

**HIV-SEROSTATUS DISCLOSURE AND PREVALENCE OF INTIMATE  
PARTNER VIOLENCE AMONG HIV-INFECTED WOMEN  
ATTENDING CARE AND TREATMENT CENTERS IN  
DAR ES SALAAM, TANZANIA**

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**MMed (Community Health) Dissertation  
Muhimbili University of Health and Allied Sciences  
October, 2014**

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**By**

**Samson Ndile**

**A dissertation Submitted in (partial) Fulfillment of the Requirements for the Degree of  
Master of Medicine (Community Health) of  
Muhimbili University of Health and Allied Sciences**

**Muhimbili University of Health and Allied Sciences  
October, 2014**

**CERTIFICATION FOR ACCEPTANCE**

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled ***HIV-serostatus Disclosure And Prevalence of Intimate Partner Violence Among HIV-infected Women Attending Care and Treatment Centers in Dar Es Salaam, Tanzania***, in (Partial) fulfillment of the requirements for the degree of Master of Medicine (Community Health) of Muhimbili University of Health and Allied Sciences.

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**Prof. G. Msamanga**

(Supervisor)

**Date:** \_\_\_\_\_

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Last but not least, I am indebted to my parents, family and other relatives. To them I say, thank you for your patience and support throughout my studies.

**DEDICATION**

This work is dedicated to my parents, *Paul* and *Illuminata Ndile*, also to my wife, *Restituta* and daughter, *Frideswida* for their endurance, support, and encouragement throughout my study period.

## **ABSTRACT**

### **Background**

Intimate partner violence (IPV) against women is a serious public health problem worldwide indicating it is a pressing health and human rights concern. Systematic reviews indicate that there is wide variation in magnitude and distribution of IPV. Sub-Saharan Africa, however, appears to have a double burden of HIV-infection and IPV. The association between HIV-serostatus disclosure with IPV is not well understood in our setting.

### **Objectives**

The objectives of this study were: first, to determine the prevalence of IPV among women who attended care and treatment centers in Ilala Municipality, Dar es Salaam. Second, to determine whether there was an association between HIV-serostatus disclosure with IPV.

### **Materials and Methods**

We conducted a cross-sectional study in Ilala Municipal, Dar es Salaam from March to April 2014. Using interviewer- administered questionnaires we assessed the prevalence and risk factors for IPV among 384 HIV-infected women attending care and treatment facilities, aged 15 years or more, and in intimate relationship. Data were recorded on questionnaires, and the information was entered to a computer and analyzed using Statistical Package for social Sciences (SPSS) software version 15.

### **Results**

The main finding was that the prevalence of IPV among HIV-infected women was 39.6% (152/384) (95% Confidence Interval [CI] = 33.4-45.8). Three quarters (75.4%) of the women reported that they had disclosed their HIV-serostatus to their partners. Compared to women who did not disclose their HIV-serostatus, those who disclosed were significantly more likely to experience IPV (Adjusted Odds Ratio (AOR) = 2.34, 95% CI = 1.20-4.56); (P = 0.01). Other factors found to be associated with IPV included whether the partner reported that he had other sexual partner(s) [AOR = 1.61, 95% CI = 1.25-2.06 (P < 0.001)] and consumed alcohol [AOR] = 1.88; 95% CI = 1.18-2.97, P = 0.01.

**Conclusion**

Among women who are HIV-infected, the prevalence of IPV in the previous twelve months was high. Our findings showed that disclosure of HIV-serostatus to partner, and if the partner consumed alcohol or had other sexual partners were significantly associated with IPV.

**Recommendations**

The study recommended that routine screening of IPV among HIV infected women should be made a policy of the country. Health care workers at all levels of health facilities should also be sensitized to ask questions on IPV when they encounter HIV- infected women. This should allow the health system to identify and intervene in situations of abuse. Couple counseling and testing should also be emphasized to reduce the likelihood of women experiencing violence from their partners. On the other hand women should not be forced to disclose their HIV-serostatus to their partners. The Ministry of health should focus on interventions that aim at preventing IPV at communities. Interventions aiming at addressing risk factors for IPV should particularly be the main focus.



## **DEFINITION OF TERMS**

**Intimate partner:** The term intimate partner refers to a spouse or partner of HIV-infected woman in a formal or informal relationship. It includes marital and non-marital relationships (cohabiting, boyfriend/girlfriend).

**Intimate partner violence:** In this study, this term has been used to describe the behavior by an intimate partner that results into physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, and emotional abuse.

**HIV- serostatus disclosure:** In this context, disclosure has been defined as the act of informing an intimate partner the HIV-serostatus of the infected person.

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## **LIST OF ABBREVIATIONS**

ART	Antiretroviral Therapy
GBV	Gender Based Violence
CTC	Care and Treatment Centers
CTS	Conflict Tactics Scale
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
SPSS	Statistical Package for Social Sciences
TDHS	Tanzania Demographic and Health Survey
WHO	World Health Organisation

## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background

Violence against women and human immunodeficiency virus (HIV) are public health problems globally with serious implications to women. Intimate partner violence (IPV) is the most common form of violence against women.<sup>[1]</sup> Others include non-sexual partner violence, female genital mutilations (FGM), honor killings and trafficking of women.<sup>[2]</sup> This form of violence has serious health and economic consequences to women and the country in general. Abused women report ill health and seek medical care more often than those who are not abused, thus weaken their contribution to the economy of the country, with much resources being utilized to care for them.<sup>[3][4]</sup>

In the past two decades, there have been increased efforts to combat HIV-infection with much emphasis placed on the most at risk populations including HIV-infected pregnant women. Globally, it is estimated that 35.3 million people were living with HIV by 2012 equivalent to 0.8% of all adults.<sup>[5]</sup> The burden of the disease varies considerably between regions and countries with sub-Saharan Africa affected the most. By 2011, the region accounted for 69% of all people living with HIV worldwide equivalent to 23.5 million adults and children.<sup>[6]</sup> About 5% of all adults in the region are living with HIV.

In contrast to other regions, women compose majority of cases in sub-Sahara. Nearly, 60% of HIV cases are women who also bare the greatest burden of care.<sup>[6]</sup> This situation is also reflected in the country level with the overall HIV prevalence in Tanzania being 5.1% where more women (6.2%) are infected than men (3.8%).<sup>[7]</sup>

Through campaigns to emphasize the importance of knowing one's own HIV-serostatus, people have been made aware of HIV-infection and its consequences. In many countries, HIV counseling and testing in reproductive and child health facilities, in particular antenatal clinics, has been made available with some countries even making it mandatory for pregnant women

to test for HIV in efforts of preventing mother to child transmission of HIV. Again, in HIV care and treatment facilities, HIV-infected individuals are counseled on the importance of disclosing their serostatus to a close person preferably a partner.

Though all these efforts have good intentions, the unlike events with serious consequences may occur especially when a woman is found to be HIV-infected. Scholars have reported that HIV-infected women are at a higher risk of IPV than women in the general population.<sup>[8][9][10][11]</sup> It is more serious in cases where a male partner is not HIV-infected.<sup>[8]</sup> With this reason, HIV-infected women often do not disclose their HIV-serostatus in the fear of negative consequences. This may lead to poor access to health services<sup>[12]</sup> and therefore worsen their health and may increase the risk of mother to child transmission of HIV in a situation where a woman is pregnant.<sup>[13]</sup>

## **1.2 Statement of the problem**

Intimate partner violence against women continues to be a public health problem in Tanzania, with adverse repercussions to women, particularly HIV-infected women. Evidence has demonstrated the link between IPV and HIV infection<sup>[14][15][16][17]</sup> with violence being a risk marker as well as a consequence of HIV infection.<sup>[18]</sup>

The magnitude of IPV is still high despite of various efforts in place to address it. WHO reports that, nearly a third (30%) of all women worldwide, who have been in a relationship, have experienced some kind of physical and/or sexual violence by their intimate partners.<sup>[2]</sup> The situation is worse in resource limited settings with WHO African region having the highest prevalence (37%) of IPV. In Tanzania, 44% of ever-married women have experienced some form of physical and/or sexual violence from their current or former spouses.<sup>[19]</sup>

For HIV-infected women, HIV-serostatus disclosure has been emphasized with regard to its numerous benefits. Unfortunately disclosure comes with potential risks of experiencing IPV. A study in Uganda reports that 36.6% of HIV-infected women have a lifetime experience of



IPV.<sup>[20]</sup> Similarly, a study in Nigeria came up with findings that 22.1% of HIV-infected women suffer domestic violence after disclosure of HIV-serostatus.

In Tanzania, studies on IPV have been conducted among some groups of women considered to be at risk. But very few have been conducted specifically in women living with HIV. These women represent a group which is more exposed to IPV and the impact on them is more severe both in terms of psychological, physical, and pathological consequences. Therefore, there is limited information on the extent of the problem among HIV-infected women in Tanzania. It is therefore necessary to gain more information on the magnitude of IPV and factors influencing it in our setting if appropriate recommendations are to be made.

### **1.3 Rationale of the study**

This study is expected to make a contribution to the already existing body of knowledge on intimate partner violence and associated factors among HIV-infected women in resource limited settings. The findings of the study are going to be used as a basis for recommendations to health care workers, policy makers, and the community for prevention and/or reduction of IPV among HIV-infected women.

### **1.4 Research questions**

1. What is the extent of intimate partner violence among HIV-infected women attending care and treatment centers in Dar es Salaam?
2. What is the association between HIV-serostatus disclosure and intimate partner violence among HIV-infected women attending care and treatment centers in Dar es Salaam?

### **1.5 Objectives**

#### **1.5.1 Broad Objective**

To determine the prevalence of intimate partner violence and its association with HIV-serostatus disclosure among HIV-infected women attending Care and Treatment Centers in Dar es Salaam.

### **1.5.2 Specific Objectives**

1. To determine the prevalence of intimate partner violence among HIV-infected women attending Care and Treatment Centers in Dar es Salaam.
2. To determine factors influencing intimate partner violence among HIV-infected women attending Care and Treatment Centers in Dar es Salaam.

