Intimate Partner Violence against Women Living with HIV in Indonesia:

Causes and Effective Intervention

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Indonesia

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Intimate Partner Violence against Women Living with HIV in Indonesia: Causes and Effective Intervention

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

By

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Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

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Signature

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Abstract

Problem: Intimate Partner Violence (IPV) is a public health concern. In Indonesia, no literature has been found to identify the causes of IPV against women living with HIV (WLHIV) and the effective interventions to overcome this situation. IPV against WLHIV has consequences such as depression and non-adherence to antiretroviral therapy (ART), which may weaken their immune system.

Objectives and Method: This thesis identifies the causes of partner violence and the effective interventions to prevent IPV against WLHIV through literature review. The Wyrod and Jewkes framework was adapted and used as an analytical framework to organise the study. Data from low-middle income countries, particularly from Asia and sub-Sahara Africa was used to illustrate the findings.

Findings: Knowledge gap and the vicious cycle of HIV which leads to impoverishment is the most specific cause of IPV against WLHIV beside gender inequalities and the culture of violence. Valuable interventions include: combining micro finance and participatory learning program on gender and domestic violence; community-based mobilisation which engages male and youth in addressing gender awareness; and decreasing trigger factor of IPV such as safer disclosure HIV status strategy and reducing harmful alcohol use program.

Conclusions and Recommendations: HIV exacerbates women's vulnerability to IPV. Stigmatisation of HIV, gender roles, ignorance, the neglection of the state to protect women from violence, has positioned women as the appropriate target of violence from their partners. Strong political commitment, law enforcement, availability of resources and the appropriate strategies are efforts to be made to prevent and reduce IPV against WLHIV.

Keywords: Intimate Partner Violence, Spousal abuse, Women Living with HIV, Low-middle income countries, Indonesia.

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List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CATAHU	Catatan Tahunan (Annual Note)
DHS	Demographic Health Survey
FSW	Female Sex Worker
GBV	Gender Based Violence
GII	Gender Inequality Index
HIV	Human Immunodeficiency Virus
IMAGE	Intervention with Microfinance for AIDS and Gender Equity
IPPI	Ikatan Perempuan Positif Indonesia
IPV	Intimate Partner Violence
KAPs	Key Affected Populations
LMIC	Low-Middle Income Country
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
NGOs	Non-Governmental Organisations
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWUD	People Who Use Drugs
SHARE	Safe Homes and Respect for Everyone
UNAIDS	The Joint United Nations Programme on HIV/AIDS
VAW	Violence Against Women
WHO	World Health Organisation
WINGS	Women's Income Generating Support
WLHIV	Women Living With HIV

Introduction

Violence has always attached me. I was used to witnessing violence perpetrated by anyone, anywhere. At that time, I had not realised that violence was a violation of human rights because it seemed that everyone accepted it as a norm. This became even more apparent when I began to work on HIV prevention efforts in 2004 in Indonesia.

I got involved in HIV issues as an outreach worker in a local NGO to prevent HIV among female sex workers (FSW). I witnessed the violence experienced by FSW both by pimps, law enforcement officers, clients, partners and the communities in their neighbourhoods. The forms of violence they experienced were also varied, from sexual abuse, physical beatings to hurling words. When I finally joined the national network of women living with HIV (IPPI), I often heard how women with HIV and women living with HIV-infected partners experience violence at least once in their lifetime. IPPI then surveyed violence against WLHIV in 2011. The result was very stifling and affirmed my commitment to continue contributing to this issue.

Now, being the chair of the national network of people living with HIV allows me to contribute more to strive for the needs of PLHIV, especially WLHIV, through advocacy and research. The study at KIT has made me able to learn to look at violence and HIV issues with a broader perspective. I chose to study Intimate Partner Violence against WLHIV because this is a very harsh form of violence experienced by women living with HIV. Besides, this issue is still ignored by many parties and has not received government attention. To date, studies focused on IPV against WLHIV cannot be found in Indonesia.

This thesis consists of seven chapters. The first chapter provides Indonesian background, covering HIV situation and violence against women in Indonesia. Chapter 2 describes the study overview, covering problem statements to methodology and conceptual framework to be discussed in chapter 3. Chapters 4 and 5 identifies findings of the causes of IPV against WLHIV and effective interventions to prevent IPV. Chapter 6 conveys the discussion and conclusions. Recommendations based on the study results are described in chapter 7.

