chapter is not an exhaustive review of all the works published on this topic, it is an appraisal of selected and recent works that are relevant to the study. In this chapter, studies from 1979 to 2010 on power imbalances, gender-based violence and HIV-infection risks among women are summarised and discussed. In the subsequent sections of this chapter, the researcher examines the problem of power imbalances, gender-based violence and HIV-infection risks by drawing on evidence of studies conducted by other researchers.

The purpose of the literature review (and of this chapter) is threefold. Firstly, by reviewing research studies that are closely related to the present study, the researcher gained new insights and learnt of new approaches that informed and supported her study and its research design. Secondly and most importantly, in this critical review of related studies the researcher aimed to identify and indicate the gap that other researchers in the field have not focused on. Thirdly, the researcher used the review to help place the study in an appropriate theoretical context. In order to fulfil these three purposes, this chapter is organised in such a way that the problem of power, gender-based violence (GBV) and HIV-infection risks are approached by presenting a definition and providing an overview on the prevalence of gender-based violence. This is followed by looking at GBV as a consequence of gender roles and norms and male dominance, especially in patriarchal societies. Furthermore, it looks at fear of violence, violent retaliation or economic suffering as obstacles to safer sex.

It further discusses Sexually Transmitted Infections (STIs) and HIV infection as a consequence of GBV – due to direct assault and women's biological vulnerability and due to self-esteem problems stemming from being the victim of violence. Finally, this chapter places the study in an appropriate theoretical context, discussing the theoretical perspectives on the problem.

2.2 OTHER RESEARCH ON THE TOPIC OF GBV

This section gives an introduction to gender-based violence and briefly discusses the definition and prevalence of GBV. Manfrin-Ledet and Porche (2003:57) identify GBV as a major public health problem affecting women, regardless of age, culture or socio-economic status. In line with Manfrin-Ledet and Porche (2003), the researcher argues that GBV is a global epidemic that affects the health and economic stability of women, their families and their communities. GBV impinge on every aspect of women's lives – from their personal health and safety and the safety of their families, to their ability to earn a living. Moreover, GBV further has serious consequences for maternal mortality.

The United Nations' Secretary-General (as quoted by the WHO 2000) states that GBV is *"rooted in the historically unequal power relations (social, economic, cultural and political), between males and females. Violence against women is perhaps the most shameful human rights violation … as long as it continues we cannot claim to be making real progress towards equality, development and peace*".

Findings from studies in the United States and Southern Africa reveal that women who are victims of GBV are at risk of becoming infected with HIV. In addition, being HIV-positive is a risk factor for violence against women (Anderson, Cockcroft & Shea 2008:74).

The researchers (Anderson *et al.* 2008) argue that GBV indirectly influences HIV risk by increasing the likelihood of high-risk behaviours (Anderson *et al.* 2008:74). GBV and HIV, according to Manfrin-Ledet and Porche (2003:56), are two critical public health concerns affecting millions of women.

2.2.1 Defining gender-based violence (GBV)

In most literature and research in this field there are different definitions of GBV. There is no standard or uniformed definition of violence against women (Manfrin-Ledet & Porche 2003). The commonly used terms 'domestic violence, domestic abuse, spouse abuse, wife abuse, battering and intimate partner violence (IPV)', are often used to cover sexual as well as non-sexual and other forms of abuse (Manfrin-Ledet & Porche 2003:57).

The Namibia Ministry of Gender Equality and Child Welfare (2009:12), notes that "definitions of GBV vary across and within countries". For the purpose of this study the researcher employed two working definitions of GBV. The one definition of GBV is by the United Nations General Assembly (1993), which defines GBV as *"any act of gender-based violence that results in or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life".* The second definition of GBV is by Dunkle *et al.* (2004): *"any act of verbal or physical force, coercion, or life-threatening deprivation, directed at an individual woman or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty and that perpetuates female subordination."*

GBV includes, but is not limited to (Dunkle *et al.* 2004) acts of physical, sexual and psychological violence by intimate partners, dating partners or family members; sexual assault and rape; childhood sexual assault of girls; sexual harassment and forced prostitution. This means that GBV is a complex phenomenon that includes a combination of physical, emotional, economic, and sexual violence, deprivation and neglect occurring in private or public life.

Both the definitions of GBV by the United Nations General Assembly (1993) and by Dunkle *et al.* (2004) are universally accepted and encompass an inclusive definition of GBV. Both definitions refer to GBV in its widest sense, as physical, sexual violence or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty. There are many similarities between the two definitions. However, the only two differences in the two definitions of GBV are that the United Nations General Assembly (1993), makes provision for *"whether occurring in public or private life"*, whilst Dunkle *et al.* (2004) more specifically refer to the fact that GBV *"perpetuates female subordination".* Although violence is also committed against men (at the hand of women and men), for the purpose of this study, the focus will be GBV as violence committed against females. In this respect, the researcher used both definitions and the term GBV as an operational definition employed for her study which goes beyond the physical dimension.

2.2.2 The prevalence of GBV

The prevalence estimates for GBV vary widely as a result of how GBV is defined. There is an emerging consensus about what constitutes GBV and how it should be measured. The WHO (2004) has designed a set of core indicators which measure aspects of GBV that are agreed on internationally, and these have been employed in a number of countries, including Namibia. According to UNAIDS (2004), women are disproportionately affected by HIV and AIDS.

Statistics have shown that women and girls make up almost 57 per cent of the adult population with HIV and AIDS in sub-Saharan Africa (www.unaids.org). Heise, Ellsberg and Gottemoeller (1999) state that globally at least one in every three women is experiencing beatings, abuse or has been coerced into sex during her lifetime. Brown *et al.* (2003) found high prevalence rates of GBV among South African women. Young women in Swaziland between the ages of 13 and 24 years have reported that one in three of them had experienced some form of sexual violence (including forced and coerced sex) as a child, whereas one in four had experienced physical violence, while three in ten had experienced emotional abuse (Anderson *et al.* 2008:74). In Namibia one out of five Namibians aged 15-49 is HIV-positive, making Namibia one of the top five HIV-affected countries in the world (LaFont & Hubbard 2007:218). According to the Namibia Ministry of Health and Social Services (2008c: vii), the highest age-specific HIV prevalence rate in Namibia is observed among women aged 30-34 years. Taken together, these statistics on the rates of HIV infection and GBV paint a picture of poor health outcomes for many women.

Factors that contribute to GBV include, among others:

i) A general breakdown in law and order, with an increase in all forms of violence, as it is happening in Namibia and other African countries;
ii) The perception by perpetrators that they will not be brought to justice;
iii) Erosion in the social structure and the normal morals of society that control acceptable behaviour in the community (WHO 2004).

2.2.3 The link between GBV and HIV infection

Researchers increasingly cite gender power imbalances and GBV as determinants of women's HIV-infection risk, both worldwide and in South Africa (Kalichman, Williams, Cherry, Belcher & Nachimson 1998).

Studies conducted in the United States and Southern Africa reveal that women victims of GBV are at increased risk of becoming infected by HIV and that being HIV-positive is a factor which increases the probability of violence against women (Anderson *et al.* 2008:73).

Brown *et al.* (2003:9) suggest that the link between GBV and HIV infection is related to three main issues, namely:

1) The possibility of the direct transmission of HIV through forced or coerced sexual acts;
2) The trauma associated with violent experiences can later impact on the sexual behaviour of women; and
3) Violence or the threat of violence may limit women's ability to adopt safer sex practices within relationships, making women vulnerable to HIV infection.

Brown *et al.* (2003:9) state that women's experiences of sexual violence at an early age have been associated with traumatic sexualisation and difficulties in adult relationships. Moreover, research has shown that there is an association between adult experiences of GBV and:

1. having multiple sex partners/multiple sexual encounters (Wingood & DiClemente 1998);
2. low condom use (Kalichman *et al.* 1998);
3. trading sex for money or drugs (Kalichman *et al.* 1998); and
4. women's inability to implement HIV-protective practices (Brown *et al.* 2003).

According to Heise *et al.* (1999), women's economic vulnerability subjects them to HIV risks because women who are economically dependent on men are less empowered to negotiate for safer sex and tend to remain in sexually risky relationships. Brown *et al.* (2003:11), state that women's economic dependence on men makes them vulnerable to transactional sex. Campbell and MacPhail (2001) argue that financial needs introduce imbalances in sexual relations, so that high percentages of women report that they are less likely to request condom use when material gain is at stake. Jacobs (2003) further states that HIV is most prevalent in parts of the world where poverty and economic inequality are extensive, where gender inequality is pervasive and where access to public services is unequal. According to Mufune (2003, as quoted in Cupido, Edwards & Jauch 2009:32), transactional sex appears to be common in the context of widespread poverty and limited employment opportunities. Sexual intercourse has become a commodity widely traded for goods and services by men and women in Namibia (Namibia Ministry of Health and Social Services 2008b:xiv).

According to Strebel, Crawford, Shefer, Cloete, Henda, Kaufman *et al.* (2006), culturally sanctioned gender roles are intimately connected with both GBV and HIV risks (Strebel *et al.* 2006). Jacobs (2003) argues that violence against women and HIV and AIDS overlap in the following ways, namely:

1) Increased risk of HIV infection due to coerced sex, limits women's ability to negotiate HIV-preventative behaviour;
2) Increased risk of violence as a result of disclosure of their HIV status to partners;
3) Forced sex in childhood or adolescence increases the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work, and substance abuse.

Sexual coercion among adolescents and adults is associated with low self-esteem and depression, and other factors that are associated with many of the risk behaviours for HIV infection. The researcher argues that the degree to which women are (or feel) able to control various aspects of their sexual lives, is a critical aspect in HIV and AIDS prevention. Violence or fear of violence has been implicated as a barrier to safer sex. The imbalances of power between women and men promote the idea of men needing sex and constrain women's ability to negotiate for safer sex or to refuse sex (Kinsman, Nyanzi & Pool 2001).

Limited sexual power (resulting in 'choice disability' where women are unable to make decisions) on the part of women is associated with inconsistent condom use. In turn, inconsistent condom use is associated with HIV infection (Pettifor, Measham, Rees & Padian 2004). The Namibia Demographic and Health Survey (NDHS) (quoted in the Namibia Ministry of Health and Social Services 2008: xiv) found that pervasive alcohol abuse and perceived low levels of HIV risk serve to foster multiple and concurrent partnerships and to discourage consistent condom use. Kinsman, Nyanzi and Pool (2001) have shown that men's use of violence is linked to their own sexual risk taking as well as their partner's risks of HIV and other sexually transmitted diseases.

2.3 THEORETICAL POINT OF DEPARTURE

In this first section several theoretical perspectives on violence against women and HIV-risk behaviour reduction are summarised. The second section focuses on the specific theoretical viewpoint chosen for the study.

2.3.1 Theoretical models on violence and abuse against women (VAAW)

According to Manfrin-Ledet and Porche (2003:59), the following are the six main theories of VAAW that emerge from literature:

1. **The psychopathology theory of the abuser** looks at abuser-specific causal factors such as mental illness, developmental disability and substance use (Manfrin-Ledet & Porche 2003:59).

2. **The social learning theory** (1973, as conceptualised by Bandura 1993), views the exposure, direct experience and observation of violence of a person in childhood as learned rather than being instinctive behaviour. Learned patterns of violence can repeat themselves over generations and can be reinforced when aggression and interpersonal violence are seen as means of resolving conflict. There is thus a strong possibility for victims of violence to become abusers themselves (Manfrin-Ledet & Porche 2003:59).

3. The **cycle of violence theory**, proposed by Walker (2006:146), posits that violence is continually repeated through three distinct phases in intimate relationships. Firstly, in the tension-building phase, the victim is subjected to controlling tactics by the perpetrator through threats and minor assaults. In the tension-building phase the victim in return will react in a calm way so as to appease the perpetrator in an attempt to prevent violence. Secondly, in the acute battering incident phase, there is an outbreak of serious violence. In this phase a battered woman might remain in the violent relationship out of concern for survival for herself and her children. Thirdly, in the honeymoon phase, the perpetrator is extremely loving and apologetic and promises to never commit violence again (Walker 2006:146).

4. The **stress theory of Pillemer and Finkelhor** (1988, as quoted by Manfrin-Ledet & Porche 2003) focuses on failures in the perpetrator's coping skills in stressful situations (Manfrin-Ledet & Porche 2003:60).

Stressful situations such as pregnancy, financial problems and job-related stress can provoke some people to become violent. The perpetrator in stressful situations has poor problem-solving and coping skills. This theory holds that stress triggers violent episodes (Manfrin-Ledet & Porche 2003:59-60).

5. **The gender-politics model or socio-political model** by Stark, Flitcraft, Zuckerman, Grey, Robinson and Frazier (1981) states that VAAW is a result of male dominance over women. This model works with the notion of male *machismo,* where men feel that their control over women is a given and violence results when such taken-for-granted assumptions are threatened (Manfrin-Ledet & Porche 2003:60).

6. **The theory of gender and power**, developed by Connell (1987), is based on sexual inequality, power imbalances, gender-specific norms and power dynamics in relationships. This theory seeks to understand the risks women experience in different social contexts (Manfrin-Ledet & Porche 2003:60). In this study, the theory of gender and power was used as the guiding theoretical framework. The major tenets of this theory are discussed below.

2.3.2 The tenets of the theory of gender and power and its applicability to HIV-infection risks

The theory of gender and power, as conceptualised by Connell (1987), and then reworked by Wingood and DiClemente (1998), posits that three major structures typify gendered relationships, namely:

1) The sexual division of labour;
2) The sexual division of power, and
3) The structure of cathexis (Wingood & DiClemente 1998:539).

2.3.2.1 The sexual division of labour

Male dominance is achieved in what Connell calls hegemonic masculinity (Demetriou 2001:339). Hegemonic masculinity encapsulates the complex nature of femininities and masculinities and the power relationships between genders (Demetriou 2001:339). At societal level, labour is allocated differently to men and women (DiClemente & Wingood 2000:542). This division of labour results in women being allocated certain occupations which are less paid whereas men are allocated well-paid positions. Such organisation of women's work limits their economic potential and confines their career path (DiClemente & Wingood 2000:543). Moreover, women are allocated "unpaid nurturing work" such as child care, domestic work or caring for the sick and the dying. This results in economic imbalances, making women economically vulnerable and dependent on men (DiClemente & Wingood 2000:542).