## CHAPTER TWO

### LITERATURE REVIEW

#### 2.1 Intimate partner violence and its magnitude

The term intimate partner violence refers to a behavior by an intimate partner that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, emotional abuse and controlling behaviors.<sup>[21]</sup> The World Health Organisation defines domestic violence or intimate partner violence as “*the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male intimate partners*”.<sup>[22]</sup> It is the most common form of violence in women’s lives globally.<sup>[14]</sup> Women are at a higher risk of violence at homes than in the streets.<sup>[1]</sup>

Violence against women serves both as a driver of the HIV-infection epidemic and at times a consequence of being HIV-positive.<sup>[18]</sup> It may increase a woman’s risk of infection through forced or coercive sexual intercourse and by limiting her ability to negotiate HIV-preventive behaviors.<sup>[14]</sup> On the other hand, being infected with HIV may put a woman at risk of experiencing violence from their partners.<sup>[14]</sup>

WHO reports that nearly one third 30% (95% CI 27.8-32.2) of all women worldwide who have been in a relationship have experienced some kind of physical and/or sexual violence by their intimate partners and as many as 38% of all murders of women are committed by their intimate partners.<sup>[2]</sup>

WHO multi-country study on women’s health and domestic violence reported that 15% to 71% of women aged between 15 and 49 were abused physically or sexually, or both at least once in their lifetime by an intimate partner.<sup>[1]</sup> The situation is worse in developing countries compared with the developed world settings. It is even worse in conflict situations. A study done in Iraq reported that more than half of women experience violence where the perpetrator is an intimate partner with lifetime prevalence of 58.6%.<sup>[21]</sup> Again, in south America, intimate partner violence has been reported to be common with a study in Bolivia reporting that 47% of

women experienced spousal abuse in the previous 12 months before the study.<sup>[23]</sup> WHO also came up with the report that suggested Africa, Eastern Mediterranean and South-East Asia regions have the highest prevalence of intimate partner violence, with 37% of ever partnered women reported having experienced physical and/or sexual intimate partner violence at some point in their lives.

Tanzania is also highly affected with the problem. According to the WHO multi-country study on women's health, 55.9% of ever partnered women in Tanzania have ever experienced physical or sexual violence, or both.<sup>[1]</sup> These findings concurs with Tanzania Demographic and Health Survey (TDHS) 2010 report<sup>[19]</sup> which concludes that, 44% of ever-married Tanzanian women aged 15-49 have experienced some form of physical and/or sexual violence from their current or former spouse. Of all the regions, Dodoma and Mara regions were reported to have had highest rates of spousal violence (emotional, physical, or sexual violence), 85% and 78% respectively. Unguja north and Pemba north were the regions reported with the lowest rates of spousal violence (emotional, physical, or sexual) against women in Tanzania with 8.3% and 11.7% respectively.

Intimate partner violence has also been reported to be very common among pregnant women in Africa. It has actually been reported that the prevalence of IPV among pregnant women in Africa is one of the highest reported globally.<sup>[24]</sup> It ranges from 2% to 57%.<sup>[24]</sup> Tanzania demographic health survey reports that 9% of ever-married women in Tanzania experienced physical violence during pregnancy.

## **2.2 Intimate partner violence and HIV**

“Women who are at risk of HIV-infection (where the spouse is HIV-positive) or who perceive themselves at a high risk of acquiring HIV-infection from the spouse may have higher levels of violence than the general population”.<sup>[8]</sup> They may experience violence either physically or sexually simply because they are unwilling to share sexual relations with their partners.

It has been reported that the risk of intimate partner violence is higher among women with HIV-infection than in the general population.<sup>[14][25]</sup> This is probably so due to the fact that

most of the times women are the first to test and diagnosed HIV-infected. Through antenatal clinic, women are advised to test for HIV with the view that if they are infected they will benefit from prevention of vertical transmission of HIV to their babies. From this, they are likely to be blamed as the cause of HIV entry in the relationships (infidelity).

A study done in Nigeria reported Intimate partner violence prevalence of 22.1% in women since being diagnosed HIV-positive.<sup>[26]</sup> Osinde et al<sup>[20]</sup> from Uganda also reported lifetime prevalence of IPV (physical or sexual) among HIV-positive women to be 36.6%.

### **2.3 Factors influencing intimate partner violence**

It must be noted that IPV is not an outcome of a single direct cause. It is a product of interrelated factors occurring within a particular societal context.<sup>[27]</sup> Several factors have been associated with intimate partner violence against women. These factors include HIV-infection, prior history of violence, and partner's alcohol and drug use.<sup>[24]</sup> Others include poverty, polygamous relationships, shorter duration of the relationship, multiple sexual partners and homelessness.<sup>[8]</sup>

#### **2.3.1 Prior history of violence before HIV diagnosis**

Strong association has been found between prior history of violence and women's HIV-serostatus.<sup>[1]</sup> Women infected with HIV are more likely to have had a physically violent male partner in their lifetime and to experience physical violence, sexual violence or both.<sup>[28]</sup> Gielen et al<sup>[29]</sup> reported that history of abuse before diagnosis was a significant factor for abuse after diagnosis.

#### **2.3.2 Age**

Age has been noted as one of the factors that influence IPV against women. It has been noted that the prevalence of domestic violence is high in the extremes of ages. Iliyasu et al<sup>[26]</sup> noted that domestic violence is more likely to occur in HIV-positive women below 20 years and above 40 years than the other age groups.

### 2.3.3 Education

Several studies have come up with findings that support education as a factor influencing IPV against women.<sup>[16][26][30]</sup> A study by Iliyasu and colleagues noted that HIV-positive women whose partners didn't have a formal education were twice as likely to experience domestic violence compared to those had tertiary education.<sup>[26]</sup>

Another study by Maziak also reported that poor education was an important correlate of physical abuse among Syrian women.<sup>[31]</sup> Similarly, Jewkes came up with findings which suggested that higher education status of women was associated with low levels of violence in some countries while in others the relation appeared to follow an inverted U-shaped pattern with low violence rates at the lowest and highest educational levels.<sup>[32]</sup> Another study by Mccloskey also came up with findings which associated low education with violence, demonstrating that women with no more than primary education were more likely to report intimate partner violence.<sup>[33]</sup>

### 2.3.4 Disclosure of HIV-serostatus

Primary prevention of HIV-infection remains the most effective strategy for controlling the disease in the world. HIV testing and counseling is an important tool for prevention and control of the disease and through it, individuals are encouraged to disclose their HIV-serostatus especially to their partners when diagnosed infected.

In many countries, disclosure of HIV-serostatus especially to a partner is encouraged with regard to the benefits that follow after disclosure. For example, knowing the serostatus of sexual partner helps to make informed decisions and the use of safer sex methods.<sup>[11][34]</sup> Other benefits include opportunity for HIV-infected individuals to receive social and emotional support and therefore increase the likelihood to seek and receive care and adhere to treatment, and increased opportunity to plan for the future carefully and thoughtfully.<sup>[11]</sup>

Several studies have reported HIV-serostatus disclosure rates to intimate partners, which have been shown to vary in different settings. In high income countries, disclosure rate has been shown to be higher than in low income settings.<sup>[35]</sup> Women in developed countries have

disclosure rates that range from 42% to 100% while in low income countries disclosure rates range between 16% to 86%.<sup>[11]</sup>

Tanzania is not different from other developing countries with disclosure of HIV-serostatus among infected individuals being a problem. Kilewo et al<sup>[13]</sup> reported disclosure rate of 16.7% among HIV-positive pregnant women to their sexual partners 18 months after diagnosis. Another study by Kiula et al<sup>[36]</sup> reported disclosure rate of 41% to partners of HIV-positive pregnant women.

It has also been seen that gender has a role to play in disclosure of HIV-serostatus. HIV-positive women are less likely to disclose their serostatus to their partners than HIV-positive men as seen in a study done in rural Malawi.<sup>[37]</sup>

Rates of disclosure have also been reported to differ in health care settings. For example, women who test their HIV-status voluntarily have been shown to have higher rates of disclosure than women who encounter testing in situation like antenatal care.

Disclosure of serostatus has been shown to influence IPV among HIV-infected women. Iliyasu et al<sup>[26]</sup> showed that women who disclosed their HIV-serostatus to their partners were more likely to experience violence. They had more than two-fold increased risk of violence compared to those that did not.

Several factors have been shown to affect HIV-serostatus disclosure to partners among people living with HIV. These include good interpersonal skills and being on ART.<sup>[38]</sup> Others include knowing partner's HIV-serostatus, advanced disease stage, low negative self-image, residing in the same house with partner, and discussion about HIV testing prior to seeking services.<sup>[39][40]</sup>

### **2.3.5 Alcohol and substance use**

It has been explained that alcohol and/or substance use may come as an outcome of violence or may cause violence per se. Women whose partner's consume alcohol are at a higher risk of

suffering from IPV.<sup>[32][41][42]</sup> Survivors of violence often turn to alcohol and drugs to cope with abuse. This in turn put them at a higher risk of practicing high risk sexual behaviours hence the risk of acquiring HIV.

### **2.3.6 Employment status**

Women who are unemployed are at a higher risk for intimate partner violence than women who are employed.<sup>[33]</sup> Hindin and colleague came up with findings that employment status being not a predictor of intimate partner violence.<sup>[43]</sup>

### **2.3.7 Parity**

Some studies have reported the association of parity with intimate partner violence.<sup>[33][44][30]</sup> Mccloskey et al<sup>[33]</sup> suggested that the likelihood of violence in past twelve months was elevated in women with problems to conceive or had borne 5 or more children.