I hope this thesis will be useful and can contribute to prevent and reduce violence against WLHIV in Indonesia.

Chapter 1. Country Background

1.1. Geographical and Demographical Profile

Geographically, Indonesia lies between two continents, Asia and Australia, and between two oceans, the Indian ocean and the Pacific (1). Famous as the world's largest archipelago, Indonesia has 17,508 islands, with some 6,000 of which are populated and an projected population of 261 million in 2016 (2). The country is assembled into 34 provinces or states which subdivide into 416 districts, 98 municipalities and more than 70,000 villages (3). The population density varies across islands and among provinces of the same island. Java, where the capital city Jakarta is located, is the most densely population island (4). At the national level the density is 133.5 inhabitants per square kilometre. Islam is the major religion (87%), followed by Christianity (7%), Catholicism (3%), Hinduism (1.7%) and Buddhism or others (4). A policy of decentralization of government was put in place in 2001 (5).

Figure 1. Map of Indonesia

Source (6)

Indonesia's annual population growth rate between 2000 and 2010 was 1.44 percent. The sex ratio between males and females was 101 per 100 and life expectancy at birth in 2016 was 67 years for men and 71 for women (2). The literacy rate of the population aged 15 years and over was 92.37 percent (7,8). The fertility rate is 2.4 births per women and infant mortality is 27/1000 births. As a lower-middle income country, the GDP per head in Indonesia was $3,400 in 2016 (2). The Gender Inequality Index (GII) was 0.467, ranking it 105 out of 159 countries (2).

1.2. Health system in Indonesia

The organisation of health services is the responsibility of Ministry of Health officials at the district, province, and national levels. The network of public health services follows the political structure of the country (1). According to the amendments of 2001 on decentralisation, "administrative and financial responsibility has been decentralised to province and district level". (9,10)

Indonesia has 10,455 health facilities, including 8,792 clinics where 8,764 are sub-district health centres (termed Pusat Kesehatan Masyarakat or Puskesmas) and 28 are specialised chest clinics (1). There are 1,653 hospitals, of which 533 are public hospitals, 867 private hospitals, 181 military/police facilities, 63 other general hospitals and nine are chest

hospitals (1). More peripheral than the district level are satellite and mobile health centres with 94% of the population living within five kilometres of a facility (4).

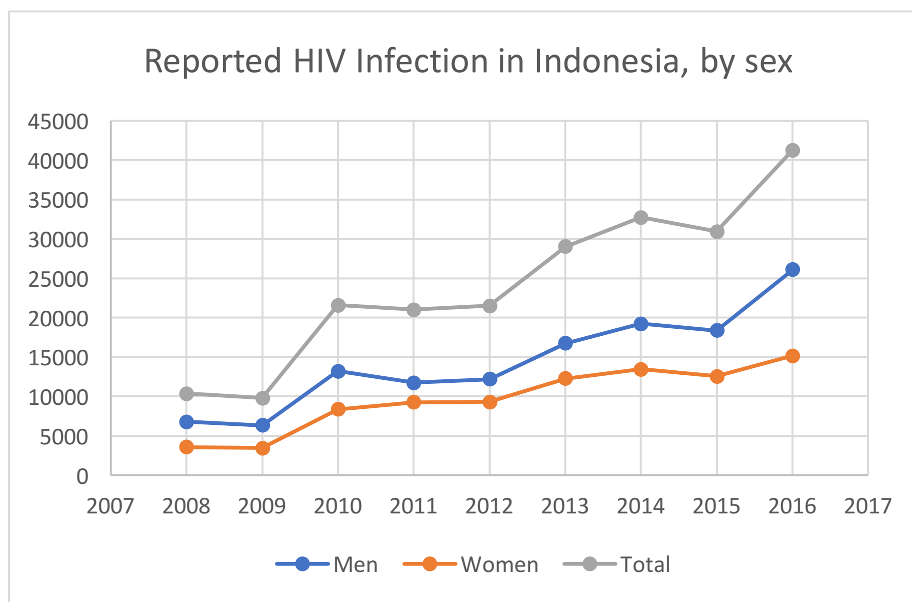
The Government of Indonesia announced Law No. 40 of 2004 on the National Social Security System in 2004 (11). This law mandates that the compulsory social security programs for the entire population, including health insurance program through a social security organising body (10). National health insurance (termed Jaminan Kesehatan Nasional or *JKN*) organised to provide health coverage to meet the basic health needs are given to every person who has paid dues or contributions paid by the government. Up to December 2015, the coverage totalled 156,790,287 JKN program participants (1).