Furthermore, Connell (1987, as quoted in Demetriou 2001:339) states that *"hegemonic masculinity can be defined as the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women*". Men's position in patriarchal societies gives them material advantages, such as higher incomes or easier access to education, something that Connell calls the "patriarchal dividend" (Demetriou 2001:341). This, in turn, gives rise to a range of economic vulnerabilities that underscore women's inability to challenge the *status quo* (Wingood & DiClemente 1998:542).

Pettifor, Measham, Rees and Padian (2004) have found that in the context of poverty, women regard money as the driving force for relationship formation. For example, young school girls have sexual relationship with older men for money so that they can buy food and clothing.

It can be concluded that poverty might fuel risky behaviours that expose women to HIV infection. Furthermore, it should be kept in mind that poor women may be unable to afford prevention materials such as condoms, increasing their exposure to HIV infection. In turn, poverty may result in girls dropping out of school so as to take care of the household chores, agricultural and home-based work (Wingood & DiClemente 1998; Pettifor *et al.* 2004).

The disparities in income, employment and access to resources with regard to gender in Namibia are clear. Of the economically inactive section of the Namibian population, 43,1 per cent is classified as homemakers, with women accounting for 70 per cent of this figure (Edwards 2007). Women do the bulk of caregiving tasks, yet are considerably under-represented in the formal economy, especially in managerial positions. Female-headed households, which account for approximately 40 per cent of all households, have a *per capita* income of N$7528. In contrast, male-headed households have a *per capita* income of N$12 248. According to the National Planning Commission (NPC) (2004, as quoted by the Namibia Ministry of Health and Social Services 2008) these figures point to a large number of single mothers and to the continued economic marginalisation of women in the Namibian society (Cupido, Edwards & Jauch 2009:32).

According to the Namibia Demographic and Health Survey (2006-7, as quoted by the Namibia Ministry of Health and Social Services 2008), despite high levels of knowledge about how HIV is transmitted and prevented, many women in Namibia lack control over their own reproductive health. Economic dependence, sexual violence and patriarchy constrain their ability to express their own sexual preferences and desires.

In Namibia the face of HIV and AIDS is a woman, because in Namibia, women account for 3 out of every 4 new infections (Namibia Ministry of Health and Social Services 2008c).

Unemployed and under-employed Namibian women are vulnerable to contract HIV because of their economic dependence on men, and they are less able to negotiate condom use. Mufune (2008, as quoted in Cupido, Edwards & Jauch 2009:32), states that in Namibia, transactional sex is seen as a normal part of forming a partnership for survival purposes. In such relationships, women exchange sex for food, money, gifts, drinks, transportation or other favours. LeBeau and Mufune (2004) argue that transactional sex is born out of a structure of omnipresent poverty and high income disparities in which young women's access to resources is almost entirely via more affluent men. On the other hand, Mufune (2008, as quoted in Cupido, Edwards & Jauch 2009:32), states that transactional sex is not necessarily linked to complete poverty; it often occurs simply to advance material security and attain goods and services beyond the individual's wealth.

2.3.2.2 The sexual division of power

Power is defined as the ability to act or influence change in a desired way at the individual, interpersonal, institutional and community level (DiClemente & Wingood 2000:543). If one person has power over another it means that the 'other' will be powerless. Powerlessness is described by Wallerstein (1992) as referring to alienation, victim-blaming, learned helplessness, internalised oppression or hidden injuries. The sexual division of power is maintained by the abuse of authority and control in relationships. According to DiClemente and Wingood (2000:543), the sexual division of power manifests as behavioural risks and inequities. Furthermore, DiClemente and Wingood (2000) argue that as the power between men and women increases in favour of men, women are more likely to experience adverse health outcomes.

2.3.2.3 The structure of cathexis

DiClemente and Wingood (2000) refer to cathexis as the structure of affective attachments and social norms.

The structure of cathexis prescribes sexual norms and defines how women should conduct themselves sexually. For example, a woman might be labelled as 'immoral' if she had premarital sex.

At the institutional level women at risk of HIV infection include those who adhere strongly to conservative cultural norms and traditional beliefs. As such, they are less likely to negotiate safer sex with men. Pettifor, Measham, Rees and Padian (2004, as quoted in Brown *et al.* 2003) argue that women will wait for their male partners to suggest using a condom. Women who internalise such norms and beliefs often remain in relationships that are physically, psychologically and economically violent. For example, Dunkle *et al.* (2004) have found that women in relationships with high levels of male control were more likely to report partner violence, yet they continued living in those situations.

2.3.3 Looking at GBV and HIV-infection risk through the lens of the theory of gender and power

In the sexual division of labour there is a differential allocation of jobs and income between the sexes. Often women do unpaid work or occupy low-paying jobs. This puts women at a disadvantage and makes them prone to abuse. A woman who is abused will be less likely to seek help if she is financially dependent on her abuser. According to Jacobs (2003), women who depend on their husbands financially, are less likely to negotiate safer sex, because of fear of rejection. Women facing abject poverty may form relationships that are driven mainly by material gain. In such relationships, safer sex is less likely to be practised.

Other social mechanisms related to the sexual division of labour include practices that favour male educational attainment. Less educational attainment put women at risk for abuse and being infected with HIV. Studies have found that women with less than a high school education are less likely to use condoms (DiClemente & Wingood 1997).

Women who are disempowered are less likely to negotiate safer sex with their partners and are thus vulnerable to HIV infection. Wallerstein (1992) and DiClemente and Wingood (2000) argue that powerlessness affect the health of people. In this regard, a woman's sense of self-efficacy can play a major role in how she approaches goals, tasks, and challenges. Women with a low sense of self-efficacy may believe that obstacles are tougher to overcome than what they really are. This fosters anxiety, stress, depression, and a narrow vision of how best to solve a problem. In addition to self-efficacy, people's behaviours often depend on their perceptions of risk. Two aspects are relevant:

i) the perceived likelihood of acquiring the infection, and
ii) the expected impact that the disease will have on one's life.

Namibia Ministry of Health and Social Services (2008a:28) states that studies conducted by SIAPAC (2005), Parker and Connolly (2008a) and UNICEF (2006) found that the behaviour of young Namibian men depend on their perception of risk. In this regard, 62 per cent of young Namibian men between the ages of 15 and 24 in five of Namibia's high prevalence communities, practised high-risk behaviours by having multiple and concurrent partners. High-risk behaviour in its wider sense, refers to *"alcohol and drug abuse, abusive behaviour (emotional, physical and financial), having anal sex with or without a condom, having multiple sexual partners, insistence on having unprotected sex (not using a condom) and having protected sex with an infected person*" (www.etd.rau.ac.za/theses). The young Namibian men between the ages of 15 and 24 in these studies did not use condoms or used condoms inconsistently. They were in denial and did not perceive themselves at risk of HIV infection. According to the Namibia Ministry of Health and Social Services (2008a:28), studies conducted by SIAPAC (2005), UNICEF (2006), and Parker and Connolly (2008a), found that some Namibian women perceived themselves at risk of HIV infection, while 33 per cent of them perceived some slight risk or no risk of becoming infected with HIV.

According to National Demography Health Survey (2006) and SIAPAC (2005, as quoted by the Ministry of Health and Social Services 2008a), a number of Namibians do not consider the usefulness of condoms, and countless women carry on not being empowered enough to take control over their sexual relationships (Namibia Ministry of Health and Social Services (2008a:28). LeBeau and Mufune (2001, as quoted in the Namibia Ministry of Health and Social Services 2008b), state that this situation contributes to many people, in particular the unemployed and poor in city centres, not being motivated to practise safer sex. LeBeau and Mufune (2001, as quoted in the Namibian Ministry of Health and Social Services 2008b:29) state that several Namibians compromise the safety of their conduct without internalising the dangers. It is also evident that the rest are in denial by pretending not to think about HIV or they prefer to position HIV far away from their minds. The researcher, in line with LeBeau and Mufune (2001, as quoted in the Namibian Ministry of Health and Social Services 2008b) argues that women who do not have HIV and AIDS education have a reduced amount of HIV/AIDS awareness. Such women will not be acquainted with HIV- and AIDS-deterrent practices such as not having sexual intercourse with an HIV-positive person, practising safer sex, or not using the same needles and syringes. These women will also not be acquainted with how HIV is transmitted and will therefore put themselves at high risk of contracting HIV.

2.4 CONCLUSION

In this chapter the researcher reviewed studies on gender power, GBV and HIV-infection risks among women. In the critical review of related studies, the researcher identified and would like to indicate the gap that other researchers in the field have not focussed on, namely, that to date no other study of this nature has been conducted in an African context and in particularly in an airline business in Namibia.

The study focussed on women, because besides the multiple social issues they are often burdened with, namely power imbalances, GBV and HIV-infection risks, another gap identified and indicated by the researcher was that very little research has been done to understand the perceptions and challenges faced by working women in an airline business in Namibia. It is however interesting to note, that although an increasing number of studies has been conducted on power imbalances, GBV and HIV/AIDS during the last ten years, most research in this fields did not focused on working women's perceptions of power, GBV and HIV-infection risks particularly in an airline business. It was thus interesting for the researcher to explore in the voices of the working women in an airline business their perceptions of power, GBV and HIV-infection risks. The fact that there was no such study conducted in an airline business in Namibia did seem to indicate, indeed, the need for such a study in order to fill the gap that other researchers in the field have not focussed on and to contribute meaningfully to research. In light of this, findings from this study are simply meant to enrich, to contribute in filling the gap and to enrich our knowledge on working women's perceptions of power, GBV and HIV-infections risks. This research, therefore meant to contribute in terms of methods, substantive knowledge, insight on theoretical enlightenment, its overall objective being to gain a better understanding of the perceptions and experiences of working women affected by power imbalances, GBV and HIV-infection risks. The critical review of related studies in filling the gap, did not only serve meaningful, but the results of the analysis could be of value for the management of any airline, gaining insights into working women's perceptions and experiences of power imbalances, GBV and HIV-infection risks in an airline business.

In this chapter the definition and prevalence of GBV were also discussed. The researcher applied the theory of gender and power to place her study in an appropriate theoretical context. It was argued that gender power inequalities, power imbalances and GBV put women at risk of HIV infection. In the following chapter, the researcher discusses the research methodology.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

In the preceding chapter, the researcher reviewed literature concerning power, GBV and HIV infection. In this chapter, the researcher focuses on the research methodology used in the study. This chapter gives a description of the methods used to answer the main research questions as detailed in Chapter 1. Emphasis is placed on the research design and sampling. Data collection methods are discussed where attention is placed on qualitative interviews and narratives. Information is also provided on data analysis and interpretation. A discussion of ethical considerations is provided where the researcher shows how she observed the ethical principles and protocols during the study. The last part of the chapter concludes with a reflection on the researcher's role.

A qualitative approach was chosen because the nature of the research problem and the stated objectives demanded an idiographic, case-based approach (Denzin & Lincoln 2003:28). This approach enabled the researcher to gain a better understanding of working women's perceptions of power, GBV and HIV-infection risks in their intimate relationships.

3.2 THE CHOSEN RESEARCH DESIGN

The study was exploratory and descriptive in nature (Neuman 2000:22). Denzin and Lincoln (2003) note that as qualitative researchers seek answers to questions that stress how social experiences are created and given meaning, their research is value-laden. The theory of gender and power was used as a theoretical point of departure and to find sensitising concepts to steer the data collection. The chosen qualitative approach offered the researcher the opportunity to seek an in-depth understanding of complex human experiences (Lietz, Langer & Furman 2006:445).

Qualitative research aims to capture the lived experiences of social actors and the meanings that people give to these experiences from their own perspectives. For the purpose of this study it is important to note that although a focus group session was important to illicit recommendations on how the respondents suggest women to cope in similar situations, due to confidentiality and the sensitive nature of this research the researcher decided not to conduct focus group sessions within the workplace of the airline business.

In order to obtain detailed, varied and extensive data in this study, the researcher conducted semi-structured, individual in-depth, face-to-face interviews, following a narrative approach.

3.2.1 In-depth, face-to- face interviews

According to Warren and Karner (2010:2), qualitative interviewing involves present-time, face-to-face interaction. The researcher used face-to-face interviews as a primary data collection technique for this study. The in-depth interviews were conducted on a dyad basis *(*one interviewer and one respondent), as described by Warren and Karner (2010:2). This enabled the researcher to focus entirely on one respondent at a time, observing and noting each woman's expressions and body language while she was responding to the questions asked.

According to Adler and Clark (2008:271), qualitative interviews can vary from unstructured to semi-structured interactions. Semi-structured interviews are described by these researchers as designed ahead of time but modified as appropriate for each individual participant. Patton (1990:278) argues that at the root of interviewing is an interest in understanding the experiences of other people and the meaning they make of those experiences. In the in-depth face-to-face interviews, the researcher did not only ask questions, but also recorded and systematically documented the participant's responses, coupled with intense probing in order to obtain deeper understanding of the responses.

All of the interviews were conducted in English. The semi-structured interview schedule was prepared in advance, but the researcher allowed the interview to flow naturally based on information gathered from the participant. The interview schedule, developed on the basis of the literature review, comprised eight main sections and 62 questions. The interview schedule (see Appendix 5) included Pulerwitz, Gortmaker and DeJong's (2000) Sexual Relationship Power Scale. An expert was interviewed to pre-test the interview schedule. She holds a Master's Degree in Social Work. The goal was to test the interview schedule in order to ensure clarity of the research instrument, as well as to establish the time to be taken in answering the questions. The expert commented positively on the interview schedule and on the way the interview was conducted. She reported that she found the questions of the interview schedule relevant and clear. She suggested the inclusion of a question under Section 8 on the sharing of an HIV-positive status, by asking the participants on how they might react if they found out that their partner was HIV-positive.

The researcher began each interview by introducing herself and explaining what her study was about, emphasising the importance of the data that the participant would give her by answering the questions she asked. The researcher made it very clear that she was not there to judge, but simply to understand the research participants, so that she could interpret what their perceptions and experiences of gender power, GBV and HIV-infection risks were.