### **2.3.8 Multiple sexual partners**

It has been suggested that women whose partners have multiple sexual contacts are more likely to suffer from violence.<sup>[42]</sup> Mccloskey reports that the likelihood of violence in the past year was elevated if her husband or partner had other sexual partners.<sup>[33]</sup>

### **2.3.9 Partner's HIV status**

HIV status of partner has also been shown to be one of the predictors of IPV. Women who are HIV-infected, whose partners are HIV-uninfected or unknown have higher chances of experiencing intimate partner violence than women who are in sero-concordant relationships.<sup>[8][29]</sup>

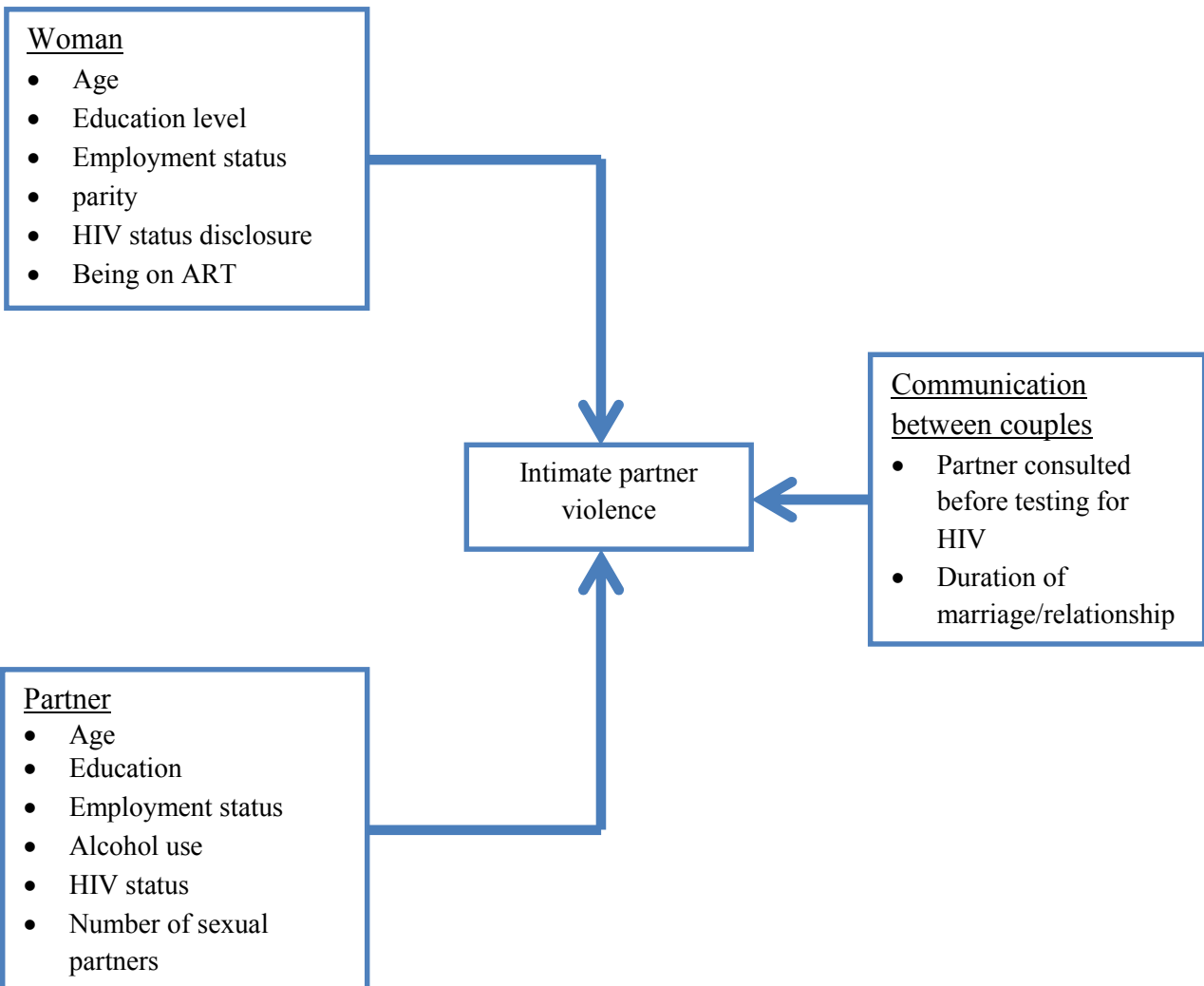


## 2.4 Conceptual framework

**Figure 1** Conceptual Framework of factors influencing intimate partner violence among in HIV-infected women

### Individual factors

### Interpersonal/relational factors



IPV against women is influenced by many interrelated factors categorized at Individual, relational, community, and societal levels as explained by the ecological model. This study focuses on individual and relational factors.

### **Individual factors**

Individual factors such as age, parity, prior history of abuse, level of education, and income level have been shown to influence IPV among HIV-infected women.

Partner's HIV status, excessive alcohol consumption and number of sexual partners have also been shown to influence IPV.

### **Interpersonal or relational factors**

Communication between couples has also been shown to influence IPV. Partner involvement before decision to test for HIV is important as it influences the outcome of HIV-serostatus disclosure and may lead to IPV. The duration of the relationship between couples has also been associated with violence.

## CHAPTER THREE

### METHODOLOGY

#### 3.1 Study design

We conducted a cross-sectional study from March to April 2014. The study design was selected because the study sought to collect information on current situation of the magnitude and factors influencing IPV among HIV-infected women.

#### 3.2 Study area

The study area was Ilala municipal which is one of the three districts in Dar es Salaam region. The study area was chosen because logistic purposes and being one of the regions with high prevalence of both HIV and violence against women. According to the Tanzania National Population Census in 2012, the region had a total population of 4,364,541 people out of which 1,220,611 people were in Ilala.<sup>[45]</sup> HIV prevalence in the region was 6.9% among adults aged 15-49 years.<sup>[7]</sup> Approximately 32% of the women aged 15-49 had ever experienced physical abuse at the 15 years and 24% had ever experienced sexual violence.<sup>[19]</sup>

Health service delivery in Ilala district were primarily based on preventive and promotive health care, rehabilitative, and curative services provided by either government or private owned health facilities. The municipal had 185 health facilities which included 9 (4.8%) hospitals, 15 (8.1%) health centres and 136 (73.5%) dispensaries. Of all the health care facilities in Ilala, 36 (19.4%) provided HIV care and treatment services (22 were public owned and 14 were privately owned).

#### 3.3 Study population

The study population consisted of HIV-infected women aged 15 years and above, who were attending care and treatment facilities at the time of the study.

### 3.3.1 Inclusion criteria

We included all HIV-positive women who were in intimate relationship, and those who were aged 15 years or more, and those who had been diagnosed to be HIV-positive within the previous twelve months).

### 3.3.2 Exclusion criteria

We excluded women who were very sick and unable to participate in the study and those considered to have a mental disorder.

### 3.4 Sample size determination

Sample size was determined using the formula for single propotion<sup>[46]</sup>

$$n = \frac{z^2 p(100-p)}{e^2}$$

Where **n** = required minimum sample size

**p**=Prevalence of IPV among HIV-infected women was set to be 50% (to maximize sample size) since no current information were available in the region

**e**=margin of error on P, which has been set at 5%

**z**=Standard normal deviate corresponding to 95% confidence interval (1.96)

Therefore: **n** =  $1.96^2 \times 50 \times (100-50) / 5^2$

$$= 3.8416 \times 2500 / 25$$

$$\mathbf{n = 384}$$

### **3.5 Sampling technique**

We used a two stage sampling procedure to select study participants. Ilala district was randomly selected from the other two districts (Kinondoni and Temeke). We then selected three health facilities from Ilala district which offer care and treatment services for HIV-infected women. These facilities were selected based on the number of HIV-infected women being served, due to the limited time available for data collection. Therefore, three facilities with highest number of HIV-positive women were selected which included Amana hospital, Mnazi mmoja hospital, and Buguruni Health Centre. We used the average number of clients attending care and treatment facilities per day to calculate the contribution of the facility on the total number of study participants required. At the facilities, we sampled randomly those women who met the inclusion criterion.

### **3.6 Data collection**

We used questionnaires to record information from the women. Initially, we prepared questions in English and then translated them into Kiswahili. Three research assistants administered the exit interviews using a Kiswahili translated questionnaire. A total of 153 women in Amana hospital, 153 women in Buguruni health centre, and 78 women in Mnazi mmoja hospital were interviewed. Before the interview, research assistants were guided to establish rapport and explain the nature of the study to each woman. Then all women were asked to participate voluntarily.

We obtained socio-demographic information of the woman and her partner. Similarly, we asked about the HIV-serostatus of the partner and whether she has disclosed her status to her partner.

We assessed intimate partner violence using modified and greatly shortened conflict tactics scale (CTS).<sup>[47]</sup> The scale has been found to be effective in measuring domestic violence and can be easily adapted for use in different cultural situations. Conflict Tactics Scale is a screening tool that measure different strategies couples use to resolve conflicts, including physical, sexual, and emotional violence. We adopted this tool because it has been validated for use in Tanzania by Tanzania Demographic and Health Survey.

### **3.7 Recruitment and training of research assistants**

Three research assistants; one intern doctor and two nurses were recruited to conduct the interviews prior to data collection. We provided the trainees the process of obtaining the required information from the women and emphasized the importance of maintaining confidentiality and record the information.

### **3.8 Pre-testing of data collection tool**

Before the actual data collection was begun, we pre-tested our data collection tool (questionnaire) at one health facility in Dar es Salaam i.e. Magomeni health centre. This facility was different from those where the study was conducted but it offers similar services to HIV-infected women.

### **3.9 Variables**

#### **3.9.1 Dependent variable**

The dependent variable was intimate partner violence, measured as the proportions of HIV-positive women who had experienced IPV in the previous 12 months following a disclosure of HIV-status to their partners.

#### **3.9.2 Independent variables**

The independent variables in this study included socio-demographic characteristics of age, parity, education level, marital status and employment status. Other variables included the duration of relationship or marriage, disclosure of HIV-serostatus to partner, partner HIV-status, partner consumed alcohol and if he had a sexual relationship with another/partner.

### **3.10 Data management and analysis**

#### **3.10.1 Data entry and analysis**

Data were coded, entered into a computer and cleaned using the Statistical Package for Social Sciences (SPSS) software version 15.

Initially, we performed univariate analysis to determine the proportion of HIV-infected women who had experienced intimate partner violence in the previous 12 months. We also

determined proportion of HIV-infected women who had experienced intimate partner violence after disclosure of HIV-serostatus to partners, and proportion on HIV-infected women who disclosed their HIV-serostatus to their partners. Thereafter, we performed bivariate analysis to measure the association between the independent variables with the dependent variable of interest in this case IPV.