1.3. HIV Situation in Indonesia

In 2012, UNAIDS mentioned that between 2001 and 2011 the number of people infected with HIV in Indonesia will continued to rise, with new infections increasing by more than 25% (12). Indonesia is experiencing the dual epidemics of HIV. First, a high-level concentrated epidemic found in almost all provinces involving Key Affected Populations (KAPs), such as female sex workers (FSWs), people who use drugs (PWUD), transgender individuals, and men who have sex with men (MSM). Second, the provinces of Papua and West Papua has a low-level generalised epidemic (13).

The national HIV prevalence rate was estimated at 0.5% among people aged 15-49 years of age in 2016 (13). The estimation of people living with HIV (PLHIV) in 2015 was 690,000 and until December 2016, the number of cumulative HIV infections in Indonesia were 236,933 cases, with the ratio of cases diagnosed among male versus female of 59 versus 41 (13).

Chart 1. Reported HIV Infection in Indonesia in 2016, by sex



Source (14)

In recent years, the number of women living with HIV (WLHIV) has increased in Indonesia. The number of cases found among women increased from around 3,500 per year in 2008 to around 15,000 women per year in 2016, compared to those found among men which increased from around 7,000 in 2008 to around 26,000 in 2016 (14). The Ministry of Health Republic of Indonesia (MOH) reported that the most frequent risk factor for HIV transmission is sexual contact among heterosexuals (66%) (14). The cumulative number

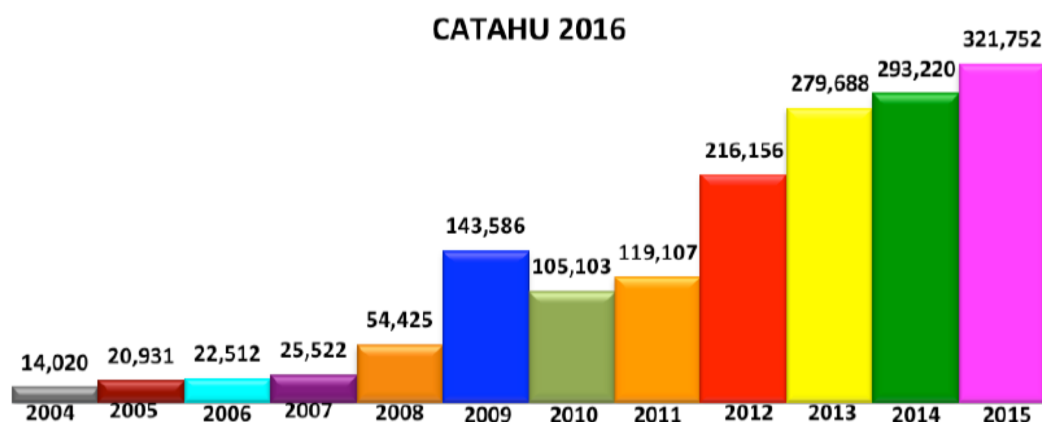
of AIDS cases among housewife has also increased (reaching 11,000 cases in 2016); putting housewife as the group with the largest number of HIV cases by occupation (14).

1.4. Violence Against Women in Indonesia

In Indonesia, the number of reported cases of Violence against Women (VAW) increased dramatically since 2007, and from year to year since 2010 (chart 1). A very high rise in the number of VAW cases occurred from 2007 to 2008 (over 100%) and from 2011 to 2012 (81%), which reached around 210,000 cases. Overall between 2010 and 2015, the number of cases increased by around 200%, which reached around 320,000 cases (15).

The 2015 VAW data is sourced from data recorded by religious courts totalling 305,535 cases and from an implementing partner of the National Women's Rights Commission of 16,217 cases (14). Data from religious courts are reported in violence that occurs in the private or personal realms. Of the 16,217 cases recorded by implementing partners of the National Women's Rights Commission, 69% or 11,207 are reported in violence that occurs in the private realms (14). As many as 11,207 cases in the domestic domain, 84% or 9,459 were cases of Intimate Partner Violence (IPV) (14).

Chart 2. The Annual Note of Violence Against Women in Indonesia in 2016



Source (15)

Violence in the realm of personal or in the household means violence carried out by people who have a family relationship (father, brother, sister, uncle, grandfather), marriage (husband) and intimate relationship (boyfriend) (15).