The researcher gave the participants the informed consent forms to read (the English translation of which is available in Appendix 4), and highlighted the fact that the researcher would be happy to answer any question that the participant may have relating to the written text. As some of the participants were well educated women with some research experience, it was easy to conduct the interviews with them. The researcher guided them through the conversation until all the important issues on the interview schedule were explored.

The researcher listened attentively and very patiently to what the participants had to say, because she wanted to let the participants say as much as possible about any particular theme she was trying to probe. As a result, the researcher did not get to the end of the interviews quickly. Some interviews took an hour and ten minutes, but the researcher found that the participants were forthcoming in the re-telling of their stories.

In fact, one of the participants regarded the interview as cathartic and said: *"Even if my life story can just change one life, I will be happy."* Another participant thanked the researcher for including her in the research, because she was desperately looking for some donor who could fund her book about her personal life story. Two of the participants indicated that they were currently in the process of writing up their own life stories. All of the participants felt grateful for the opportunity to tell an outsider about their perceptions and experiences.

The researcher tape-recorded her interviews. None of the participants objected to this as they understood how important accuracy was for the credibility of the findings. The interviews took place in the researcher's office – an arrangement preferred by all of the participants. In addition to the interviews, respondents were encouraged to write down further narratives about the issues discussed. A deadline was agreed upon for submission of their narratives. This was two weeks after the individual interviews were conducted. The narratives were used to complement the in-depth interview transcripts.

3.2.2 Choosing a narrative approach

According to Overcash (2003:179), narrative research can be defined as collecting and analysing people's accounts of experiences and their interpretations of those experiences.

Narrative research enables the exploration of personal experiences beyond the boundaries of a questionnaire, providing insight into decisions and actions (Overcash 2003). A narrative account details someone's unique experiences and perceptions. The reason why the researcher wished to follow a narrative approach in this study is that she wished to examine the central issues from the perspective of women, to access their stories, to *"tap into their usual ways of expressing themselves",* and "*to incorporate the context and chronology of events while imparting meaning and relaying larger cultural themes and values"* (Ismail, Berman & Ward-Griffin 2007:461). In her experience of women's talk about abuse and violence (as described in the earlier part of this dissertation), the researcher became familiar with the potential of narration to, in the voices of the narrators, contextualise unique experiences and to offer insights into the dynamics of GBV and women's vulnerability to HIV.

3.3 RECRUITMENT, SAMPLING AND INCLUSION CRITERIA

According to Adler and Clark (2008:121), for many exploratory studies and much qualitative research, purposive sampling is desirable. The participants were recruited on a voluntary basis, using a purposive sampling technique.

The target population consisted of working women between the ages of 38 and 44 years who experienced power imbalances, GBV and HIV-infection risk. Participants of this study were selected in accordance with the following criteria:

- Participants were women working at an airline business;
- Participants had all experienced some form of power imbalances, GBV and HIV-infection risks;
- Participants were all over 18 years of age;
- Participants were all voluntarily willing to participate in this study and to be interviewed and tape-recorded.

The researcher approached those women who indicated in 2008 that they would like to participate in a study to share their personal experiences of GBV for their participation in this study. An information letter and informed consent form (which are available in Appendix 3) were handed to the eligible participants by the researcher.

3.4 DATA ANALYSIS AND INTERPRETATION

Data analysis and interpretation as described by Liamputtong and Ezzy (2005:257) is the process through which the researchers intentionally immerse themselves in data by reading and rereading the data. In this regard, as pointed out by Du Plessis (2009:2), researchers have to order and reduce data according to the objectives and topics of discussion. The data was analysed and interpreted by applying a generalised inductive approach for qualitative data analysis.

Such an approach, according to Thomas (2003:2), is a systematic procedure for analysing qualitative data, guided by specific objectives. Shortly after each interview, the researcher transcribed each qualitative interview from the audio-tape recording. Analytic memos were added to the transcriptions. The analytic memos were intended to record the researcher's emotional responses to the interviews, including her thoughts, feelings and biases to help the analytic process.

The researcher studied all the interview transcripts, narratives and her field notes as well as her reflective notes. She read and reread the interviews several times in order to understand and highlight commonalities. Linkages and expressions were later grouped into themes. Such themes were used as codes to organise the data by coding sections of text.

3.5 ISSUES OF RELIABILITY AND VALIDITY

According to Neuman (2007:120), *"qualitative researchers are more interested in authenticity than validity. Authenticity means giving a fair, honest and balanced account of social life from the viewpoint of someone who lives it every day".*

The researcher found it imperative to understand the experiences of the participants from their point of view. The credibility of the data-generation process was enhanced and protected through immersion in the narration of the research participants. In this regard, Neuman (2007:249) explains that *"field researchers depend on what members tell them. This makes the credibility of members and their statements part of reliability…field researchers takes subjectivity and context into account as they evaluate credibility".*

The open-endedness of narrative research is the strength of the method, and there is no primary method for assessment of validity and reliability (Overcash 2003). Narrative methods lend themselves to a holistic view of human experience. Overcash (2003:182) states that, as with all research, one final test of validity exists, namely the ability of the researcher to determine whether there is something abnormal or generally wrong with the data. By critically reviewing the research conclusions, questions may present themselves concerning the population, method of analysis or general procedures. In qualitative research, consistency tends to be a foremost element to collecting and analysing the data. Consistency has been achieved in the interviews by using the interview schedule, the use of a secure setting in which the interviews were conducted and the use of the participants' own writing. Rolfe (2006:305) emphasises the trustworthiness of qualitative work, which encompasses:

1. credibility, which is comparable with internal validity;
2. dependability, which is the same as reliability;
3. transferability, which is similar to external validity; and
4. conformability.

The researcher is a social worker by profession, familiar with counselling. She is experienced in working with women on the issue of GBV and HIV and AIDS for many years. The narrations generated presented a credible overview of lived experiences of GBV. The researcher knows and understands different cultures such as Baster, Nama-Damara, Oshiwambo and Oshiherero. The transferability of the data was evaluated in terms of the meaningfulness of the findings (see Chapter 5). Rolfe (2006:309) declares: *"Quality judgements entail a subjective 'reading' of the research text, and the responsibility for appraising research lies with the reader rather than with the writer of the report; with the consumer of the research rather than with the researchers themselves. This does not preclude the researchers from appraising the quality of their own work, but rather suggests that the readings of the researchers carry no more authority than those of the consumers of that research."*

3.6 ETHICAL CONSIDERATIONS

The ethical principles of confidentiality and respect are especially relevant in the research field of GBV, due to the traumatic and sensitive nature of the subject material (Heise, Ellsberg & Gottemoeller 1999). The researcher thus carefully considered the issues of confidentiality, disclosure and the need to ensure adequate and informed consent. The researcher submitted a research proposal for human participation research to the University of South Africa's Ethical Clearance Committee. Clearance was granted (see Appendix 6).

3.6.1 Confidentiality

In order to protect the privacy of the participants, the researcher ensured that interviews took place at a venue away from the public eye and that no unnecessary disturbances occurred. The researcher set up an informed consent form in which she undertook to protect the confidentiality of the participants and their data (see Appendix 4).

Furthermore, the researcher pledged to keep all participants' responses strictly confidential. In order to protect the identity of the participant, the researcher disguised the participants' real names by using pseudonyms in the field notes and transcripts of the interviews. The researcher also ensured that the data was kept locked in a safe and secure place to protect the confidentiality of the information from others, until it can be destroyed.

3.6.2 Voluntary, informed consent

Neuman (2000:96) points out that a researcher must never coerce anyone into participating. In this regard, the researcher ensured voluntary participation by all the participants by asking them to sign a statement of 'informed consent' (see Appendix 4: Informed Consent Form).

Each participant was given a full explanation of the purpose of the study. They were informed that their information was for the purposes of academic research only. The participants were reminded that their participation was voluntary and that they could withdraw at any time without any threat to their families or themselves. Two of the participants withdrew from the study prior to the in-depth, face-to-face interviews. One of the two is in an abusive marital relationship and has since registered a divorce case. The other woman withdrew her participation, explaining that she felt that she would betray her husband by participating in the study. She explained that she really wanted to tell her story, but despite the abuse she suffered in her marriage, she did not feel confident or safe to participate.

Both the participants' withdrawals were respected and they were referred to external psychologists and therapists. All of the participants signed the consent forms in duplicate (one was for the researcher and the other for the participant). A guarantee of confidentiality of records and the protection of the identity of the participant was included in the written informed consent statement.

This helped the participants to build trust and confidence amongst themselves, also with the researcher.

3.6.3 Provision of debriefing, counselling and additional information

Considering the potential emotional strain the participants might experience, the researcher made sure that provision was made for participants to debrief at the end of each interview in order to make sure that no one went home feeling distressed. The researcher offered all participants with referral information for local support services specialising in violence against women and HIV and AIDS. Contact details for additional information, debriefing or counselling were provided.

3.7 REFLECTING ON THE ROLE OF THE RESEARCHER

According to Malacrida (2007:1329-1339), traditional reflective journaling is very important in ensuring the emotional safety of researchers. Given the researcher's professional status in the workplace as a social worker responsible for employee wellness, and being a working colleague to the participants with whom the interviews were conducted, personal and emotionally overwhelming issues were of concern. Babbie and Mouton (2008:317) point out that reactivity might occur in such studies, since research participants react to the characteristics of the researcher.

However, the researcher endeavoured not to allow her professional role to interfere with her role as a researcher. The researcher ensured that she remained the investigator, not the helper or counsellor. The researcher ensured that referral systems were in place. In research, the emotional response from the researcher in collecting, analysing and interpreting data can also shape the research process. Hearing, typing, reading and coding the stories of the participants, can make the researcher feel sad.

However, due to the researcher's experience in such a process and her training as a social worker, she had listening, counselling and communication skills. This also tempered the emotional impact of the research, as the researcher knew that she was doing something about it – she could make a difference. In this qualitative research, the researcher was the insider, telling the story to the outsiders, without imposing her own conceptual frameworks with the hope that the findings of her research may assist decision-makers to understand better the situation of working women's perceptions and experiences of power, GBV and HIV-infection risks. These skills enabled the researcher to feel empathy for the participants. The researcher ensured her own emotional safety (and by extension that of her research participants) by arranging appropriate debriefing sessions in consultation with her mentor.

In an important discussion about the implications of the values, histories and social locations of researchers who engaged in the study of other people's lives, Mauther and Doucet (2003) encourage qualitative researchers to develop a practical and visible process of reflectivity. They are of the opinion that in this process, an understanding of the self in relation to the research and an accounting for one's research choices can be achieved. Thus, before analysing other people's accounts of their lives, it seemed appropriate for the researcher to reflect on her own accounts. The researcher's primary reason of engaging in this study was to provide an opportunity for emancipatory knowledge production in which participants' stories are told as a way of naming hurts and outlining injustices and as a way to move forward.

3.8 SUMMARY

This chapter considered the research methodology, namely the research design, sampling techniques, data collection methods and instruments, data analysis and interpretation, issues of reliability and validity, followed by ethical considerations and a reflection on the role of the researcher.

The research design followed a qualitative approach and sought to investigate the perceptions on power, GBV and HIV infections in the intimate relationships of women working at an airline business. The study used a non-probability sampling technique and a total of five working women were interviewed as participants on a voluntary basis. The focus was on collecting in-depth data through in-depth interview transcripts, narratives, research journal records, field notes and reflective notes. Reflective approaches ensure the emotional safety of researchers and foster opportunities for emancipatory consciousness among research team members (Malacrida 2007).

In the next chapter (Chapter 4), the researcher will be dealing with the research findings and interpretations.

CHAPTER 4: FINDINGS

4.1 INTRODUCTION

In this chapter the researcher presents the findings and the analysis thereof. The data was generated through semi-structured, in-depth, face-to-face interviews that elicited narrations of lived experience. As such, this chapter is a rendition of the stories of five women working in an airline business, who shared their perceptions and experiences of power, GBV and HIV-infection risks in their intimate relationships. Such a rendition is structured through a re-reading of the theoretical backdrop to the study as presented in Chapter 2 of the dissertation, a reflection on the objectives of the study and various cycles of data generation and interpretation. The biographical profiles of the research participants are described below. To protect the identities of the research participants, the researcher assigned pseudonyms to each woman. Readers are thus introduced to Sandra, Meghan, Carien, Faith and Lina. Moreover, the names of significant others in the women's profiles and narrations have also been changed to protect the identities of such individuals.

The chapter commences with a biographical account of the participants, which is then followed by a presentation of the research findings and interpretation in terms of working women's perceptions and their experiences of power, GBV and HIV-infection risks. The chapter concludes with a summary of the interpretations of the research findings and a conclusion.

4.2 CHARACTERISTICS OF THE PARTICIPANTS

The researcher interviewed a total of five working women in an airline business. These women were between the ages of 36 and 44 years and shared their experiences and perceptions of power, GBV and HIV-infection risks.

Four of the women were high school graduates, while only one did not graduate from high school due to a teenage pregnancy. At the time of the study, three out of the five participants interviewed had been working in the airline business as supervisors in office administration positions for ten to 15 years, while one participant had been occupying a senior position at middle-management level for the past 18 years. The non-high school graduate had been working as a shift worker in the airline business for seven years, which placed her on the lower level as a shift worker within the large middle occupational ranks group in the airline business. This group consisted mainly of women in supervisory and middle-management positions. While the majority of women were not in managerial positions and therefore were not from the upper occupational ranks, it is also evident that they did not belong to the lower occupational groupings, which are mainly characterised by workers with low levels of literacy. The majority of the participants belonged to what could be described as a middle-income group.

The majority of the participants were Oshiwambo-speaking and were in the 36- to 43-years age bracket, while two of the participants were Afrikaans-speaking and in the 42- to 44-years age bracket. All of the participants were well-versed in English. Four of the five participants had been married. At the time of the study, two of them were still married, while two had been divorced, and one participant had never been married.

All five of the participants had motherhood experiences and had raised their own biological children. The research did not require determining what the HIV status of the participants was. However, during the researcher's journey of discovery, one participant, a single mother, voluntarily disclosed that she was HIV-positive. Another participant disclosed that she was part of a serodiscordant, couple as her husband was HIV-positive and she was HIV-negative.