For variables which showed significant association ( $P < 0.2$ ) with dependent variable, we applied multivariate logistic regression model to identify the significant predictors of intimate partner violence.

### **3.10.2 Quality assurance**

The author (SN) made regular supervision on daily basis and in each day, he reviewed the filled questionnaires to ensure completeness and accuracy of the information collected. In case of a missing data, the respective research assistant was informed and rectifications were effected at the end of each day.

### **3.11 Ethical considerations**

Ethical clearance was obtained from the Muhimbili University of Health and Allied Sciences (MUHAS) Research and Publications committee. Similarly, we obtained permission to conduct the study from the District Medical Officer and the in-charges of all the health facilities.

We used informed consent forms to request HIV-infected women who met our inclusion criteria to participate willingly in the study. They were informed about the aim of the study before being asked to participate. We also assured them that their refusal to participate would not affect the services they receive from the facility and therefore were free to withdraw from the study at any time. Privacy and confidentiality were also strictly adhered to. No participant's name was recorded. We identified them using numbers given during the interview.

## **CHAPTER FOUR**

### **RESULTS**

#### **4.1 Socio-demographic characteristics of study participants**

In this study, we approached 384 HIV- infected women and all of them agreed to participate. Table 1 provides the Socio-demographic characteristics of the women. Their mean age was 34.7 years  $\pm$  Standard deviation (SD) 8.9 and 42% (162/384) were in the age group of 25-34 years. Two thirds (65.9%) (253/384) were married and 57.8% (222/384) had one to three children. Sixty two percent (62.2%) (239/384) of women had primary school education and 30% (115/384) had attained secondary education or higher while, 52% (199/279) had spouses who had secondary education or higher.



**Table 1:** Socio-demographic characteristics of study participants (n=384)

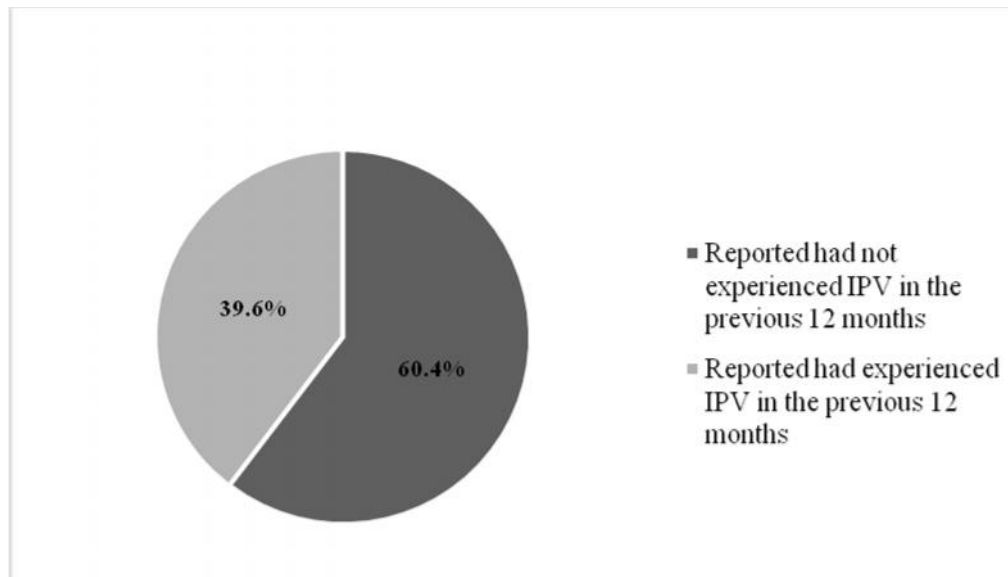
<b>Characteristics</b>	<b>No (%)</b>
<b>Age group of the women (years)</b>	
Mean $\pm$ SD (34.7 $\pm$ 8.9)	
< 25	58 (15.1)
25-34	162 (42.2)
35-44	123 (32.0)
$\geq$ 45	41 (10.7)
<b>Marital status</b>	
Married (monogamous)	194 (50.5)
Married (polygamous)	59 (15.4)
Cohabiting	91 (23.7)
Dating	40 (10.4)
<b>Number of children</b>	
0	136 (35.4)
1	104 (27.1)
2 - 3	118 (30.7)
$\geq$ 4	26 (6.8)
<b>Maternal education</b>	
No formal	30 (7.8)
Primary	239 (62.2)
Secondary	90 (23.4)
Tertiary	25 (6.5)
<b>Maternal employment status</b>	
Unemployed	134 (7.8)
Employed	191 (53.2)
Self-employed/business	59 (39.0)
<b>Partner's education*</b>	
No formal	6 (1.6)
Primary	174 (45.9)
Secondary	147 (38.3)
Tertiary	52 (13.5)

\*Five respondents did not know their partner's education status

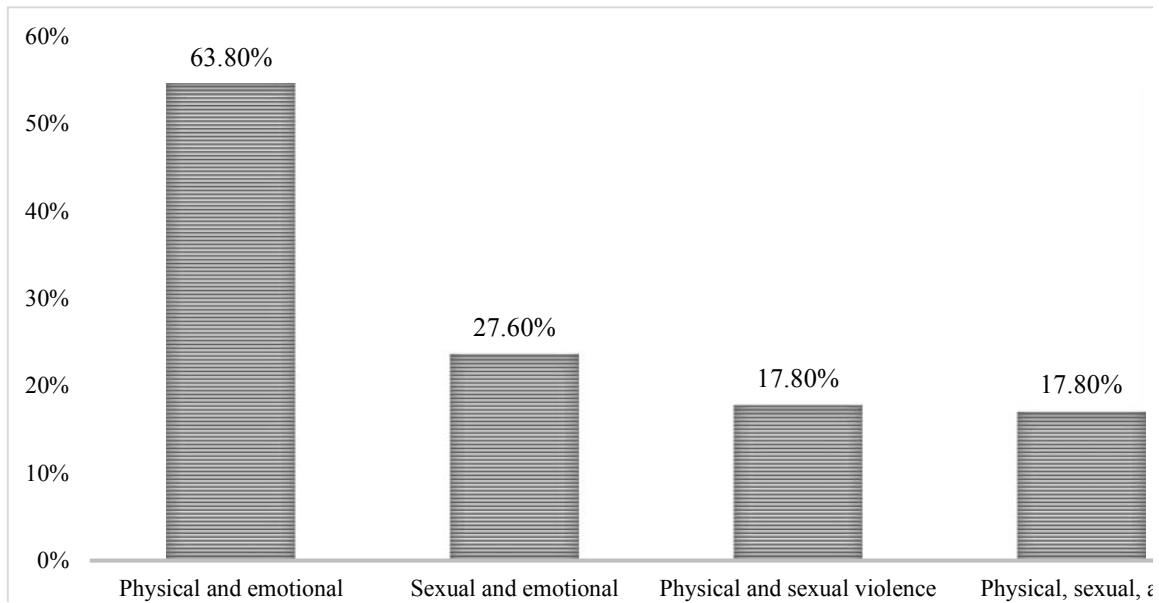
#### 4.2 Prevalence of intimate partner violence in the previous 12 months

We determined the prevalence of intimate partner violence in the previous 12 months among study participants. Our results showed that 39.6% (152/384) of the women reported they had experienced physical, sexual, or emotional abuse from their intimate partners. The remaining 60.4% (232/384) denied that they had experienced any kind of abuse from their intimate partners within the previous 12 months as demonstrated in (Fig. 2).

**Figure 2:** Prevalence of intimate partner violence in the previous 12 months among HIV-infected women



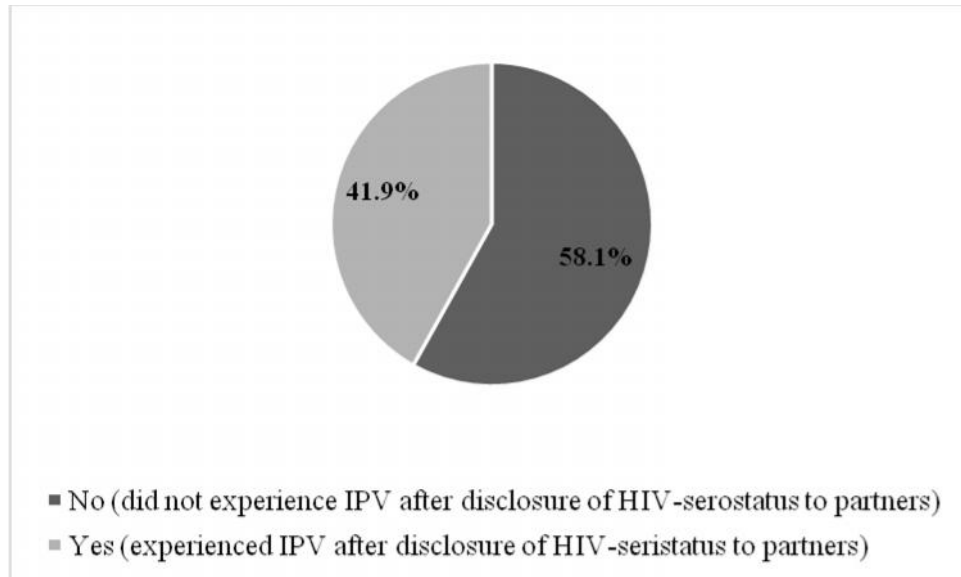
Among the 152 HIV-infected women who had experienced intimate partner violence, 133 (87.5%) reported experiencing psychological/emotional abuse, while 97 (63.8%) and 42 (27.6%) of the women stated that they had experienced physical and sexual abuse respectively. There was an overlap on the types of violence experienced by women. For instance, all women who experienced physical violence also reported emotional abuse. Similarly, all women who experienced sexual abuse also reported emotional abuse, while 17.8% (27/152) reported that they had experienced physical and sexual violence. Seventeen percent mentioned they had experienced all forms of violence (Fig. 3).