In the realm of IPV in 2015, the most prominent of violence is physical violence occurred 4,304 cases (38%), followed by 3,325 cases of sexual violence (30%), 2,607 cases of psychological violence (23%) and economic violence 971 cases (9%) (16). In general, violence against women takes places due to their "vulnerable position" because of the strong patriarchal culture in the society which places women in unequal power relations between women and men and wives and husbands (15).

Chapter 2. Study Overview

2.1. Problem Statement and Justification

Intimate partner violence or IPV has become an important and global public health concern (17). Intimate partner violence (IPV) is defined as "physical, emotional, psychological, verbal, and/or sexual abuse between two individuals engaged in a current or previous romantic relationship" (18). According to WHO (2012), among all socioeconomic, culture and religions, women bear the burden of IPV more than men and partner violence occurs in all settings (19). In some contexts, widely held beliefs in traditional gender relations are a central driver of IPV (19).

A multi-nations study on intimate partner violence against women was conducted by WHO, In 2005 (19). More than 24,000 women from 10 countries[1] have been involved in the study, representing diverse cultures, geographies, and in urban and rural areas. The study showed, around 4-75% women reported ever having violence by a partner at some point in their lives, with varied forms such as physical violence, sexual abuse and emotionally abusive act (19). This shows that IPV is widespread in all the countries studied.

IPV brings consequences such as physical health (19), injury, disability, mental health including depression, post-traumatic stress syndrome, and anxiety (20). In addition, IPV can cause HIV transmission (21), low birth weight (22), unwanted pregnancy, and induced abortion and death from homicide (23). Several factors has been associated with IPV, which include having multiple sexual partners and severe alcohol use (24). For the woman, risk factors include HIV-infected status (25), low education or low socio-economic status (24), pregnancy and being in a cohabitating relationship.

In developing country settings, studies shows that HIV-positive women are more likely to be susceptible to IPV than HIV-negative women (25,26). Whilst the number of WLHIV in Indonesia has continued to increase (14), they also encounter particular challenges, including stigma, violence, and discrimination (27). WLHIV are highly vulnerable to experience different forms of violence such as physical violence, emotional violence, sexual violence and psychological violence, which leads them to the poor quality of life (28). As cited by Aryal, 2012, globally around 60-75% of physical violence and 32 to 36% of sexual violence is committed by WLHIV's male partners. Intimate partner violence also makes them more prone to depression and nonadherence to their antiretroviral therapy (ART), which may weaken their immune system (29). However, IPV is an iceberg phenomenon since it underestimated, undisclosed (30), and, in the Indonesian context, it is a social taboo, especially among women living with HIV (27).

In 2012, a National Organization for Women Living with HIV (WLHIV) in Indonesia (IPPI) conducted a survey engaging 110 women living with HIV to identify and document the types of violence they have experienced (27). The survey showed that 29% of women experienced sexual violence, 25% experienced physical violence, 29% experienced economic discrimination and 14% had undergone forced or coerced sterilization (27).

There is paucity of literature related with intimate partner violence against women living with HIV in Indonesia. Recently, only a few studies had been conducted but none of them focus on IPV. Therefore, due to the scarcity of the study on this topic, another study needs to be conducted to explore the causes of intimate partner violence which is experienced by WLHIV in Indonesia. In addition, the study needs to be conducted to identify effective interventions to prevent and reduce acts of IPV among HIV-positive women.

The study will focus on the following questions:

1. What are the most specific causes of intimate partner violence among WLHIV?

[1] Countries included: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Thailand, the former state union of Serbia and Montenegro, and the United Republic of Tanzania.

2. What are the effective interventions have been implemented to prevent and reduce intimate partner violence among WLHIV, and how well are they working?

2.2. Aim and Objectives

The aim of the study is to explore the factors influencing intimate partner violence among HIV-positive women in Asian, African and Latin American countries to inform the interventions which might be applicable to the Indonesian context to contribute of preventing further deterioration of the current situation or reducing IPV impact among them.

The specific research objectives are:

a. To summarise evidence on the extent of IPV among WLHIV in Asian, sub-Saharan African and Latin America countries.
b. To explore the causes and risk factors of intimate partner violence among WLHIV in Asia, sub-Sahara Africa and Latin America countries.
c. To identify effective interventions to prevent and reduce IPV among WLHIV, therefore, it can be adapted for the Indonesia context.
d. Using the results of the study, inform policy makers as well as women's organization and activists to recognize the problem and develop better policy and interventions for preventing and reducing intimate partner violence among WLHIV in Indonesia.