So in addition to having to deal with the challenges posed by power imbalances and GBV, one participant in the study also carried the psychological burden of being a person living with HIV. The other participant who was part of a serodiscordant couple was faced with the emotional burden of ensuring that her husband lived positively with HIV, while needing to guard herself from becoming infected with HIV. Faith revealed: *"I go for voluntary counselling and testing on a regular basis since I know that my partner is HIV-positive despite the fact that we use condoms. I need to check on myself, because I think my husband is not faithful."*

The fact that the research participants came from different ethnic groups, had different educational qualifications and work experiences in different fields, as well as the fact that their marital status and HIV statuses were different, made them a unique study group who was not typical for women in Namibia. In providing the biographical sketch of each of the research participants below, the researcher wanted to provide the reader with a context for better understanding these women's stories.

4.2.1 Sandra

Sandra, 36 years old, was the youngest participant. She was Oshiwambo and English speaking. She completed high school and took up several jobs doing administrative work. At the time of the data gathering she had been working in the airline business for 15 years in a supervisory capacity. At the age of 20, Sandra started a long-term intimate relationship with Simon, who was six years her senior. According to her, Simon established himself as the major decision-maker in the relationship (which lasted eight years), whereas Sandra was submissive. This relationship was characterised by different forms of GBV, such as economic abuse, physical abuse and sexual abuse. Simon was involved in multiple concurrent sexual relationships. According to Sandra, this resulted in both of them becoming infected with HIV.

The relationship also produced an unwanted pregnancy. Antenatal HIV-testing revealed to Sandra that she was HIV-positive. She gave birth to a baby girl, now 12 years of age, who at the time of data gathering still tested HIV-negative. Sandra's relationship with Simon did not last long after the birth of their daughter. Simon passed away in 2004, because his HIV infection had already progressed to an advanced stage. For the 12 years prior to the interviews, Sandra lived with HIV as a single working mother. At the time of the study she was the only participant who never got married and was not involved in other sexual relationships. During the time of the interview, Sandra had already completed two years of antiretroviral therapy (ART). Apart from the researcher, Sandra had disclosed her HIV status to some of her immediate family members, close friends and to some of the managers in the airline business.

4.2.2 Meghan

Meghan was 42 years old and spoke Afrikaans and English. Like Sandra, she held several jobs after graduating from high school, but furthered her qualifications to the level of a postgraduate degree. At the time of the data gathering she had been working with the airline business for 15 years as a flight attendant and for 3 years in a middle-management position. Meghan was a divorcee who had been married for 17 years, separated for two years and divorced for the past four years. Her marriage had produced two children.

Meghan's husband was her first and only serious love and sexual relationship. During the first year of marriage, her husband became involved in a relationship with another woman. This extra-marital relationship produced a child. The affair resulted in a breakdown of trust in the spousal relationship, which was exacerbated by emotional abuse perpetrated by the husband. In addition, the couple reportedly had many arguments which escalated into physical fights about finances and the extra-marital relationship.

4.2.3 Faith

Faith was 43 years old, an Oshiwambo and English speaking. She had been married for 20 years. She met her husband, Fanie and got married to him while they were in exile in Angola. Faith had been working in the airline business for 12 years in a supervisory capacity. The couple have three children. After graduating from high school, Faith furthered her qualifications in tertiary studies. Faith reported that her husband abused alcohol and had multiple concurrent sexual relationships. According to Faith, this risky lifestyle resulted in him being infected with HIV.

Faith was at risk of HIV infection from her husband, because they had not used condoms prior to discovering his HIV-positive status. However, at the time of the study Faith tested negative for HIV.

4.2.4 Lina

Lina was 43 years old and spoke Oshiwambo and English. Lina had been married for the past 17 years and have three children. Lina and her husband both graduated from high school. At the time of this research, Lina was furthering her postgraduate studies in Human Resources Management. Lina described how her husband had suffered from negative childhood experiences which according to her caused him to be a negative person. Lina and the children reportedly suffered emotional and psychological abuse at the hands of this man. At the time of the interview, Lina has been working in the airline business for the past ten years in a supervisory capacity.

4.2.5 Carien

Carien, 44 years old, was the eldest participant interviewed. She spoke Afrikaans and English and was the only participant not to have completed high school.

At the age of 17 years and while still in Grade 10, Carien met and fell in love with Kevin, who was several years older than her. The relationship resulted in an unintended pregnancy which forced Carien to leave school. Carien claimed that she had been sexually abused by her grandfather from the age of 8 until his death, when she was 13 years old.

Carien's parents disapproved of her relationship with Kevin, because of the age difference and because they perceived Kevin as abusive. Despite their concerns, the couple married and Carien gave birth to a son. One day, while Carien was breastfeeding this baby, Kevin allegedly attacked her with a broomstick. Unlike her parents, Carien did not perceive Kevin as abusive. A second baby followed soon after and the alleged physical abuse continued. Although Carien divorced Kevin, she married him a second time in the hope that he would change his abusive behaviour. However, these aspirations were soon proven ill-conceived and the marriage once again failed.

Carien was the only participant who remarried twice and had divorced twice. She was also the only participant who did not graduate from high school and who also quitted different jobs on her ex-husband's demands. Particularly striking in Carien's case, was her low education level, alleged childhood sexual abuse and marital abuse. Carien regarded herself as a survivor of alleged childhood sexual abuse and marital abuse. In her diary Carien wrote: *"I am dedicating this narrative to abused women who live in fear, hatred and with a low self-esteem. May each one of you find something in this narrative that will encourage you to fight the spiritual battle for the eternal destiny of your life."*

In the following section, the researcher lists themes that were used for the analysis and discussion of the research findings.

4.3 THEMES FOR THE ANALYSIS OF THE FINDINGS

Analysis of the tape-recorded transcripts of the women's in-depth, face-to-face interviews and their narratives led to the following 13 emerging themes, namely:

1. Perceptions of power
2. Childhood perceptions of power in the family of orientation
3. Perceived influences of relationships on working lives of the respondents
4. Perceived influences of relationships on the health of the respondents
5. The Sexual Relationship Power Scale
6. Perceptions of GBV
7. Consequences of GBV on working women
8. Perceived relationship between GBV and HIV
9. Condom use
10. Justification for the use of physical violence by a man against a woman
11. Substance abuse by intimate partners
12. Childhood sexual abuse
13. Respondents' suggestions on how to address GBV at the workplace.

Each of these sub-themes is explored below.

4.4 PERCEPTIONS OF POWER

The participants' different perceptions of power became the central theme emerging from the data, which is in line with the first and second research objectives. The majority of the participants perceived power as favouring men and as rendering women particularly vulnerable to GBV and HIV infection.

Faith told the researcher: *"Uh … to me, I understand that the power is on men's side, because many men use power against women according to my experience."*

This finding is similar to the findings by Ashton *et al. (*2006, as quoted by LaFont & Hubbard 2007:221), stating that there is a widespread belief in Namibia that men are superior to women and that they are thus entitled to dominate women. This belief persists, despite the Namibian constitution and many other laws that promote women's equality.

Sandra expressed her perception on power as follows: *"…my male counterpart would have more power and as a woman I had less power. I will be submissive, in which case my male counterpart used his powers in whatever decisions that had to be made on social grounds…even on the well-being of the relationship for that matter…"*

Sandra's narration revealed her lived reality of gender and power imbalances. She experienced the domination of male power at both an emotional and a physical level. In terms of physical domination, gender power imbalances constrained Sandra's decision-making powers in her relationship, and she could not prevent physical attacks. The following excerpts by Lina and Meghan show how they understood power:

"Um…I understand power as a right I have in my marriage to take some decisions" – Lina. Meghan told the researcher: *"My perception of gender power …is to stand up for my rights, having rights to education, to be my own self and taking care of myself."*

Lina and Meghan resisted their husbands' controlling powers over their lives in their marital relationships. Meghan opted to leave the relationship, whilst Lina asserted herself as an equal partner in the decision-making processes in her intimate relationship.

What was significant about Meghan was that she managed to overcome the controlling power her husband had over her by divorcing him. She left the abusive relationship and never returned. She created a new, independent life for herself. Meghan's case thus differed from the third phase of the cycle of violence theory by Walker (2006).

While Walker (2006) found that the honeymoon phase reinforces the cycle by convincing the victim that things will change and leaving her with feelings of self-blame, depression and helplessness, Meghan's experience was exactly the opposite. Her perception and experiences of gender power imbalances clearly show that some women manage to retain a certain amount of inner power and strength to escape a violent relationship.

Carien expressed her perception of power as follows: *"My understanding of power in a relationship is when I am married I think power is respect. You cannot love somebody if you do not have respect…that is my understanding."*

Carien's perception and understanding of power were different from those of all the other participants in the study. This is a very interesting finding, which shows that there is a difference between participants' perceptions of gender power.

4.5 CHILDHOOD PERCEPTIONS OF POWER IN THE FAMILY OF ORIENTATION

For the majority of the participants interviewed, their childhood perceptions of power in their families of orientation were tainted by memories of conflict between their parents. All of these women's fathers worked and occupied the traditional breadwinner roles. Two of these fathers abused alcohol, but in all of the cases the mothers vacillated between positions of being powerful and being powerless.

The women narrated how their mothers often held power as the persons in charge of the households, while their husbands were away at work or when they were incapacitated by alcohol. When these fathers were at home, however, they held the position of power and the mothers became submissive. In this regard, these women's socialisation in their families of orientation was to regard women as naturally submissive to men and perpetually at risk of GBV.

Sandra explained it as follows: *"In my case, I would say that a lot of the decisions could have possibly come from my father, but I had an unstable childhood where my father was an alcoholic. We were a big family unit with grandmother and grandfather, uncles and sisters staying as an extended family together, and as a result the role of my father was often exercised by another member of the family unit. My father was not there to exercise his powers, because of his drinking problem. My grandmother or the uncle would exercise that power."*

Meghan said: *"…thinking back, my dad was a full-blown alcoholic and my mom was the controlling power in the house…She took care of the discipline, she was the breadwinner. My dad worked, but never brought home the money."*

Two of the participants told the researcher that they had modelled their own submissiveness to their partners on their mothers' behaviour, but only to some extent. All of the participants felt that in their own intimate relationships, the men were socialised to be in control of the household. Three of them felt that they were like their mothers, by taking the lead in the decision-making at household level. One woman consulted with her husband when it came to decision-making on all matters. Another participant said that she consulted her husband only when it came to important decisions regarding the children. Two of the participants learnt from the negative experiences of GBV from their mothers, who had been exposed to alcohol abuse and physical abuse, not to be silent about violence.

They learnt to become self-assertive and not to tolerate GBV. Both of them were also exposed to violence in their own intimate relationship, but they asserted themselves by leaving such relationships. One of the participants said that her childhood experience of being unloved and unappreciated motivated her to conscientiously improve her own motherhood role. Another participant informed the researcher that her mother used to give her corporal punishment as child, but in her current role as a parent, she avoided it.

4.6 PERCEIVED INFLUENCE OF RELATIONSHIPS ON THE WORKING LIVES OF THE RESPONDENTS

All five of the participants reported that power imbalances and GBV negatively affected every aspect of their personal health, well-being and working lives. These findings are similar to the findings of Manfrin-Ledet and Porche (2003).

The participants perceived the influences of power and GBV relationships on their working lives as barriers to their economic development, because GBV negatively affected their concentration levels at work, making them less productive in the workplace.

Sandra, for example, said: *"…the emotional abuse affected my working life in the sense that I lost concentration on my work. My partner regarded my work as less important. There were times that I had to stay away from work, because of a situation (physical fight), that had arisen at home the previous day. The unhappiness made me as an individual not able to concentrate at work."*

Faith said: *"When we sometimes had differences with each other at home, then that made me very unhappy. When I reached work, I am not feeling good. I feel stressed. Sometimes I feel emotional.*

Sometimes I even cry at home and when I come to work that is not good. I am suffering at work, because outside I look okay, but inside I am struggling, I am not fine."

The majority of the participants experienced that GBV in its different forms contributed to their physical tiredness in the workplace, which in turn contributed to them encountering backlogs in their workload. This expanded the cycle of GBV to their homes where they in turn had stressful outburst towards their children. In this regard, Lina said: *"I am the one who takes the lead in the house; my husband does not support me at all. This has an influence on me as a mother and a working woman. It imposes too much pressure and stress on me. It is really affecting me in my workplace, because most of the times when I come to work I am tired. The tiredness contributes to some backlog in my work and performance…the thing is, I am already tired, so when I reach work then there is also another type of stress awaiting me. So when I go back home I am still tired and it then causes me to stress with my family at home, which also affects my children."*

4.7 PERCEIVED INFLUENCE OF RELATIONSHIPS ON THE HEALTH OF THE RESPONDENTS

Sandra narrated her experience as follows: *"Unfortunately, it happened on a very emotional level, because I was a bit inexperienced and unexposed to relationships. The fact that I was very young and my boyfriend six years older than me, contributed to me not being in a position of power to take decisions to protect myself from compromising my health. My boyfriend used to drink a lot and had a lot of other sexual partners. When I found out that our relationship was not confined to only the two of us, but that there were other people involved, I went for an HIV test and discovered that I was HIV-positive."*

Sandra's experience of the perceived influence that her relationship had on her health was similar to what DiClemente and Wingood (2000) found, namely that as power between men and women increases and favours men, women will be more likely to experience adverse health outcomes. Meaning that men's control over women's sexuality, for example men deciding when, where and with whom to have sex, greatly contributes to the spread of HIV.

Sandra perceived power inequalities between men and women to play a key role in putting women at risk of HIV infection. In this regard, Sandra's perception and experience of the perceived influence that her relationship had on her health resonated with the research findings by Pettifor, Measham, Rees and Padian (2004:1996), stating that gender power imbalances play a key role in the HIV epidemic. Sandra perceived her lack of sexual and decision-making powers in her intimate relationship as constraining, because it decreased the likelihood of consistent condom use and increased her risk of becoming infected with HIV. Her perception and experiences clearly reflected gender power imbalances, which are similar to the findings by several other researchers (DiClemente & Wingood1997), who suggested that gender power imbalances constrain women in negotiating safer sex.

Sandra's experience is an example of a woman who was a victim of power imbalances and GBV, and as a result she became infected by HIV. Sandra's experiences resonate with research findings by Brown *et al.* (2003). It is evident from Sandra's lived experience that she did not have, amongst others, the communication and assertiveness skills to cope with gender power imbalances and GBV. Her low self-efficacy and lack of power and control in her intimate relationship, contributed to her being less likely to negotiate safer sex with her partner – and that is just some of the many reasons for her to have become HIV-positive.