**Figure 3:** Proportion of overlapping forms of violence experienced by women

#### 4.3 Prevalence of intimate partner violence after disclosure of HIV-serostatus to partner

In this study, we investigated also for the percentage of HIV-infected women who had experienced intimate partner violence after disclosing their HIV-serostatus to their partner. Out of 289 women who shared their HIV-serostatus to their partner, 121 (41.9%) reported that they had experienced a certain type of violence from their intimate partner sometime after disclosing their status (Fig. 4).

**Figure 4:** Prevalence of intimate partner violence after disclosure of HIV status to partners



The commonest forms of violence reported by the women were emotional violence followed by physical violence, 85% and 63.6% respectively. While, the least common was sexual abuse (20.7%).

#### **4.4 Partner consulted before testing for HIV**

We asked the women if they had consulted their partners before taking an HIV test. Results showed that 58% (222/384) had discussed with their partner before taking their HIV test while 42% (162/384) did not consult their partner.

#### **4.5 Disclosure of HIV-Serostatus and perceived barriers to disclose**

We asked the women if they had disclosed their HIV-serostatus to their partner. The finding was 75.3% (289/384) of the women responded that they had shared their HIV-serostatus to their partner while 24.7% (95/384) had not.

Table 2 provides perceived barriers for not sharing HIV-Serostatus to partners. Of those who did not disclose, the commonest reason was fear of being rejected or abandoned or divorced

by their partner (Table 2). However, 14% of women mentioned that they had plans to disclose their status in future.

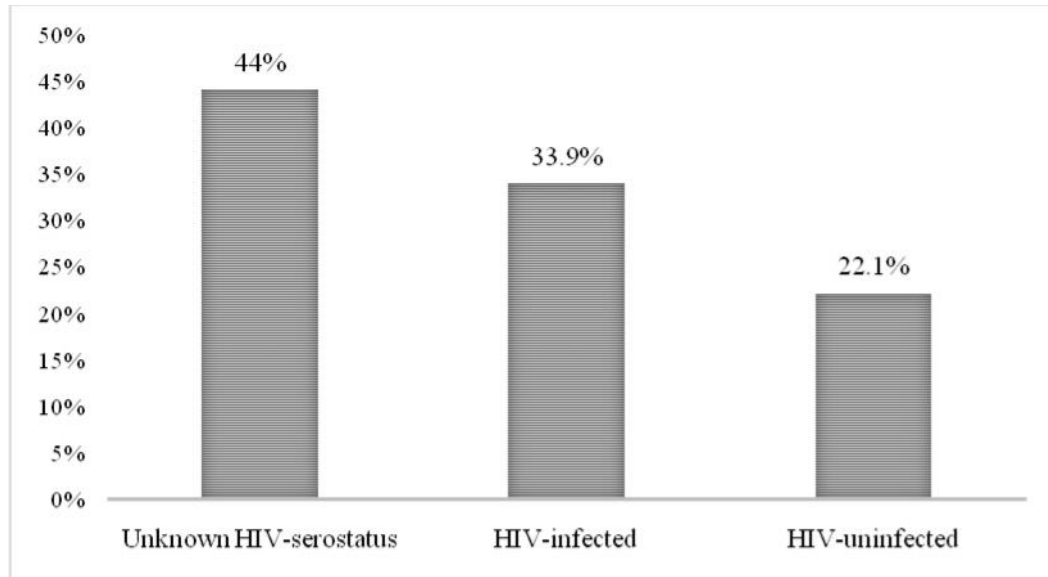
**Table 2:** Perceived barriers for not sharing HIV-serostatus to spouse/partner

<b>Perceived barrier</b>	<b>No (%)</b>
Fear of Divorce, rejection, or abandonment	61 (64.2)
Fear of abuse (verbal or physical)	15(15.8)
Accusation of being unfaithful	6 (6.3)
Plan to disclose	13 (13.7)

#### **4.6 Partner's HIV-serostatus**

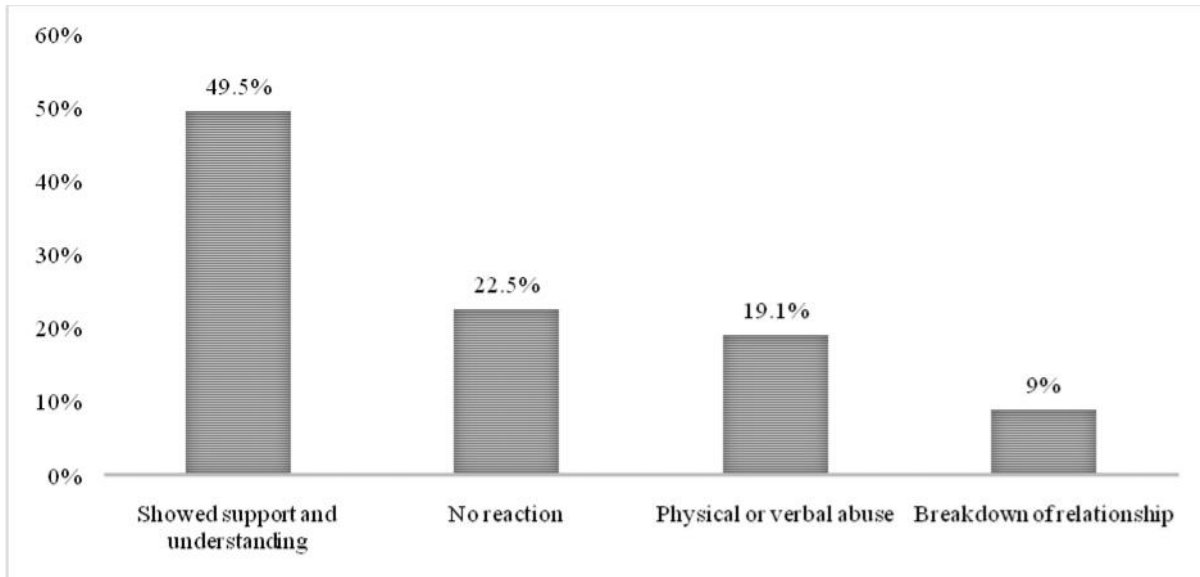
We asked the women whether they knew if their partner had done the HIV test. Over half (56%) responded affirmatively. This meant that they knew that their partner had tested for HIV. On the contrary, 23% mentioned that their partner had not tested, while 21% were unsure. Furthermore, women were asked if their partner had shared their serostatus with them. Although all the 384 women were HIV positive, almost one fifth (22.1%) (85/384) of the partner's HIV test results were discordant.

Figure 5 provides HIV-serostatus of partners who had done the HIV test. Results showed that 33.9% of the male partners were HIV-infected.

**Figure 5:** HIV-serostatus of partner

#### 4.7 Partner reaction after disclosure of HIV-serostatus

Women were asked to mention what were the immediate reactions of their partner after disclosure of HIV-serostatus. Half (49.5%) (143/289) of the women who shared their HIV-serostatus to their partner responded that they received support from their partner (Fig. 6). On the contrary, 19.1% reported events of verbal or physical abuse. A small proportion (9%) of the women reported breakdown of relationship as an outcome of disclosing their serostatus to their partners.

**Figure 6:** Partner's reaction after being informed of HIV-serostatus of the women

#### 4.8 Factors influencing intimate partner violence in the previous 12 months

Several variables were found to be associated with intimate partner violence in the previous 12 months. These factors include; Partner's age ( $P = 0.04$ ), disclosure of HIV-serostatus to partner ( $P = 0.001$ ), partner alcohol consumption (0.002), partner other sexual relationships (0.0001), and consultation with partner before testing for HIV (0.02). Variables such as age of the women, marital status, education, duration of relationship, parity, employment, being on ART, and partner HIV-serostatus showed no statistical significance to intimate partner violence. Table 3 demonstrates socio-demographic characteristics of respondents with occurrence of intimate partner violence in the previous 12 months.

**Table 3:** Socio-demographic characteristics stratified by the presence or absence of intimate partner violence

Characteristic	<u>Intimate Partner Violence</u>			$\chi^2$	df	P-value
	Yes	No (%)	Total (%)			
<b>HIV status disclosure to partner</b>						
Disclosed	128 (44.3)	161 (55.7)	289 (100)	10.82	1	<b>0.001</b>
Not disclosed	24 (25.3)	71 (74.7)	95 (100)			
Total	152 (39.6)	232 (60.4)	384 (100)			
<b>Partner's age</b>						
<25	3 (16.7)	15 (83.3)	18 (100)	8.29	3	<b>0.04</b>
25-34	45 (46.9)	51 (53.1)	96 (100)			
35-44	61 (42.1)	84 (57.9)	145 (100)			
>44	41 (33.6)	81 (66.4)	122 (100)			
Total	150 (39.4)	231 (60.6)	381 (100)			
<b>Partner's alcohol consumption</b>						
Yes	67 (50.4)	66 (49.6)	133 (100)	9.91	1	<b>0.002</b>
No	85 (33.9)	166 (66.1)	251 (100)			
Total	145 (39.6)	232 (60.4)	384 (100)			
<b>Partner other sexual relations</b>						
Has other sexual partner(s)	64 (57.1)	48 (42.9)	112 (100)	22.22	2	<b>&lt;0.001</b>
No other sexual partner(s)	14 (24.6)	43 (75.4)	57 (100)			
Don't know	74 (34.4)	141 (65.6)	215 (100)			
Total	152 (39.6)	232 (60.4)	384 (100)			
<b>Partner's consultation before testing for HIV</b>						
Partner consulted	99 (44.6)	123 (55.4)	222 (100)	5.53	1	<b>0.02</b>
Partner not consulted	53 (32.7)	109 (67.3)	162 (100)			
Total	152 (39.6)	232 (60.4)	384 (100)			
<b>Partner's HIV-serostatus</b>						
Positive	41 (31.5)	89 (68.5)	130 (100)	5.57	2	<b>0.06</b>
Negative	39 (45.9)	46 (54.1)	85 (100)			
Don't know	72 (42.6)	97 (57.4)	169 (100)			
Total	152 (39.6)	232 (60.4)	384 (100)			



**Table 3-continued**

<b>Characteristic</b>	<b>IPV (Yes)</b>	<b>IPV (No)</b>	<b>Total</b>	$\chi^2$	<b>df</b>	<b>P-value</b>
<b>Age of respondent</b>						
<25	18	26	44			
25-34	73	92	165			
35-44	44	83	127			
>44	17	31	48			
Total	152	232	384	3.17	3	0.36
<b>Parity</b>						
0	56	80	136			
1	47	57	104			
2-3	42	76	118			
>4	7	19	26			
Total	152	232	384	4.04	3	0.26
<b>Marital status of respondent</b>						
Married (monogamous)	79	115	194			
Married (polygamous)	22	37	59			
Cohabiting	42	49	91			
Not married, not living with partner under same roof	9	31	40			
Total	152	232	384	6.76	3	0.08
<b>Education of respondent</b>						
No formal education	11	19	30			
Primary	97	142	239			
Secondary and above	44	71	115			
Total	152	232	384	0.29	2	0.86
<b>Education of partner</b>						
No formal education	3	3	6			
Primary	69	205	174			
Secondary and above	78	121	199			
Total	150	229	379	0.28	2	0.86
<b>Responder's employment</b>						
No employment	56	78	134			
Employed	75	116	191			
Business	21	38	59			
Total	152	232	384	0.67	2	0.71
<b>Partner employment*</b>						
No employment	12	18	30			
Employment	75	129	204			
Business	65	84	149			
Total	152	231	383	1.69	1	0.43

**Table 3-continued**

<b>Characteristic</b>	<b>IPV (Yes)</b>	<b>IPV (No)</b>	<b>Total</b>	$\chi^2$	<b>df</b>	<b>P-value</b>
<b>Duration of relationship</b>						
Up to 3 years	64	87	151			
More than 3 years	88	145	233			
Total	152	232	384	0.82	1	0.37
<b>ART medication</b>						
On ART	129	186	315			
Not on ART	23	46	69			
Total	152	232	384	1.37	1	0.24

\*One respondent did not know employment status of her partner

#### **4.9 Predictors of intimate partner violence**

Factors which showed statistical significance to occurrence of intimate partner violence were further subjected to logistic regression analysis to determine the true predictors of intimate partner violence among HIV-infected women.

Table 4 indicates that disclosure of HIV status to partner, partner's alcohol consumption, and partner's other sexual relations were found to be the true predictors of IPV. Women who disclosed their HIV-serostatus to their partners were twice more likely to experience IPV compared to those who did not disclose. Similarly, women whose partners were reported to consume alcohol had more than 80% increased risk of IPV compared to those whose partner's do not consume alcohol. Women whose partner's engage themselves in other sexual relationships had more than 60% increased risk of IPV compared to those whose partner's had no other sexual relations. After adjusting for confounders, partner's age and partner's consultation before taking a HIV test had no significant effect on occurrence of IPV.

**Table 4:** Logistic regression on the factors influencing intimate partner violence among HIV infected women

<b>Predictor</b>	<b>Crude odds ratio</b>	<b>Adjusted odds ratio (95% CI)</b>	<b>P - value</b>
<b>Husband/partner other sexual partners</b>			
No other sexual partner(s)	Referent		
Has other sexual partner(s)	1.54	1.61 (1.25-2.06)	<b>0.000</b>
<b>Partner's alcohol consumption</b>			
No	Referent		
Yes	1.98	1.88 (1.18-2.97)	<b>0.01</b>
<b>HIV-serostatus disclosure to partner</b>			
Not disclosed	Referent		
Disclosed	2.35	2.34 (1.20-4.56)	<b>0.01</b>

## CHAPTER FIVE

### DISCUSSION

In this study we investigated the magnitude and factors associated with intimate partner violence with interest on HIV-serostatus disclosure. Our results show that among women who attended care and treatment centers, the prevalence of intimate partner violence in the previous 12 months was 39.6% (95% CI = 33.4-45.8%). HIV-serostatus disclosure, partner alcohol consumption, and partner other sexual relations were found to be the predictors of IPV.

The rate of IPV observed in this study was higher than reported in Uganda, Nigeria, and northern Tanzania (29.3%, 22.1%, and 17.7% respectively),<sup>[20][26][48]</sup> but lower than 64.5% reported by Nyamhanga and colleagues in Tarime, Tanzania.<sup>[49]</sup> Nevertheless, the findings are comparable with the Tanzania demographic health survey report where 44% of ever married women experience IPV. These findings may indicate the need for screening and counseling for IPV in all HIV-infected women since poor health outcome following abuse is the most likely consequence.<sup>[50][51]</sup>

The association of IPV and disclosure of HIV-serostatus has been documented elsewhere.<sup>[26]</sup> The findings of this study show that women who disclosed their HIV status to their partner were twice as likely to experience IPV compared to those who did not disclose (Adjusted odds ratio =2.34, 95% CI= 1.20-4.56, P = 0.01). These findings are consistent with a study reported from Nigeria.<sup>[26]</sup> Generally, HIV-serostatus disclosure is very important in the efforts of controlling the spread of HIV-infection, and is therefore, emphasized by WHO in its protocols for HIV counseling and testing. Disclosure increases social and psychological support for the infected partner which leads to improved access to HIV care and treatment services thereby reducing related morbidity and mortality. However, results have shown that disclosure may expose women to abuse, therefore, health care works in contact with HIV-infected women should be extra careful when addressing this issue. Depending on circumstances, women should be encouraged to share their HIV-serostatus to their partners but they should not be forced to do so.

Three quarters of the women (75.3%) who participated in the study reported that they had disclosed their HIV-serostatus to their partner. This finding is similar with a study from Malawi which reported high disclosure rates of 84.4% and 91.1% in women and men respectively.<sup>[37]</sup> On the contrary, the findings are higher compared to other studies done in Dar es Salaam and Zimbabwe with disclosure rates of 40% and 57% respectively.<sup>[40][52]</sup>

A quarter of women did not disclose their HIV-serostatus to their partner. The commonest reason for not disclosing was fear of abandonment, rejection, or divorce followed by fear of physical or verbal abuse. These findings were similar with findings reported by Kilewo and colleagues in Dar es Salaam and several other studies.<sup>[13][35][53]</sup>

Another finding from this study was that, women who reported that their partner's had other sexual relations were 61% more likely to experience IPV compared to women who denied that their partner had other sexual relations (AOR = 1.61, 95% CI = 1.25-2.06). Our findings were in agreement with other studies from Tanzania and Uganda, where women whose partner had other sexual partners were more likely to experience IPV compared with those women who denied their partners had other sexual relationships.<sup>[33][42]</sup> This could probably be explained by the fact that other sexual relationships result in unequal love, jealousy, and neglect. On the other hand, if a woman suspected her partner had another sexual partner she thought the partner might become more abusive and disrespectful because of jealousy. In such a situation, IPV was more likely to occur.

We also observed that the odds of experiencing IPV was 88% higher in women whose partner consumed alcohol compared to women whose partner did not (AOR=1.88, 95% CI = 1.18-2.97). Our findings were consistent with other studies which had demonstrated that partner alcohol consumption was a significant predictor of IPV.<sup>[32][41][42][54]</sup> Consumption of alcohol is widespread in Tanzania and is particularly important not only because of its contribution to IPV. It is however, a major barrier to sexual behavior change. Alcohol is believed to operate as a situational factor in increasing the likelihood of violence by reducing inhibitions, clouding judgment and impairing an individual's ability to interpret cues.

The present study failed to identify variables such as age, parity, marital status, duration of relationship, and education (both respondent and their partners) as predictors of IPV among HIV-infected women. This is in contrast to previous studies elsewhere<sup>[8][16][26][29][30][31][32][33]</sup> where such factors were found to influence the occurrence of IPV.

We acknowledge that the study had some limitations. It was conducted in Dar es Salaam and included HIV-infected women attending care and treatment facilities. This might be context specific and this could affect generalization of the findings. Another limitation was recall bias because by asking women to recall events caused by their intimate partners presented some difficulties. Women have a tendency to minimize recalling experiences of violence. To minimize this, recall bias was limited to 12 months period. Furthermore, this study focused on intimate partner violence perpetrated by men against women and therefore we could have missed violence from other origins for example the women themselves as perpetrators and non-partner violence. Finally, this study was based on cross-sectional design and probably it was impossible to infer a causal relationship between the variables.

## CHAPTER SIX

### CONCLUSION AND RECOMMENDATIONS

#### 6.1 Conclusion

The subject of this dissertation was beyond the question of a public health problem. The objective was to study IPV focusing on the magnitude and associated factors among HIV-infected women in a Tanzanian context.

The findings of the study suggested that IPV among HIV-infected women was still a big problem in Tanzania. Disclosure of HIV-serostatus, partner alcohol consumption, and partner other sexual relations were found to increase the likelihood of HIV-infected women experiencing IPV.

These findings had serious implications in HIV control efforts. Sharing HIV-serostatus among partners has been considered as an important milestone for the health of the HIV-infected partner. If women experience violence after disclosing their serostatus to their partners, this might lead to low disclosure rates and therefore it would hamper HIV prevention efforts.

By reducing the incidence of IPV, it is conceivable to improve the health of the women. This study provided insight for policy makers, public health interventionists, and researchers who are attempting to tackle the issue of IPV in Tanzania.

#### 6.2 Recommendations

##### 6.2.1 Recommendations for practice

1. The magnitude of IPV among HIV - infected women was unacceptable. Health care workers at facilities in contact with HIV-infected women, particularly HIV care and treatment and antenatal clinics need to ask questions about IPV to all HIV - infected women as part of routine survey. The encouraging news is that Ministry of Health and

Social Welfare has already begun training HCWs on dealing with domestic violence. This approach should be intensified throughout the country, involving all levels of health facilities to ensure that women at risk of violence are screened.

2. Disclosure of HIV serostatus to partners has been found to increase the likelihood that HIV-infected women may experience IPV. With this reason, HCW should be extra careful when addressing the issue. They need to listen, to be non-judgmental and empathetic in order to empower the women to find their own solutions. Women should not be forced to disclose their status to their partners. Instead more emphasis should be placed on encouraging couple counseling and testing, which has been found to lower incidences of violence after receiving results.