Meghan reported: *"When I was still married I did not take care of my whole self: of my physical, my spiritual and my mental side. I went through a very deep dark hole of stress and depression, and at the end I was suicidal. The whole relationship really impacted my life and my health in a big way. I did not eat properly, I did not exercise properly. I really neglected myself."*

Campbell (2002:1331) states that increased health problems such as Sexually Transmitted Infections (STIs), post-traumatic stress disorder and depression are well documented in research on abused women. It is evident from Meghan's experience that she experienced self-reported gastro-intestinal symptoms (for example, loss of appetite, eating disorders) and diagnosed functional mental health effects such as depression and post-traumatic stress disorder. In Meghan and Carien's experiences of GBV it resulted in suicidal ideation.

Carien said: *"I was* two *months in an institution where I received treatment for severe depression. The very same day upon arrival from the institution, my husband was asking me: 'Why are you not dying?' Then I told him I think I must die. I took the anti-depressant tablets which I got from the therapist while we were arguing, and drank it. I tried to commit suicide, because I did not want to live anymore because of what my husband did. After I had taken a handful of tablets I fell down and my husband was running away telling the people that I took tablets. The next day when I opened my eyes, I saw I was in hospital again."*

Evidence from the in-depth interviews with Faith and Lina revealed how GBV negatively affects women's health through fatigue, stress and high blood pressure.

Faith said: *"This relationship influenced my health … my husband abuses alcohol and he is spending a lot of money when he is drinking alcohol … other than looking after the household. As a married man he is supposed to look after the household…*

Sometimes I cannot manage to pay water and electricity, buying food, paying school fees. It sometimes caused me to borrow money somewhere and that makes me stress. It makes me suffer from high blood pressure. It really affects my health."

Lina: *"Most of the times I am tired and…the more stress I have, the more tired I am. It has a negative impact on my health, because it led to things such as high blood pressure, it led me to suffer from fatigue and maybe all other related diseases."*

4.8 THE SEXUAL RELATIONSHIP POWER SCALE: TABLE AND DISCUSSION

The researcher administered the South African adaptation of the Sexual Control Power Subscale from the Sexual Relationship Power Scale (SRPS) by Pulerwitz, Gortmaker and DeJong (2000). It measured the women's perceptions and experiences of being controlled in their decision-making and relationships by their partners. Eight questions were used to construct the decision-making subscale and these were drawn in part from the SRPS, which contains 23 items in the two subscales (Decision-making dominance scale and Relationship control). Table 2.1 below lists the eight statements about women's decision-making powers in their intimate relationships, to which the respondents could respond: "my partner", "both of us equally" or "me".

Overall, two of the participants (Meghan and Faith) reported that they take the lead in decision-making at household level. Lina's responses showed that decision-making rests equally with her and her partner. Sandra and Carien's overall responses showed that their partners were dominant in decision-making.

In response to the question of who usually has more say about serious things, the majority of the participants reported themselves, while only one participant responded her partner, and the other one reported both of them. In response to who has more power in the relationship, three of the participants reported themselves, while the other two reported their partners.

TABLE 2.1: DECISION-MAKING DOMINANCE SUBSCALE

Question	Sandra	Meghan	Carien	Faith	Lina
1. Who usually has more say about when you talk about serious things?	Both	Me	Partner	Me	Me
2. In general, who do you think has more power in your relationship?	Partner	Me	Partner	Me	Me
3 Who usually has more say about whose friends to go out with?	Partner	Me	Partner	Both	Both
4. Who usually has more say about whether you have sex?	Partner	Me	Partner	Partner	Both
5. Who usually has more say about what you do together?	Partner	Me	Both	Partner	Me
6. Who usually has more say about how often you see one another?	Partner	Me	Both	Me	Me
7. Who usually has more say about whether you use condoms?	Partner	Both	Me	Both	Both
8. Who usually has more say about what types of sexual acts you do?	Both	Partner	Both	Me	Both
Modal response in terms of the lead decision-maker	Partner	Me	Partner	Me	Me/Both

On the question of who holds the most decision-making power about whose friends to go out with, two of the participants reported their partners, two of them reported that this was a joint decision, and one woman said that she decided on this. In response to the question on who usually has more say about whether to have sex, the majority (three) of the participants reported that their male partners usually initiate sexual intercourse, whereas one participant responded that she made such decisions, and one reported that they decided on this as a couple. On who usually has more say about what to do together, two of the participants reported that they took the lead, while the other two reported that their partners took such decisions, and one participant reported that this was a joint decision. In response to who usually has more say about how often to see one another, three of the participants reported that they took such decisions, while one reported her partner, and the other one said that this was a joint decision.

On who usually has more say about whether to use condoms, three reported that this was a joint decision with their partners, while one reported that she took the decision, and another said that her partner took the decision on condom use.

In response to who usually has more say about what types of sexual acts to do, three participants reported joint decision-making with their partners, while one reported that her partner decided, and another indicated that she took such decisions.

The Relationship control subscale, shown in Table 2.2 below, displays the participants' responses to certain statements on sexual decision-making in their intimate relationships. The items in Table 2.2 show mixed results. Overall, two of the participants (Faith and Lina) reported that they took the lead in relationship control. Meghan's responses showed that for her, relationship control fluctuated between her and her partner. Sandra and Carien's overall responses showed that their partners were dominant in relationship control.

In terms of the statement that suggested condom use might result in violence, most of the respondents disagreed, while only Carien strongly agreed that this might be a possibility. However, in response to the question that suggested condom use might result in their partners becoming angry, three of the respondents agreed, whereas two disagreed. Thus, although the majority of the women reported condom use as a joint decision (Table 2.1 above), and most of them disagreed that this would result in violence, most of them also reported that condom negotiation might result in their partners becoming angry. In response to the eighth statement in the Table, referring to suggested condom used possibly resulting in the male partner suspecting the woman of having sex with other people, two of the participants strongly agreed, and three disagreed. It thus seems that the research respondents as a group held ambivalent feelings regarding condom use negotiation in their intimate relationships.

TABLE 2.2: THE RELATIONSHIP CONTROL SUBSCALE

Statement	Sandra	Meghan	Carien	Faith	Lina
1. If I asked my partner to use a condom, he would get violent	Disagree	Strongly Disagree	Strongly Agree	Strongly Disagree	Disagree
2. If I asked my partner to use a condom, he would get angry	Agree	Disagree	Strongly Agree	Disagree	Agree
3. Most of the time, we do what my partner wants to do	Agree	Disagree	Strongly Agree	Disagree	Disagree
4. My partner won't let me wear certain things	Strongly Agree	Strongly Agree	Strongly Agree	Disagree	Disagree
5. When my partner and I are together, I'm pretty quiet	Strongly Agree	Strongly Agree	Agree	Disagree	Disagree
6. My partner has more say than I do about important decisions that affect us	Agree	Agree	Agree	Disagree	Strongly Disagree
7. My partner tells me who I can spend time with	Strongly Agree	Agree	Strongly Agree	Disagree	Disagree
8. If I asked my partner to use a condom, he would think I'm having sex with other people	Strongly Agree	Disagree	Strongly Agree	Disagree	Disagree
9. I feel trapped or stuck in our relationship	Strongly Agree	Strongly Agree	Strongly Agree	Disagree	Agree
10. My partner does what he wants, even if I do not want him to	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Agree
11. I am more committed to our relationship than my partner	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree
12. When my partner and I disagree he gets his way most of the times	Agree	Agree	Strongly Agree	Strongly Agree	Agree
13. My partner gets more out of our relationship than I do	Strongly Agree	Disagree	Strongly Agree	Strongly Agree	Agree
14. My partner always wants to know where I am	Strongly Agree	Disagree	Strongly Agree	Strongly Disagree	Disagree
15. My partner might be having sex with someone else	Strongly Agree	Strongly Agree	Strongly Agree	Strongly Agree	Disagree
16. Modal response in terms of relationship control	Strongly agree	Strongly agree/disagree	Strongly agree	Disagree	Disagree

In response to the statement that the couple mostly do what their partners want to do, three of the participants disagreed, while one agreed and the other one strongly agreed.

On the item testing perceptions on whether their partners would not let them wear certain things, three of the participants strongly agreed, while the other two

disagreed. Thus three of the five women felt that their partners controlled their physical appearance.

In response to the statement about being quiet and reticent in the relationship, two participants strongly agreed, one agreed and the other two of them disagreed. Thus, three of the five women felt that they were able to communicate in their relationships and the other two women felt unable to communicate in their relationships. However, when it came to perceptions on whether the male partners had a greater say about important decisions that affected the couple, the opposite trend was found as three of the participants agreed, while one of them disagreed and the other one strongly disagreed.

In response to the statement that male partners told them who they were allowed to spend time with, two respondents strongly agreed, while two disagreed and one participant agreed. In response to the statement that the respondents felt trapped or stuck in their relationship, three of the respondents strongly agreed, one agreed and the other one disagreed.

The tenth statement tested whether the women felt that their partners did whatever they wanted, even if they (the women) were opposed to the idea. All of the women confirmed this, as four of the participants strongly agreed and one of them agreed with this statement. In response to the statement that the women were more committed to the relationship than their partners, all of the participants strongly agreed. Statement number 12 in the table tested the respondents' perceptions on whether they felt that during disagreements, their male partners usually got their way. Again, all of the respondents felt that this was true of their relationships, as two of the participants strongly agreed, while three agreed.

In response to the statement that their partners got more out of the relationships than they did, three of the participants strongly agreed, while one agreed and the other one disagreed. Responding to the statement about their partners always

wanting to know where they were, two of the women strongly agreed, while two disagreed and one strongly disagreed. Finally, in response to the statement that their partners might be having sex with someone else, four of the participants strongly agreed, and only one participant disagreed. As multiple concurrent sexual partnerships present a risk for the transmission of STIs including HIV, four of the five women in this study perceived their relationship as possibly posing such a risk.

4.9 PERCEPTIONS OF GENDER-BASED VIOLENCE

All of the participants interviewed in the study had, in line with other researchers (Dunkle, Jewkes, Brown, Gray, McIntyre and Harlow 2004), correctly defined GBV as not limited to acts of physical abuse, sexual abuse or psychological abuse by intimate partners, dating partners or family members; childhood sexual assault of girls and rape. In the section to follow, the researcher discusses findings on emotional abuse or psychological abuse, physical abuse, sexual abuse and economic abuse as per the participants' perceptions and experiences.

4.9.1 Emotional or psychological abuse

For Lina, Faith, Meghan, Sandra and Carien, exposure to emotional abuse in the form of insults, belittlement and humiliation by male partners in the presence of other people, invariably led to stress disorders and depression-related diseases.

Lina said: *"My partner abuses me emotionally in the form of constant insults and he always wants to be dominant*", and Faith said: *"When we sometimes had differences with each other at home, then that made me very unhappy.*
When I reached work, I am not feeling good. I feel stressed. Sometimes I feel emotional. Sometimes I even cry…"

Meghan told the researcher: *"I felt emotionally abused, because most of the times in our relationship and in my marriage he made me feel like I am nothing. He made me feel as if I do not have any brains. This is why I am quiet in his company. He has a high profile job and when we were invited to high profile meetings and parties, he would just look at me when I had to say something. When I had a conversation with someone, he always looked at me in a very intimidating manner. It was as if I had to count my words. So I think that is emotional or psychological abuse. He made me think that I am unable to converse with people … I am a dumb blonde. When I had to speak I felt small and it felt like I really did not have brains. And that is one of the main reasons why I divorced my husband. He abused me emotionally and psychologically, causing me to suffer from depression."*

Sandra narrated her emotional abuse as follows: *"I remember the exact time I decided to take my time in serving him and his friend food. He became so angry and felt that I disrespected him. By the time I served him the food it was still hot coming out of the microwave. He threw the plate of food in my face. I was lucky that the hot food fell from the plate and passed my face, but the plate broke into my face. I felt very humiliated. It was then that I realised that something was wrong. I had allowed the situation to happen. I decided to do something. It was then that I stood up and ended the relationship."*

Meghan and Sandra's lived experiences of emotional abuse can be better understood in terms of the structure of cathexis, where male superiority causes abuse instead of reciprocity and intimacy.

Carien narrated her emotional abuse as follows: *"My partner was that kind of person who never cared whether everybody knew what was happening to me… he abused me emotionally…so much so that I terminated our relationship. But then after some time I took him back again. I married him twice and I divorced*

him twice. I still do not know why I took him back several times. I was emotionally very attached to him. When he was crying – asking me not to leave him – I would then stay with him in the hope that he might change his behaviour. I would then take him back. I forgave him hundreds of times."

Carien's emotional attachment to her intimate partner demonstrates her emotional vulnerability. Carien's case can be analysed in terms of the third phase of the cycle of violence theory, which offers an explanation for why battered women stay in an abusive relationship. The abuser convinces the victim that things will change and leaves her with feelings of self-blame, depression and helplessness. It took many years of physical and emotional suffering before Carien was able to leave the relationship permanently.

4.9.2 Physical abuse

Three of the participants – Sandra, Meghan and Carien – suffered physical abuse at the hands of their male partners, while the other two participants never experienced physical violence. Sandra said: *"My partner used to slap me in the face. At some stage my partner kept me hostage; he did not want me to go out. And because of the controlling powers he had by locking me up in the house I was not able to go anywhere…When my partner and I would not agree on an issue it resulted in a beating or a slap…It was then that I realised that something was wrong. I had allowed the situation to happen. I decided to do something. It was then that I stood up and ended the relationship."*

Meghan narrated: *"Yes, through our 17 years of marriage, once or twice I got a slap or two, and that was usually because of certain decisions I made or for the fact that I was who I was."*

What is significant about Sandra and Meghan's experiences of physical violence is that they managed to break the cycle of violence. They both left the abusive relationships and never returned.

Carien narrated her experience of physical violence as follows: *"My ex-husband on several occasions, while I was breastfeeding the two baby boys respectively, physically beat me with broomsticks.*

He was so upset and didn't even care about the babies…He always used to beat me in front of the children…The next day I would call work, informing them that I was not feeling well and that I would not go to work. However, after two days, when I got to work the blue eyes were not gone permanently. I would then cover it with make-up, and lied to my colleagues that I had bumped into a cupboard. I always feared Kevin. I thought it was love, but it was actually fear, hatred and anxiety."

Carien's lived experience of physical violence shows coercive control, which occurs when a victim and a perpetrator are locked in a prolonged relationship such as a marriage. Her experience of physical violence is typical of abused women who are likely to stay in abusive relationships or return after leaving such relationships, mainly due to the emotional ties with the abusive partner.

4.9.3 Sexual abuse

Two of the participants – Carien and Sandra – reported alleged sexual abuse. Carien said: *"With my previous partner (ex-husband), he had forced sex on me.*

I can still recall…I remember that day when I was drinking the tablets, wanting to commit suicide. All I remember was that he dragged me into the lounge, where he turned me onto my stomach and had anal sex with me, against my will. I do not know whether I felt it. I was not myself."

Carien regards herself as a victim of different forms of GBV, where she in particular survived repeated emotional abuse, physical abuse, sexual abuse and economic abuse, which in turn contributed to her having a reduced sense of self-worth. Her inability to implement prevention strategies meant that she accepted high-risk practices.

Sandra narrated her experience of alleged sexual abuse as follows: *"I would say force in terms of after such a situation had arisen then obviously I would then not have been up to sex. But then I would feel intimidated by this part of the relationship…then he would be frightening me that either he would get out of the relationship, because there is someone else…that is why I did not agree to that extent. But maybe also then from a weakness point of view, I would then agree to do it."*

4.9.4 Economic abuse

The majority of the participants (four out of the five) reported economic abuse in their intimate relationships, with their male partners controlling the household income and the spending. In addition, these men failed to provide enough money to cover domestic and child-care expenses, but would spend their meagre income on alcohol or entertaining casual sexual partners. Sandra's partner prohibited her from generating a self-salaried job and locked her up in the house to prevent her from having social contact with other people.

Sandra said: *"My partner had different sexual partners who also had financial needs, and he would spend his part of the income with the outside partners which was supposed to be shared by the household.*
At times I would compromise, and spend money on him. I would provide him with money to spend with his friends and entertain them, or buy him expensive clothing…My partner prevented me from selling, he would prefer me to stay in an environment where he knows the people I am interacting with, and probably also

to keep an eye on what I am doing. He tried to prevent me from socialising with others outside our relationship."

In Sandra's case she was economically independent from her intimate partner. However, her partner's controlling powers in their intimate sexual relationship played a key role in her being HIV-positive.

According to Faith: *"My husband many times failed to provide money to run the household or to look after the children, but then he had money to spend on alcohol. For example, my husband will just go to the bank to withdraw N$1000 and then go to the shebeen. When he comes home he will have nothing, not even ten dollars…imagine. Then the next morning he will go to the cash loan, where he leaves the bank card. Then he uses that money from the cash loan to go and drink, and when he comes home he has nothing."*

Meghan told me: *"Yes, it was once, he was so cross, we had a fight and he wanted me to stop flying. I asked him where I am going to get a job tomorrow! ... So at times he distrusted me and he wanted me to stop flying. So he once prevented me. He took my car and I could not get to work. I had to take a taxi."*

Sandra, Meghan and Carien were all locked up at home by their controlling partners, who wished to prevent them from going to work. Carien's partner often took any cash she had on her, away from her with force. In addition he forced her to resign from two previous jobs.

Carien explained: *"I was working at the University of Namibia for 12 years. I had a very good job. He made me resign.*
He forced me to resign because he said that I was sleeping with other men…He one day came into my office and said, 'Today you are going to resign.' He wanted my pension money. So I resigned from the University of Namibia. After I received my pension money he was the one in charge of my money. I then got

another job at the Namibian National Broadcasting Corporation. I also worked there for 12 years, but he once again forced me to resign, accusing me of sleeping around with other men. This time I was so afraid and shy – thinking that people knew what happened before – so I was forced to resign again. I took my pension money and we went to South Africa."

4.10 THE CONSEQUENCES OF GBV FOR WORKING WOMEN

Meghan resigned from a job due to GBV. Carien also resigned twice from previous jobs due to her experience of GBV. The following excerpts show how GBV impacted on working women's lives.

Meghan said: *"Due to depression, I could not cope and concentrate when I had to get to my work. GBV really had an impact on my decision-making, because by then I worked in a highly safety-conscious environment on the aircraft. I could not make decisions – that is the reason why my psychologist advised me not to go to work or to fly. She grounded me for treatment of depression for a certain period of time until I got my confidence back and had a balance. So, yes of course it greatly impacted on my thinking and my decision-making and my normal progress and working environment."*

Meghan's excerpt highlights working women's experiences as victims of GBV, which are similar to findings by Anderson *et al.* (2008:75), who state that it includes 'choice disability', reduced self-esteem, lack of coping skills, or psychopathology such as depression.

Carien's experience as a victim of GBV and a working woman as illustrated in the following: *"Yes, GBV affected me a lot as a working woman because I was always afraid. I was stressed. I sometimes even took my stress out on my colleagues, which was not good. I could not concentrate at work. In the morning I would feel fresh and happy, but when it came to lunch time and by five o'clock I*

was in fear, because I had to go home. I knew that I was going to be beaten up. I knew that we were going to have arguments. I knew it all. When I arrive home I am tired and if I am not in a mood to perform sexual activities then I face violence."

The majority of the participants confirmed that women working in aviation are at risk of GBV due to the nature of their jobs. This is because the aviation business often demands shift work or being away from home for some time. In this regard Meghan said: *"He once wanted me to quit my job. We had a fight and he wanted me to stop flying. At times he distrusted me and he wanted me to stop flying. He once even prevented me from getting to work. He took my car and I could not get to work. I had to take a taxi. The emotional and psychological abuse in my marriage was one of the main reasons why I divorced my husband."*

Carien said: *"In my case I am working shifts, and let me say working shifts is a problem. I know that I am going to be beaten if I refuse sex. I know all the…I know, I know, I know…"*

Experiences from all of the participants indicated that GBV happens behind closed doors in the domestic sphere. The perpetrator cannot abuse the victim publicly, because of the fear of witnesses.

Sandra's perception is that: *"…women are most at risk of GBV at home, because home is an environment where man is protected from the outside, where the outside might not see what happens in the inside of the home …*
Men might have the power at home where they will lock you up, because they may be scared that if you as the wife go out, you maybe go the police and they fear the authorities."

4.11 PERCEIVED RELATIONSHIP BETWEEN GBV AND HIV

All of the participants had heard of HIV and AIDS. All of them were able to correctly identify how HIV is transmitted. The majority of them learned about HIV and AIDS at school, via the media (mainly the radio, television and newspapers), at the workplace and through other people. However, according to the Namibia Demographic and Health Survey (2006-7, as quoted in the Namibia Ministry of Health and Social Services 2008a), despite high levels of knowledge about modes of HIV transmission and prevention many women in Namibia lack control over their own reproductive health. In the study a number of the participants faced challenges in negotiating safer sex. All of the participants interviewed felt personally at risk to become infected with HIV. All five the participants knew about VCT, had gone for testing and knew their HIV status. Four of them also knew their husband's/partner's HIV status.

Moreover, all five women perceived that there was a link between GBV and HIV. In this regard, Sandra said: *"Women in relationships do not really have a lot of say. They do not have the power to decide in a relationship. The male partner will always be the one to initiate the sexual activities…And above the fact that you as a woman know, especially in a situation whereby there are multiple concurrent partners involved, you will not say much out of fear that the man will get violent. Based on my personal experience, as a woman I found it difficult to get out of that relationship. I pretend to accept the abuse...I had to settle for this abusive relationship where my partner was involved in multiple concurrent relationships, abused alcohol … in which I became infected with HIV as well. I said it is okay, he will come back tomorrow. The violence just never stopped…I always felt a victim."*

Sandra's perception and experience of the link between GBV and HIV resonates with the research findings by Wingood and DiClemente (1998), who found that there is an association between adult experiences of GBV and having multiple sex partners, having multiple sexual encounters and low condom use.

Faith also confirmed that she perceived a link between GBV and HIV: *"Yes, I do see a relationship between these two, because…to me some people are difficult to talk to when it comes to the part of sex. You want to ask the person to use a condom, but you are afraid he will not want to use a condom and then it causes you to be infected by HIV."* Sandra said: *"The socio-cultural challenges are such a pity, because the cultural norms are withholding women from exercising their rights, we women do not have a choice on whether to be infected or not infected."*

Sandra's narration is supported by Strebel *et al.* (2006), as they state that culturally-sanctioned gender roles are intimately connected with both GBV and HIV risks.

4.12 CONDOM USE

The majority of the participants confirmed that they were able to negotiate condom use with their partners. Faith's husband is HIV-positive, whereas she has been HIV-negative for the past five years. They are using condoms as a protective measure. However, Sandra's experience at the hands of a controlling partner resulted in her being HIV-positive. This finding that the majority of the participants reported that they were able to insist or negotiate for condom use is different from most of the findings by other researchers (Ipinge *et al.* 2004, as quoted by LaFont & Hubbard 2007: 222).

Although this warrants further investigation, the researcher speculates that, because the five women had high levels of education, and because the use of condoms could be construed as protecting the males in these relationships, most of these women found condom use less problematic than what is usually reported in terms of women who are disempowered because of GBV.

4.13 JUSTIFICATION FOR THE USE OF PHYSICAL VIOLENCE BY A MAN AGAINST A WOMAN

The majority of the women interviewed said that physical violence by a man against a woman or vice versa can never be justified. However, one of the well educated participants (Lina) believed that if a woman betrayed her husband or the other way around, violence committed towards a person based on the above-mentioned reason is justified. Lina said: *"If you suspect your husband has got another wife or it can be the other way around where your lover suspects that what you always say is not true, and he catches you, it can result in the man beating you. So, yes I justify violence in such instance."*

Lina's statement is an interesting, but very important finding of the study, showing that there is a significant difference between the respondent's perceptions and her level of understanding of the justification of GBV committed. This finding reveals that there are still misconceptions that undermine the promotion of women's rights. This problem is compounded by cultural and religious beliefs that normalise GBV with a part of a relationship.

4.14 SUBSTANCE ABUSE

The study did not plan to explore women's experiences of substance abuse by their intimate partners. However, it emerged as a new theme to be explored in understanding the challenges faced by women.

Two of the participants reported childhood experiences of alcoholic fathers who physically abused their mothers, while three women reported that their male partners abused alcohol.

4.15 CHILDHOOD SEXUAL ABUSE

Another new theme that emerged from the study was childhood sexual abuse. Only Carien reported alleged childhood sexual abuse.

She claimed that she had been sexually abused as a child by her paternal grandfather from the age of 8 until his death, when she was 13 years old. She said; *"I could not tell my parents or somebody older, because I was afraid that they would not believe me. I was afraid they would beat me. I did not like my grandfather at all. I hate him because in my mind I knew that the things he did, was so wrong..."*

4.16 RESPONDENTS' SUGGESTIONS ON HOW TO ADDRESS GBV AT THE WORKPLACE

The participants experienced GBV exclusively behind closed doors in their homes and at the hands of their husbands or male partners (and in one case of a grandfather). They did not experience GBV at the workplace – in fact; the workplace was a sanctuary away from the chaos of their homes. Thus, their suggestions pertained to how the workplace might extend its influence to address problems experienced by women in their domestic and familial spheres. One such suggestion was that workplaces could conduct educational sessions on the signs, possible causes, and prevention of GBV and HIV infection. The participants suggested that workplaces should employ trained professionals in whom the staff can confide to get assistance for GBV. This was seen as preferable to women going to the police, as many women are too fearful to report abuse to the police.

The women suggested the investigation of granting special family leave for women facing GBV to get the help that they need and to address their domestic problems. The women identified the need for workplaces to train all managers and supervisors in maintaining confidentiality, non-discrimination and in the handling of disclosure. They also suggested the establishment of workplace support groups for women facing GBV. Other suggestions were to have gender-specific activities for women and men separately, to educate them on issues of GBV.

4.17 DISCUSSION: SUMMARY AND INTERPRETATION

The study explored working women's perceptions of power, gender-based violence and HIV-infection risks in an airline business in Namibia. The findings of the study do support the theoretical perspective that our understanding of power in relationships be viewed from a contextualized gender lens. The findings in this chapter demonstrate that the study has successfully addressed the research goal and objectives as set out in Chapter 1.

The researcher has successfully explored (in the voices of the participants) the first research objective, which was to gauge women's perceptions and experiences of power imbalances and GBV. The study generated evidence that showed that all of the participants experienced power imbalances and different forms of GBV in their personal relationships with males. From the analysis of the experiences of these women, it is apparent that there are some commonalities in their experiences of power imbalances and GBV. The majority of women in the study perceived power imbalances in their intimate relationships as one of the determinants putting them at increased risk of GBV and HIV infection. Power imbalances were perceived as constraining women in negotiating safer sex. They all experienced constrained decision-making powers.

Overall, the study suggested that power imbalances by controlling men who commit GBV against their female partners have negative outcomes for the emotional health of the women.

All five the participants reported emotional or psychological abuse at the hands of their intimate partners, while the majority of them reported economic abuse, closely followed by physical abuse, and two alleged that they experienced forceful sexual abuse. The majority of the group of women reported economic abuse in their intimate relationships, with their partners controlling their financial

income, while failing to provide money for the housekeeping or the children. Overall, the data showed lasting evidence that all of the participants showed emotional scars from their GBV experiences.

In terms of the second research objective regarding challenges experienced by working women regarding power imbalances and GBV, the evidence showed that all of the women experienced such challenges – only not in their workplaces, but rather in their homes. To the majority of the participants, the workplace's EAP represented a space in which they could learn coping skills to address gender power imbalances and GBV. The workplace, through its interventions such as EAP and access to a social worker, enabled the majority of the women to forge new identities as women who have survived and conquered GBV. The women made use of workplace-related support structures such as earning a salary to make them financially independent to some extent, access to EAP and to on-site VCT and risk prevention (in the form of free condom distribution). The study found that the workplace EAP provided a safe and supportive platform where women gained emotional healing.

The third research objective was to gauge through the narrations of the research participants, how power imbalances and GBV put working women at risk of HIV infection. The findings showed unexpected results. There was no clear or direct link between GBV and HIV.