### **6.2.2 Recommendations for policy**

1. This study demonstrated that IPV is still a big problem among HIV infected women in our setting. Most of these women go unidentified simply because our health system has not been set to detect them and intervene where necessary. With this reason, policy makers and health program managers should ensure that HIV infected women subjected to abuse are identified and appropriate support is provided to them. This should include sensitizing all health care providers about IPV and its consequences so that they are able to identify, counsel, and take necessary actions when faced with such situations.
2. Evidence based Interventions for prevention of IPV and other forms of abuse should be established. This should particularly target HIV infected women because of high risk of abuse in this group. Interventions targeting the community should especially be employed. Education to the community to raise its awareness and knowledge and therefore reduce its tolerance towards IPV and other forms of abuse could be a starting point. Then other interventions that address risk factors for abuse should also be used. Interventions that address excessive alcohol consumption and multiple sexual relations



should especially be employed as the findings of this study have suggested their role in increasing the risk of IPV in HIV infected women.

### **6.2.3 Recommendations for further research**

This study assessed factors that influence IPV from the women's perspectives in Tanzania using cross-sectional design. Further research is needed to assess influencing factors using follow-up study to determine the efficacy of interventions against IPV. Again, further research is needed to assess perpetrators perspectives on IPV.

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## APPENDICES

### 8.1 QUESTIONNAIRE ENGLISH VERSION

#### HIV status disclosure and Intimate Partner violence among HIV infected women attending Care and Treatment Facilities in Dar es Salaam

#### I. GENERAL INFORMATION

1. Questionnaire number

--	--	--

2. Date of interview

--	--	--	--	--	--	--	--

3. Health facility \_\_\_\_\_

#### II. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT

4. Age in years \_\_\_\_\_

5. Marital Status

1. Married (Monogamous)
2. Married (Polygamous)
3. Cohabiting
4. Not married and not living with sexual partner under the same roof
5. Separated

6. For how long have you been together with your partner/husband?

\_\_\_\_\_

(Years)

\_\_\_\_\_

(Months)

7. How many children have you given birth to your partner/husband? \_\_\_\_\_

8. Level of education

1. No formal education
2. Primary education
3. Secondary education
4. College/University

9. Employment

1. Student
2. Unemployed
3. Self employed
4. Employed

10. Are you on ART medications?

1. Yes
2. No

**Now I would like to ask you questions about your partner/husband**

11. How old is your partner? \_\_\_\_\_

12. What is your partner's level of education?

1. No formal Education
2. Primary education
3. Secondary education
4. College/University
5. Don't know



13. What is your partner's employment status?
  1. Student
  2. Unemployed
  3. Self employed
  4. Employed
  5. Don't know
14. Does your partner/husband drink alcohol? (if no or don't know, go to 16)
  1. Yes
  2. No
  3. Don't know
15. How often does he get drunk?
  1. Never
  2. Only sometimes
  3. Often
16. Does he have other sex partners?
  1. Yes
  2. No
  3. Don't know
17. Has he ever been tested for HIV?
  1. Yes
  2. No
  3. Don't know
18. What is his HIV-status?
  1. HIV positive/infected
  2. HIV negative/uninfected
  3. Don't know

### III. DISCLOSURE

19. Did you discuss with your partner before testing for HIV?
  1. Yes
  2. No

20. Have you shared your HIV-serostatus to your partner? (If yes also respond to the violence checklist i.e. violence after disclosure of HIV status. If no, go to 22)

1. Yes
2. No

21. Can you tell me how your partner reacted when you told him about your HIV- status?

1. He showed support and understanding
  2. He told me he was also going to test for HIV
  3. He did not react at all
  4. He blamed me for the results (verbal abuse)
  5. He physically assaulted me
  6. He told me to pack my things and leave the house
  7. He packed his things and left the house
  8. Others, specify: \_\_\_\_\_
- 

22. Why have you not shared your status to your partner?

1. I still plan to tell him
  2. Fear of divorce
  3. Fear of rejection/abandonment
  4. He will verbally abuse me
  5. He will beat me (physically abuse me)
  6. He will not care
  7. He will accuse me of being unfaithful/ Infidelity
  8. Others \_\_\_\_\_
- 
- 
-

#### IV. VIOLENCE ASSESSMENT (modified conflict tactics scale)

Now I would like to ask you questions about some other important aspects of a woman's life. I know that some of these questions are very personal. However, your answers are crucial for helping to understand the condition of women in Tanzania. Let me assure you that your answers are completely confidential and will not be told to anyone and no one else will know that you were asked these questions.

Now I am going to ask you questions of what might happen when you and your partner have differences especially since diagnosed HIV infected and when you disclosed your status to your partner. Please respond by saying yes or no, and if the response is yes indicate how often such events occurred.

**Does/Did your partner/husband ever do any of the following for the past one year? Or after disclosing your HIV-serostatus (for those who have shared their HIV status to their partners i.e.**

**Yes to question 20?**

No.	Questions	Coding categories	
		In the past year	After disclosure of your HIV status
1.	Push you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
2.	Shake you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
3.	Throw something at you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
4.	Slap you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
5.	Twist your arm?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often

6.	Pull your hair?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
7.	Punch you with his fist?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
8.	Punch you with something that could hurt you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
9.	Kick you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
10.	Drag you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
11.	Beat you up?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
12.	Try to choke you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
13.	Burn you on purpose?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
14.	Threaten or attack you with a knife?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
15.	Threaten or attack you with a gun or any other weapon?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
16.	Physically force you to have sexual intercourse with him	1. Yes 2. No ↓	1. Yes 2. No ↓

	even when you did not want to?	How often? 1. Sometimes 2. Often	How often? 1. Sometimes 2. Often
17	Force you to perform any sexual acts you did not want to?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
18	Say or do something to humiliate you in front of others?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
19	Threaten to hurt or harm you or someone close to you?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often
20	Insult you or make you feel bad about yourself?	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often	1. Yes 2. No ↓ How often? 1. Sometimes 2. Often

**Did the following ever happen as a result of what your partner/husband did to you?**

23. You had cuts, bruised or aches?

1. Yes
2. No

24. You had eye injuries, sprains, dislocations, or burns?

1. Yes
2. No

25. You had deep wounds, broken bones, broken teeth, or any other serious injury?

1. Yes
2. No

26. If at least one yes to violence assessment after disclosure of HIV status to partner, how long after disclosure of your serostatus did violence occur?

1. Immediately after disclosure of HIV-serostatus status to partner
2. A week after disclosure of HIV-serostatus to partner
3. A month after disclosure of HIV-serostatus to partner
4. Sometime after disclosure of HIV-serostatus to partner (specify).....

**Thank you for your participation**

## 8.2 QUESTIONNAIRE SWAHILI VERSION

**Dodoso la utafifi kuhusu ukatili wa kijinsia kwa wanawake wanaoishi na virusi vya ukimwi wanaopata huduma katika vituo vya huduma na matibabu Dar es salaam.**

### I. MAELEZO YA AWALI

1. Namba ya dodoso \_\_\_\_\_

--	--	--

2. Tarehe \_\_\_\_\_

--	--	--	--	--	--	--	--

3. Kituo \_\_\_\_\_

### II. MAELEZO BINAFSI

4. Umri kwa miaka \_\_\_\_\_

5. Hali yako ya ndoa/mahusiano

1. Nimeolewa ndoa ya mke mmoja
2. Nimeolewa ndoa ya wake wengi
3. Ninaishi kinyumba
4. Nina mwenza ila hatuishi pamoja
5. Tumetengana

6. Je, wewe na mwenza wako mmekuwa katika mahusiano kwa muda gani?

\_\_\_\_\_ (miaka)

\_\_\_\_\_ (miezi)

7. Mmezaa watoto wangapi na huyu mwenza wako? \_\_\_\_\_

8. Elimu

1. Sijasoma
2. Msingi
3. Sekondari
4. Chuo/chuo kikuu

9. Kazi

1. Mwanafunzi
2. Sina ajira
3. Nimejiajiri
4. Nimeajiriwa

10. Je, unatumia dawa za kupunguza makali ya virusi vya ukimwi (ARVs)?

1. Ndiyo
2. Hapana

**Sasa nitapenda kukuuliza zaidi kuhusu mwenza wako**

11. Je, mwenza wako ana umri gani? \_\_\_\_\_

12. Je, mwenza wako ana kiwango gani cha elimu?

1. Hajasoma
2. Elimu ya msingi
3. Elimu ya sekondari
4. Elimu ya chuo
5. Sijui

13. Ajira ya mwenza wako?

1. Mwanafunzi
2. Hana ajira
3. Amejiajiri
4. Amejiriwa
5. Sijui

14. Je mwenzako anakunywa pombe? (kama jibu ni hapana au sijui nenda 16)

1. Ndiyo
2. Hapana
3. Sijui

15. Ni mara ngapi anakunywa pombe kupita kiasi?

1. Hanywi pombe kupita kiasi
2. Mara chache
3. Mara nyingi

16. Je, mwenzako ana mahusiano ya kimapenzi na wanawake wengine?

1. Ndiyo
2. Hapana
3. Sijui

17. Je, mwenzako amewahi kupima VVU?

1. Ndiyo
2. Hapana
3. Sijui

18. Je hali ya maambukizi ya mwenzako ni ipi?

1. Ana maambukizi ya VVU
2. Hana maambukizi ya VVU
3. Sijui

### **III. KUMSHIRIKISHA MWENZA HALI YAKO YA MAAMBUKIZI**

19. Je uliwahi kuzungumza na kukubaliana na mwenzako kabla ya kupima virusi vya ukimwi?

1. Ndiyo
2. Hapana

20. Je, umemshirikisha mwenzako hali yako ya maambukizi? (kama ndio pia jibu kiwango cha unyanyasaji baada ya kumshirikisha mweza, kama hapana nenda 22)

1. Ndiyo
2. Hapana



21. Unaweza ukaniambia Mwenza wako alichukuliaje majibu yako ya VVU?

1. Alielewa na kunipa ushirikiano
  2. Aliniambia na yeye ataenda kupima VVU
  3. Hakufanya chochote
  4. Alinilaumu kwa maneno makali/masimango
  5. Alinipiga/alinjjeruhi
  6. Alinifukuza nyumbani
  7. Alichukua vitu vyake na kuondoka nyumbani
  8. Sababu nyingine, eleza:
- 

22. Ni sababu gani zinazokufanya usimshirikishe mwenza hali yako ya maambukizi?

1. Nipanga kumwambia
  2. Hofu ya kupewe talaka
  3. Hofu ya kutelekezwa
  4. Atanisema vibaya
  5. Atanipiga
  6. Hatanijali
  7. Atanilaumu kwa kutokuwa mwaminifu
  8. Mengine:
- 

### III. KUPIMA KIWANGO CHA UNYANYASAJI

Japokuwa watu wenza wanakuwa pamoja mara nyingi hutokea wakati wakatofautiana, wikalumbana, kukasirikiana au kupigana kwasababu hawapo kwenye hali ya kawaida, wamechokana au kwasababu nyingine. Lakini wenza huwa wana njia za kutatua matatizo yao wenyewe. Tafadhali niambie ni mara ngapi mambo haya yamekutokea baada ya kungudulika kuwa na maambukizi ya virusi vya ukimwi na pia kabla ya kungudulika na maambukizi ya virusi vya ukimwi.