Whereas only one of the five women in the study tested HIV-positive, the study showed that all of the women were aware of the fact that violent relationships represent a context of risk to women's health, putting them at risk of HIV infection. All five the women went for VCT.

They all knew their HIV statuses and the majority of them reported that they were able to successfully negotiate condom use. This meant that they were able to directly address the link between GBV and HIV. For four of the five women in the study, this had worked out favourably. The one woman who is HIV-positive was

able to avoid further or compounded infections. This woman blamed her HIV infection on her abusive partner's controlling powers and multiple sexual relationships. Her lack of sexual decision-making powers in her intimate relationship decreased the likelihood of consistent condom use and it increased her risk of becoming infected with HIV. Another woman in the study was in a marital relationship with an HIV-positive male, but remained uninfected herself, because she reported successful condom use. The study thus offers some support for the notion that consistent and correct condom use can protect against HIV infection.

The findings as reported in this chapter show that working women can negotiate their HIV-infection risks well, because they earn a salary, which makes them financially self-sufficient to some extent. Having access to EAP, and learning about VCT and risk prevention in the workplace has enabled the majority of the women in the study to avoid risks. Thus, being working women, the respondents were able to turn their GBV experiences into positive outcomes for themselves. However, this should also be seen in the light of the possibility that the women who had volunteered to participate in the study probably self-selected as those who have already dealt with the immediate physical dangers of GBV. The study also found that there were working women at the study site who had withdrawn their voluntary inclusion in the study, because they did not feel safe to do so.
The volunteer group seems to still struggle with the emotional scars of their experience, but as part of their recovery, they are able to act as a resource for other women who are facing GBV and are still unable to do something about it. The findings suggest that women who have left a relationship dominated by GBV can still have good reproductive health outcomes if they receive VCT and learn to negotiate condom use in their intimate relationships.

In summary, it is important to note that the findings cannot be generalised and should be viewed only in terms of the five women's social standing and their economic backgrounds – all of the women had relatively high levels of income,

they were all in salaried employment and had access to EAP and VCT at the workplace. Thus, they had resources to turn their GBV experiences into moments of empowerment. Although this study cannot be generalised to all women in the airline business, their perceptions and experiences can be useful for understanding the ways in which prevention strategies can be developed and delivered. The study offers examples of the resourcefulness and strength of women to address the challenges they face in terms of power imbalances, GBV and HIV-infection risks.

4.18 CONCLUSION

Based on the analysis and interpretation of the participants' stories, it is clear from the research findings that power imbalances, GBV and HIV-infection risks are social problems experienced by women. It is evident from the findings of the study that power imbalances place women at increased risk of GBV and becoming HIV-infected. The research findings showed that all of the women showed emotional scars from their GBV experiences. Whereas only one of the five women tested HIV-positive, the majority of women in this study were not placed at risk of HIV infection by the GBV in their relationships. Thus, the study finding postulates that there is no direct link between GBV and HIV infection.

In the next chapter (Chapter 5), the researcher will be discussing general conclusions of the study and recommendations for policies and programmes.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4, the researcher provided a discussion of the research findings and interpretations. As explained in Chapter 1, the purpose of this study was to explore working women's perceptions of power, GBV and HIV-infection risks in order to understand some of the challenges women faced. In order to answer the above research question, the researcher used concepts as discussed in the literature review in Chapter 2, and employed qualitative methods as described in Chapter 3. The aim of this chapter is to provide a discussion of the general conclusions and recommendations of the study, with specific emphasis on the limitations of the study, suggestions for further research in the field of power imbalances, GBV and HIV-infection risks amongst women, as well as recommendations for policies and programmes.

5.2 LIMITATIONS OF THE STUDY

The study has highlighted various important aspects of working women's health and life experiences in the airline business. However, it is important to be mindful of the limitations. The participants in this study were recruited as a small, non-probability sample consisting exclusively of five women who all experienced some form of power imbalances, GBV and HIV-infection risks. Fisher, Foret, Laing, Stoeckel and Townsend (2002:117) state that there is no such thing as a perfect study. Even if not all the cultural groups in Namibia are presented in the study, one should realise that the results were representative of a small population of only women in an airline business and cannot be extrapolated to the rest of the aviation workplace environment. The researcher identified three more limitations that are discussed below.

5.2.1 Study site

The study site was restricted to a specific airline business in Namibia, namely Air Namibia. The results of the study can therefore not be fully representative of the entire airline nor of other airlines in the country or elsewhere.

5.2.2 Gender

All of the participants in the study were women. Men were not part of the study and the interpretation of these findings should be limited to women. The researcher has included only women based on women's vulnerability to most health and psycho-social problems such as gender power imbalances, GBV and HIV-infection risks.

5.2.3 The sample size

The sample size of the study was very small, as only five women were interviewed. Low recruitment rates are well-reported disadvantages of qualitative research. The study heavily relied on self-reported data from interviews and narratives. The selected sample could only represent a limited number of the total population at Air Namibia. This implies that the findings of this study should be interpreted with caution, because the general airline population was not fully represented.

5.3 SUGGESTIONS FOR FURTHER RESEARCH

As this study has highlighted, power imbalances, GBV and HIV-infection risks are increasingly being recognised as human rights violation and public health problems with dire consequences. As mentioned earlier in the study, the findings showed unexpected results. The study did not establish a clear or direct link between GBV and HIV.

In order to fully understand the link between GBV and HIV/AIDS in intimate relationships, the researcher would like to propose that further studies be conducted in the following areas:

- On the intricate dynamics of GBV and HIV/AIDS within intimate relationships, including men;

- On gender-sensitive workplace policies and programmes addressing power imbalances, GBV and HIV-infection risks in intimate relationships.

- The researcher in line with Maman, Campbell, Sweat and Gielen (2000, as quoted in Manfrin-Ledet & Porche 2003:64), recommends further studies on males' perspective of safer sex practices in developing prevention strategies that do not place the burden of responsibility for safer sex on women alone (Maman *et al.* 2000).

5.4 RECOMMENDATIONS FOR POLICY AND PRACTICE

The researcher believes that her present study through its literature review had successfully filled the gap that other researchers in the field have not focused on namely, to focus on working women's perceptions of power, GBV and HIV-infection risks: an explorative study among female employees in an airline business in Namibia. Secondly, the study has also filled some of the gaps in the society's understanding of working women's perceptions and experiences of power, GBV and HIV-infection risks in an airline business. Seeing in particular that no study has ever examined working women's perceptions of power, GBV and HIV-infection risks in an airline business in Namibia, the researcher was most interested to explore working women's perceptions, experiences and challenges faced in order to recommend policy, programme development and practice.

In order to reduce the prevalence and incidences of power imbalances, GBV and HIV/AIDS among working women in an airline business in Namibia, long-term commitment and strategies for policy and practice, involving all segments of the society at all levels are recommended.

This study has helped to understand gender and power differences as conceptualized in Connell's theory of gender and power. The researcher recommends that this understanding be used for practical purposes in terms of policy and practice.

In addressing the study findings in Chapter 4, the researcher would like to make the following recommendations to the following groups of people for policy and practice purposes:

5.4.1 Personal level

To reduce the prevalence and incidences of power, GBV and HIV-infection risks among female employees in an airline business in Namibia, cultural reorientation and socialization are recommended at a personal level, meaning working towards changing attitudes and norms. The researcher therefore recommends the development of Behavioural Change Communication strategies in the airline business that creates public awareness and challenge individual and collective beliefs, attitudes and general mindsets in the elimination of power imbalances, GBV and HIV/AIDS at a personal level.

5.4.2 Company/Institutional level

At company level, the airline business in Namibia should expand and continuously support efforts such as access to EAP access, VCT as well as the promotion of correct and consistent use of condoms, which are found to be key elements of HIV prevention in this study.

It is imperative that professionals in the airline business, working with women who experience power imbalances, GBV and HIV-infection risks, remain sensitive as possible whenever they interact with their clients or patients. Expanded airline business HIV workplace prevention programmes in Namibia should include discussions on gender roles and expectations, relationships and sexuality for both men and women. Men as essential stakeholders in the airline business in Namibia should be engaged in HIV prevention efforts in the enhancement of women's sexual decision-making powers. The values of the airline business regarding power, GBV and HIV-infection risks must be made explicit through the implementation of company policies and programmes.

5.4.3 Community level

At the level of community in Namibia, the researcher recommends that in particular, norms that consider women as inferior and equality as undesirable or impossible should be eliminated. In this way, ordinary people in Namibia can be encouraged to question social norms that perpetuate GBV, injustice and inequality. The study showed that the airline business' Employee Assistance Programme activities such as VCT and the use of condoms are essential efforts in the prevention of HIV infections and therefore this needs to be encouraged at the community level as well.

5.4.4 Government level

At the level of government in Namibia, the researcher strongly recommends legislation that holds enforcement weight, meaning not only to have well-defined laws passed, but enforcing these laws, which recognize women's legal rights, especially ones that punish offenders can help and will greatly contribute in big measures to the reduction of incidences of power imbalances, GBV and HIV/AIDS.

For the Namibian government involved in policies and programmes targeting women, there is a need to ensure through the enforcement and implementation of laws in Namibia, that women can exercise their rights to have control over and decide freely and responsibly on matters related to their health and sexuality in order to increase women's ability to protect themselves from GBV and HIV infection.

The Namibian government could also help to reduce working women's vulnerability to power imbalances, GBV and HIV-infection in the airline business by the development and implementation of workplace policies for airline businesses and the creation of more job opportunities that will help to reduce the financial inequality for women, enhance and protect women's rights and thereby give them more power and authority.

The researcher believes that the development and implementation of these policies will allow more working women in the airline business to be emotionally and financially independent. It will improve working women's decision-making powers in their family and it will also increase their access to health care services. Lastly, it is vital for top government leadership to speak out against power imbalances, GBV and HIV infection and to ensure the full protection of women's equal rights through implementation of policies and programmes in the Namibian airline business.

5.4.5 Donor Agencies

It is imperative for donor agencies in Namibia to make funding available for workplace projects and programmes in the airline business, which support social change campaigns, workplace advocacy efforts and other related programmes aimed at creating space for changing behaviours and practices within families, airline businesses, and communities.

Such investments will contribute to the reduction of power imbalances, GBV practices and HIV-infection risks amongst women in the airline business in Namibia. It can create safer, more stable airline business employee assistance workplace programmes, policies, families, communities and also improve the quality of life for women and their families worldwide.

5.5 SUMMARY AND CONCLUSION

In this chapter the researcher provided discussions of the general research conclusions and recommendations.

The limitations of the study, suggestions for future research as well as recommendations for policies and practices were discussed. In this study it was argued that power imbalances, GBV and HIV-infection risks have existed for decades, and have been perpetuated and sustained by the belief that men should have power and control over women. The study explored the perceptions and experiences of power, GBV and HIV-infection risks in the intimate relationships of a few women working in an airline business. All of the participants in the study reported power imbalances which put some of them at increased risk of GBV and HIV infection in their intimate relationships.

All of the participants reported some form of GBV. Although they all reported experiences of GBV, there were differences in the extent and types of GBV experienced. The results of this research show that all of the participants reported emotional or psychological abuse at the hands of their intimate partners during their lives, while at the same time the majority were subjected to economic abuse, followed by physical abuse and two alleged to have been sexually abused. One participant reported childhood sexual abuse and two reported alleged forceful sexual intercourse in their adult intimate relationships, resulting in one of them being infected with HIV.

Given the challenges faced by the participants of this study, a full understanding of women's perceptions and experiences of power, GBV and HIV-infection risks becomes complex and requires further research – which includes men. The researcher concludes her study with the understanding gained from the perceptions and experiences of the participants interviewed, which agree with the results of other researchers (Dunkle *et al.* 2004), namely that power imbalances by controlling relationships put women at high risk of GBV and HIV infection. Risk factors such as lack of sexual powers in relationships, low self-esteem, and mood disorders of partners with substance abuse problems increase women's HIV-infection risks (Kalichman *et al.* 1998).

In an attempt to successfully address the problems of power imbalances, GBV and HIV, the researcher would like to advocate for community and societal transformations which challenge cultures that condone male dominant norms of gender relations (Brown *et al.* 2003:1420).

Finally, the study's exploration of the lived experiences of the women does not support the assumption that there is a direct link between GBV and HIV-infection risks. For the majority of women in this study, GBV did not place all of them at risk for HIV infection.

In conclusion, the researcher would like to end her dissertation with a statement from the United Nations former Secretary-General Mr. Kofi Annan, addressed to all those partners involved in the prevention and combating of GBV in the world, stating: *"Empowerment of women and girls must be made a priority focus area for HIV prevention to protect themselves against the virus … What is needed is positive change that will give more power and confidence to women and girls. Change that will transform relations between women and men at all levels of society"* (Pettifor, Measham, Rees & Padian 2004:2003).

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APPENDIX 1: ACCESS LETTER

Through: The General Manager: Human Resources
Ms. T M Namases
Air Namibia

Attention: The Chief Executive Officer
Mr. Kosmas Egumbo
Air Namibia
Private Bag 713
Windhoek
Namibia

RE: Authorisation to conduct a MA Research in Social Behaviour Studies in HIV/AIDS in Air Namibia

Dear Mr. Egumbo

My name is Rachel Freeman, Senior Officer responsible for the Employee Wellness Programme in Air Namibia. I am pursuing a Masters Degree (MA) in Social Behaviour Studies in HIV/AIDS with the University of South Africa (UNISA). As part of the requirements for my Master's Degree, I have to complete a research dissertation.

The central research problem is to explore from the narratives of working women, what their perceptions are of gender power, gender-based violence and HIV-infection risks within intimate relationships. This problem will be addressed, by conducting an explorative, qualitative study among female employees in an airline business.

Purpose: The main purpose of the study is to explore working women's perceptions of gender power, gender-based violence and HIV-infection risks within their intimate relationships, and to provide insight into some of the challenges working women experience in the workplace regarding power, gender-based violence and HIV-infection risks.

Procedure: The information will be collected mainly through in-depth, face-to-face interviews with a volunteer sample of women. A semi-structured interview schedule will be used and the interviews will be tape-recorded. The researcher will personally transcribe the tape-recorded interviews.

Discomforts or risks: Some women may be reluctant to give their opinions on matters regarding power, gender-based violence and HIV-infection risks.