**Tafadhali jibu ndiyo au hapana**

**Je, mwenza wako ameishawahi kukufanyia yafuatayo katika kipindi cha mwaka mmoja uliopita? Au baada ya kumshirikisha hali yako ya maambukizi (kwa wale waliojibu ndio swali 20)?**

Na.	Maswali	Vipengele	
		Katika mwaka uliopita	Baada ya kumshirikisha majibu ya ukimwi
21	Kukusukuma kwa nguvu?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi

22	Kukutingisha kwa nguvu?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
23	Kukurushia kitu kwa hasira?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
24	Kukupiga kibao?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Marachache 2. Mara nyingi
25	Kukunja/kupinda mkono wako kwa hasira?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Marachache 2. Mara nyingi
26	Kuvuta nywele zako kwa hasira?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
27	Kukupiga ngumi?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
28	Kukupiga na kitu ambacho kingekuumba?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
29	Kukupiga mateke?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara nyingi 2. Mara chache
30	Kukuburuza/kuvuta kwa hasira?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara nyingi 2. Mara chache
31	Kukupiga?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
32	Kukukaba?	2. Ndiyo 2. Hapana ↓	2. Ndiyo 2. Hapana ↓

		Mara ngapi? 2. Mara chache 2. Mara nyingi	Mara ngapi? 2. Mara chache 2. Mara nyingi
33	Kukuchoma na/kukuunguza kwa makusudi?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
34	Kutishia kukushambulia kwa kisu?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
35	Kutishia kukushambulia kwa bunduki au silaha nyingine yeyote?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
36	Kukulazimisha kwa nguvu kufanya mapenzi naye wakati wewe hukutaka?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
37	Kukulazimisha kufanya matendo mengine ya yeyote kimapenzi hata kama hukutaka?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
38	Kukudhalilisha mbele ya wengine kwa kusema au kufanya kitu chochote?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
39	Kutishia kukudhuru au kumdhuru mtu wako yeyote wa karibu?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi
40	Kukutukana au kukufanya ujisikie vibaya?	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi	2. Ndiyo 2. Hapana ↓ Mara ngapi? 2. Mara chache 2. Mara nyingi

**Je, yafuatayo yalitokea baada ya kufanyiwa unyanyasaji na mwenza wako?**

23. Kupata mikwaruzo au maumivu mwilini?

1. Ndiyo
2. Hapana

24. Kupata maumivu makali mwilini, kudhurika jicho, kuteguka, kuungua?
1. Ndiyo
  2. Hapana
25. Kupata jeraha kubwa, kuvunjika, meno kuvunjika/kungoka, au jeraha lingine lolote kubwa?
1. Ndiyo
  2. Hapana
26. Ni muda gani baada ya kumshirikisha mwenza hali yako ya maambukizi unyanyasaji huu ulitokea (kama amejibu ndio angalau kipengele kimoja katika sehemu ya unyanyasaji baada ya kumshirikisha mwenza)
1. Mara tu baada ya kumshirikisha mwenza hali ya maambukizi
  2. Wiki moja baada ya kumshirikisha mwenza hali ya maambukizi
  3. Mwezi mmoja baada ya kumshirikisha mwenza hali ya maambukizi
  4. Muda Fulani baada ya kumshirikisha mwenza hali ya maambukizi (eleza):

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**Asante kwa kushiriki katika utafiti huu**

### 8.3 CONSENT FORM (ENGLISH VERSION)

#### PATIENT CONSENT FORM

Hello, my name is ..... On behalf of Muhimbili University of Health and Allied Sciences (MUHAS), we are doing research on HIV status disclosure and intimate partner violence among HIV infected women in Dar es Salaam.

#### **The aim of the study**

The aim of this study is to find out the incidence of intimate partner violence and associated factors among HIV positive women. The findings of the study will add more insight to the existing body knowledge and therefore enable suggestions for proper intervention measures to combat the HIV and violence against women.

#### **Procedure**

I would like you to participate in this study. If you choose to participate, an interviewer will ask you a series of questions about you and your partner's background, history of partner's violence before and after being diagnosed HIV infected, and outcome of disclosure of HIV-status. It will take about 30 minutes to finish the interview.

#### **Confidentiality**

All the information obtained from you will be kept private, only study staff will be able to see any information you give us. The information will be used for the purpose of the research study only and not for any other reason. Your name or anything else that might identify you will not appear in any reports, instead number will be used.

#### **Right to refuse or withdraw**

It is your choice to be in this study, you can skip any question you do not want to answer. You are free to drop out from the study whenever you feel like, the drop out will not affect the services you receive here at this clinic or any other clinic. However, we would like you to participate in this study because your views are very important.

#### **Benefit**

Your participation in this study will provide useful information for us and other stakeholders which will aid in the fight against violence especially among women living with HIV-infection.

**Risks**

We do not expect any harm to you or your family as a result of participation in this study although some questions will be personal.

**Whom to contact**

In case of any inquiry please contact the principal investigator:

**Dr. Samson Ndile**

**MUHAS,**

**P. O. BOX 65001,**

**Dar es Salaam,**

**Mobile number: 0713645347**

Or

**Professor G. Msamanga,**

**MUHAS,**

**P. O. BOX 65001,**

**Dar es Salaam.**

I ..... have read or been told about the contents of this form and understand. My questions have been answered. I agree to participate in this study.

Signature of participant.....

Signature of witness (if participant cannot write).....

Date.....

Signature of researcher/research assistant .....

## 8.4 CONSENT FORM (KISWAHILI VERSION)

### FOMU YA RIDHAA

Habari, mimi naitwa..... kwa niaba ya Chuo Kikuu cha Afya na Sayansi ya Tiba cha Muhimbili tunafanya utafiti kwa wanawake wanaoishi na virusi vya ukimwi kuangalia hali ya uwazi juu ya maambukizi ya virusi vya ukimwi na ukatili kwa wanawake hapa Dar es Salaam.

#### Lengo la Utafiti

Utafiti huu unalenga kuainisha kiwango na mambo yanayochangia kutokea ukatili kwa wanawake wanaoishi na virusi vya ukimwi. Taarifa hii itasaidia kuongeza ufahamu na kubuni mikakati itakayosaidia kupambana na ukatili dhidi ya wanawake na pia kupunguza hali ya maambukizi ya virusi vya ukimwi.

#### Utaratibu

Napendelea ushiriki katika utafiti huu. Kama utachagua kushiriki, mhojaji atakuuliza mfululizo wa maswali kuhusu historia yako na ya mwenza wako. Pia atakuuliza maswali kuhusu ukatili dhidi ya wanawake kabla na baada ya wewe kugundulika kuwa una maambukizi ya virusi vya ukimwi.

Natarajia kwamba, mahojiano haya yatachukua muda wa dakika 30.

#### Usiri

Taarifa zote utakazonipatia zitakuwa ni siri na hazitaonyeshwa kwa mtu yeyote zaidi ya wafanyakazi wa utafiti huu tu. Taarifa hizi zitatumika kwa lengo la utafiti tu na sio sababu nyingine yeyote. Jina lako au kitu chochote cha kukutambulisha hakitaonekana kwenye ripoti badala yake tutatumia namba.

#### Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari. Unaweza kusitisha mahojiano wakati wowote endapo utaona ni vyema kufanya hivyo na hakutakuwa na athari zozote na hutapoteza stahili zako za kupata huduma katika kliniki hii au nyingine. Hata hivyo, kama utashiriki utatusaidia sana

katika utafiti huu kwani taarifa utakazotoa zitasaidia sana katika kupanga mikakati ya kupunguza ukatili dhidi ya wanawake wanaoishi na virusi vya ukimwi.

### **Faida**

Kama utakubali kushiriki katika utafiti huu, tunategemea kwamba taarifa tutakazozipata kutoka kwako zitakuwa na maana kwetu na kwa wadau wengine hasa katika kuzuia ukatili kwa wanawake wanaoishi na virusi vya ukimwi.

### **Madhara**

Hatutegemei ya kwamba utapata madhara yoyote kwa kushiriki kwako katika utafiti huu japo baadhi ya maswali utakayoulizwa ni ya binafsi zaidi.

### **Watu wa kuwasiliana nao**

Kama una maswali katika utafiti huu unaweza kuwasiliana na mtafiti mkuu, **Dr. Samson Ndile** kutoka Chuo Kikuu cha Tiba na Sayansi Muhimbili, S.L.P. 65001, Dar es Salaam. Simu namba 0713 645347 au **Professor. G. Msamangawa** Chuo Kikuu cha Sayansi na Tiba Muhimbili, S.L.P. 65001, Dar es Salaam.

Mimi.....nimesoma/nimesomewa fomu hii ya idhini na nimeielewa. Maswali yangu yamejibiwa. Nakubali kushiriki katika utafiti huu.

Saini ya mshiriki.....

Saini ya shahidi (kwa wasiojua kuandika) .....

Tarehe.....

Saini ya mtafiti/ mtafiti msaidizi .....