Statement of confidentiality: Although interviewees are requested to sign a consent form, no names or identifying details appear on the interview schedule and no personal information can be associated with the responses. Signed consent forms, the tape recordings, notes taken during the interview or any other documentation related to the research will be kept locked in a secure cupboard in the researcher's home.

These materials will be destroyed completely five years after the completion of the study.

Freedom to refuse participation: Interviewees may choose to stop participation in the study at any time. They may refuse to answer certain questions or ask not to answer certain questions

should they wish to do so. Such information will only be used for the stated purpose of this research and will not be given to a third party. When the data has been processed, the questionnaires will be destroyed. The findings of the research will be the final submission of my dissertation at UNISA.

Thanking you in advance for your authorisation and support.

Yours sincerely

See Appendix 2: A signed copy of access granted to conduct research.

APPENDIX 2: APPROVAL OF ACCESS

Rachel.Freeman@airnamibia.aero

Through: The General Manager: Human Resources
Ms. T M Namases
Air Namibia

Attention: The Chief Executive Officer
Mr. Kosmas Egumbo
Air Namibia
Private Bag 713
Windhoek
Namibia

RE: Authorization to conduct a MA Research in Social Behaviour Studies in HIV/AIDS in Air Namibia

Dear Mr. Egumbo

My name is Rachel Freeman, Senior Officer responsible for the Employee Wellness Programme in Air Namibia. I am pursuing a Masters Degree (MA) in Social Behaviour Studies in HIV/AIDS with the University of South Africa (UNISA). As part of the requirements for my Master's Degree, I have to complete a research dissertation.

The central research problem is to explore from the narratives of working women, what their perceptions are of power, gender-based violence and HIV-infection risks within intimate relationships. This problem will be addressed, by conducting an explorative, qualitative study among female employees in an airline business.

Purpose: The main purpose of the study is to explore working women's perceptions of power, gender-based violence and HIV-infection risks within their intimate relationships. In order to understand working women's perceptions of gender power, gender-based violence and HIV-infection risks in their intimate relationships. To provide insight on some of the challenges working women experience in the workplace regarding power, gender-based violence and HIV-infection risks

Procedure: The information will be collected mainly through in-depth face-to-face interviews with a volunteer sample of women. A semi- structures interview schedule will be used and the interviews will be tape recorded. The researcher will personally transcribe the tape-recorded interviews

Discomforts or risks: Some women may be reluctant to give their opinions on matters regarding power, gender-based violence and HIV-infection risks.

Statement of confidentiality: Although interviewees are requested to sign a consent form, no names or identifying details appear on the interview-schedule and no personal information can be associated with the responses. Signed consent forms, the tape recordings, notes taken during the interview or any other documentation related to the research will be kept locked in a secure cupboard in the researcher's home. These materials will be destroyed completely five years after the completion of the study.

Freedom to refuse participation: Interviewees may choose to stop participation in the study at any time. They may refuse to answer certain questions or ask not to answer certain questions should they wish to do so.
Such information will only be used for the stated purpose of this research and will not be given to a third party. When the data has been processed, the questionnaires will be destroyed. The findings of the research will be the final submission of my dissertation at UNISA.

Thanking you in advance for your authorization and support.

Yours sincerely

Recommended
06/07/2009

approved
16/7/09

APPENDIX 3: INFORMATION LETTER

Title of project: Working Women's perceptions of gender power, gender-based violence and HIV-infection risks in their intimate relationships

Investigator Name: Rachel Freeman

Address: Employee Wellness, Air Namibia
P O Box 50457, Bachbrecht, Windhoek, Namibia

Telephone number: +264-812520601

Purpose: The main purpose of the study is to explore working women's perceptions of gender power, gender-based violence and HIV-infection risks within their intimate relationships. The intended interviewees are female employees in an airline business. The aim is to understand some of the challenges women experience in their intimate relationships and at the workplace. As an outcome of the research, recommendations will be made about the development of supportive systems for working women.

Procedure: The information will be collected mainly through in-depth, face-to-face interviews with a volunteer sample of women. A semi-structured interview schedule will be used and the interviews will be tape-recorded. The researcher will personally transcribe the tape-recorded interviews.

Discomforts or risks: Some women may be reluctant to give their opinions on matters regarding gender power, gender-based violence and HIV-infection risks.

Statement of confidentiality: Although interviewees are requested to sign a consent form, no names or identifying details will appear on the interview schedule and no personal information can be associated with the responses. Signed consent forms, the tape recordings, notes taken during the interview or any other documentation related to the research will be kept locked in a secure cupboard in the researcher's home. These materials will be destroyed completely five years after the completion of the study.

Freedom to refuse participation: Interviewees may choose to stop participation in the study at any time. They may refuse to answer certain questions or ask not to answer certain questions should they wish to do so.

APPENDIX 4: INFORMED CONSENT FORM

Title of project: Working Women's Perceptions of Gender Power, Gender-Based Violence and HIV-Infection Risks in their Intimate Relationships

Investigator's Name: Rachel Freeman

Dear Interviewee

On the previous page, the aim of the study is explained. To protect your rights as a participant in this study, please respond to the following questions:

1. Do you understand that your participation in this study is voluntary?
   Yes No

2. Have you read the attached information letter?

   Yes No

3. Do you understand that participation implies that I will conduct an interview with you?

   Yes No

4. Do you understand that your name will be known only to the researcher and that your true identity will NOT be made public?

   Yes No

5. Do you consent to having our interview tape-recorded?

   Yes No

I agree to take part in this study by being interviewed. I understand that my name will not be associated with the interview in the write-up of the findings.

Signature of participant: _____Date: _____

Signature of the researcher: _____Date: _____

Signed copies of this consent form must be:
1) Retained on file and
2) Given to the Participant

APPENDIX 5: INTERVIEW SCHEDULE

Working Women's perceptions of gender power, gender-based violence and HIV-infection risks in their intimate relationships

Introduction

I am **Rachel Freeman**, Master's student at the University of South Africa (UNISA). I am interested in working women's perceptions of gender power, gender-based violence and HIV-infection risks. I am currently working with Air Namibia as a Senior Officer, Wellness. I am a Social Worker by profession.

I am talking to working women in an airline business about gender power, gender-based violence and HIV infections. I wish to find out what their perceptions and experiences are about intimate relationships. I also wish to know if and how women deal with these issues in the workplace.

I want you to feel free to say exactly what you think and feel. There is no right or wrong answer to the questions that I ask. Your opinions and experiences are important to me. Everything you say is treated as highly confidential. Your responses will not be connected with you when I write up my findings – in other words, I would mask your true identity and you will remain anonymous for the purposes of my report. I have secured a private venue where we can conduct the interview during working hours.

I shall ask certain questions and, with your permission, tape-record our discussion. I shall also make a few notes for myself during the session. This will enable me to accurately capture everything that we discuss.

Some of my questions might be personal. If you are uncomfortable with a question, you do not have to answer it if you wish. You may also stop the interview at any time. It will take about 1 hour to complete the interview. After that, you may ask me questions if you want.

Do you have any questions?

SECTION 1: BIOGRAPHICAL DETAILS. First, I shall ask a few biographical details for the purposes of comparison.

1. How old are you?
2. What is your home language?
3. What is your current marital status? (Probe: how long in the relationship, kind of relationship, etc.)
4. Do you have any children? (Probe: own children, how many, ages)
5. What is your highest level of education?
6. How many years have you been working in aviation/the airline business?

SECTION 2: GENDER-BASED POWER

7. What is your understanding of gender power in an intimate relationship?
8. Thinking back to your childhood – who held the most decision-making power in your household? Was it your mother or your father? Give me examples.
9. Comparing your experiences of power in your childhood circumstances and your current (or most recent relationship), what are the similarities? What are the differences?

10. Do the dynamics of power in your current (or most recent) relationship influence your working life? How?
11. Do you feel that your current (or most recent) relationship influences your health? How?

In the *Decision-Making Dominance Subscale* below, please answer the following questions by responding to the statement as 1 = My Partner, 2 = Both of us equally and 3 = Me.

No	Question (1 = My partner; 2 = Both of us equally; 3 = Me)
12	Who usually has more say about when you talk about serious things?
13	In general, who do you think has more power in your relationship?
14	Who usually has more say about whose friends to go out with?
15	Who usually has more say about whether you have sex?
16	Who usually has more say about what you do together?
17	Who usually has more say about how often you see one another?
18	Who usually has more say about whether you use condoms?
19	Who usually has more say about what types of sexual acts you do?

***(*Source: Pulerwitz, Gortmaker & DeJong. 2000. *Sexual Relationship Power Scale*)**

SECTION 3: RELATIONSHIP CONTROL. In the *Relationship Control Subscale below,* please answer the following questions by responding to the statement as: 1 = Strongly Agree, 2 =Agree, 3 = Disagree or 4 =Strongly Disagree**.**

20 If I asked my partner to use a condom, he would get violent.
21 If I asked my partner to use a condom, he would get angry.
22 Most of the time, we do what my partner wants to do.
23 My partner won't let me wear certain things.
24 When my partner and I are together, I'm pretty quiet.
25 My partner has more say than I do about important decisions that affect us.
26 My partner tells me who I can spend time with.
27 If I asked my partner to use a condom, he would think I'm having sex with other people.
28 I feel trapped or stuck in our relationship.
29 My partner does what he wants, even if I do not want him to.
30 I am more committed to our relationship than my partner is.
31 When my partner and I disagree, he gets his way most of the time.
32 My partner gets more out of our relationship than I do.
33 My partner always wants to know where I am.
34 My partner might be having sex with someone else.

(Source: Pulerwitz, Gortmaker & DeJong. 2000. *Sexual Relationship Power Scale*)

SECTION 4: PERCEPTIONS OF GENDER-BASED VIOLENCE

35. How would you define gender-based violence?
35.1 Let us talk about psychological or emotional violence as a sub-category of gender-based violence. Have you ever felt harmed emotionally or psychologically by your partner or another man important to you? (For example, constant insults, humiliation at home or in public, destruction of objects you felt close to, ridicule, rejection, manipulation, threats, isolation from friends or family members, etc.) If Yes, when did this happen? By whom?
35.2 Has your partner or another man important to you ever caused you physical harm? (Examples: hitting, burning or kicking you?) If Yes; when did this happen? By whom?
35.3 Were you ever forced to have sexual contact or intercourse? If Yes, when did this happen? By whom?
35. 4 Have you ever ended a relationship because you felt at risk of violence (emotional, physical or sexual) or abuse? If yes – probe for details.
35.5 Have you ever resigned from a job due to gender-based violence (emotional, physical or sexual) or the threat of such violence? If yes – probe for details.

36. Does gender-based violence affect you as a working woman? How?
37. How do you see the relationship between gender-based violence and the risk of HIV infection?
38. Do you think that working women are at risk of becoming the victims of gender-based violence? What are the reasons for your answer?
39. Do you think that women working in aviation or the airline industry are particularly at risk of becoming the victims of gender-based violence? What are the reasons for your answer?
40. In your own opinion – where are working women most at risk of becoming victims of gender-based violence: at home, at work, or elsewhere?
41. In your opinion, are there instances where the use of physical violence by a man against a woman is justified? Please give reasons for your answer.

SECTION 5: PERCEPTIONS OF ECONOMIC GENDER-BASED ABUSE

42. In your understanding, what is economic gender-based abuse?
43. Has your partner or another man important to you ever failed to provide money to run the house or look after the children but had money for other things?
44. Has your partner or another man important to you ever taken your earnings or pay packet from you?
45. Has your partner or another man important to you tried to prevent you from going to work, selling, or making money in any other way?

SECTION 6: PERCEPTIONS OF HIV-INFECTION RISKS

46. Can you tell me how HIV is transmitted? (probe)
47. Have you ever personally felt at risk of HIV infection? Why or why not?
48. Have you ever gone for VCT? If not, will you ever go? (Probe for reasons)
49. You must not disclose your status to me, but do you know your HIV status?
50. If you ever feel that you are at risk of being infected with HIV – what would you do?
51. Do you think that working women are at risk of HIV infection? What are the reasons for your answer?
52. Do you think that women working in aviation or the airline industry are particularly at risk of HIV infection? What are the reasons for your answer?

SECTION 7: SOCIO-CULTURAL CHALLENGES

53. How do you feel about the use of condoms to protect women from HIV and other sexually-transmitted diseases?
54. If you ever found yourself in a situation in which you had to use condoms to protect yourself from HIV infection, a STI or pregnancy – would you be able to insist on using a condom during sex?

SECTION 8: SHARING OF HIV-POSITIVE STATUS

55. Since you have known about your status, have you told anyone in your family?
56. Whom did you tell and how?
57. How is that person's reaction towards you?
58. Tell me about your feelings after you told someone?
59. Do you know your partner's HIV status?
60. If you know your partner's HIV status and there is a discordant result between you and your partner, how have you dealt with the discordant result?

Section 9: RECOMMENDATIONS

61. How can the airline business contribute to the alleviation of gender-based violence?
62. How can the airline business contribute to the alleviation of HIV-infection risks for women?

UNISA

Department of Sociology
College of Human Sciences
15 March 2010

Proposed title: *Working women's perceptions of gender power, gender based violence and HIV-infection risks: An explorative study among female employees in an airline business.*

Principal investigator: Rachel Johanna Freeman (student number 45610398)

Reviewed and processed as: Class approval (see paragraph 10.7 of the UNISA Guidelines for Ethics Review)

Approval status recommended by reviewers: Approved

The Higher Degrees Committee of the Department of Sociology has reviewed the application for ethical review and considers the methodological, technical and ethical aspects of the request to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines:

- To only start this research study after obtaining informed consent from your research participants
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To work in close collaboration with your supervisor(s) and to record the way in which the ethical guidelines as suggested in your proposal has been implemented in your research
- To notify the Higher Degrees Committee of the Department of Sociology in writing immediately if any change to the study is proposed and await approval before proceeding with the proposed change
- To notify the Higher Degrees Committee of the Department of Sociology in writing immediately if any adverse event occurs.

Approvals are valid for ONE academic year after which a request for a continuation of the approval must be submitted to your supervisor(s).

Kind regards

D. Gelderblom (Prof)
Chair: Department of Sociology
Tel + 27 12 429 6301

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