2.3. Methodology

This study is based on secondary research, and the research method used for this study was a rigorous, iterative literature review (31). The study searched for, reviewed, and analysed the existing literature on causes of intimate partner violence on WLHIV. Furthermore, the study examined existing studies on intervention program on IPV among WLHIV. Geographical criteria for the search were developed, focusing on countries in Asia, Africa, and Latin America, to enable findings from other settings to have most applicability or relevance to the Indonesian context.

Understanding the causes of IPV among Women living with HIV is difficult since it is solely the outcome of its social contexts (24). The status of women including HIV status, gender norms, HIV stigma, and socioeconomic status as risk factors for societal conditions, are challenging to measure, especially across societies (32). Therefore, the study in many community contexts is needed (24). To date, there are less than five unpublished studies from Indonesia regarding IPV against WLHIV. In addition, according to database searches, there are only few published studies on partner violence among HIV-positive women in Asia. The study expanded the location to countries which have similarity of situation with Indonesia. Gender structures, the similarity of HIV epidemic, and Moslem countries, are some of the criteria that used to chose the location of the study. Some countries in Asia, sub-Saharan Africa, and Latin America are the places that might have close similarities to the Indonesian context.

2.3.1. Search strategy

The study searched two online databases: PubMed and Google Scholar. Due to the scarcity of literature on this topic and the relevance of causal factors across societies in any time period, no time limit was set. We included the research before the search date of 31 July 2017. Based on the study objectives we used the search terms described in Table 1 below.

Table 1. Search terms used for PubMed and Google Scholar

From PubMed we used terms as follows:

Women living with HIV	("women with HIV" OR "women living with HIV" OR "HIV-infected women" OR "HIV-positive women" OR "HIV-infected girls.")
AND	
Violence	(violence OR abuse OR "intimate partner violence" OR "spouse abuse." OR "sexual coercion" OR "sexual violence"[MESH Major Topic])
AND	
Geographical Area	(Asia OR Africa OR "Latin America" OR "developing country" OR "low, middle-income country." OR "resource poor" OR "limited source.").

From Google Scholar we used terms as follows:

"Women with HIV" OR "Women living with HIV" OR "HIV-infected women" OR "HIV-positive women" OR "HIV-infected girls"
AND
Violence OR Abuse OR "Intimate partner violence" OR "spouse abuse"
AND
Asia OR Africa OR "Latin America" OR "developing countries" OR "Low-middle income countries" OR "low-income countries"

2.3.2. Inclusion criteria

Inclusion criteria were used to identify literature which will be included or excluded in this study. Inclusion criteria for the literature review were as follows:

1. Studies published in a peer-reviewed journal;
2. Studies assessing primary causes at individual level, contributing factors and deeper structural factors of intimate partner violence among HIV-positive women;
3. Studies evaluating interventions to prevent and reduce IPV among WLHIV;
4. We included studies among all populations of women living with HIV, including adolescents (10 to 19 years) and young women and women from key affected populations (female sex workers and females who use drugs).

The study searches for English articles, and reports from Indonesia with Indonesia language also included in the study. The reason to include Indonesia's articles is that of it certainly relevant with the study. The study from Indonesia that met the inclusion criteria was translated into English.

2.3.3. Number and Hits

Initially, the database search from PubMed generated with 82 published citations and 145 literature items from Google Scholar. After we removed duplications and applied the

inclusion criteria, we ended up with 95 literature items (see figure 2). Then 95 abstracts were reviewed and 17 were removed because they were not directly relevant to the study questions and matched with exclusion criteria (see table 2). After reading the full content, we excluded 37 more literature, add 12 articles from screening of references of included articles and finally arrived with 49 papers as shown in figures 2, with 7 studies are based on Asia, 34 From sub-Sahara Africa, 8 from global review and none from Latin America.

Table 2. Exclusion Criteria

Exclusion Criteria:
1. Only mention about the type of intimate partner violence. 2. Only mention the impact or consequences of intimate partner violence. 3. Only mention about how intimate partner violence increases HIV risk.

2.3.4. Iterative and rigorous search

The study then examined the reference of all studies included in the review to check and see other resources that might be relevant.

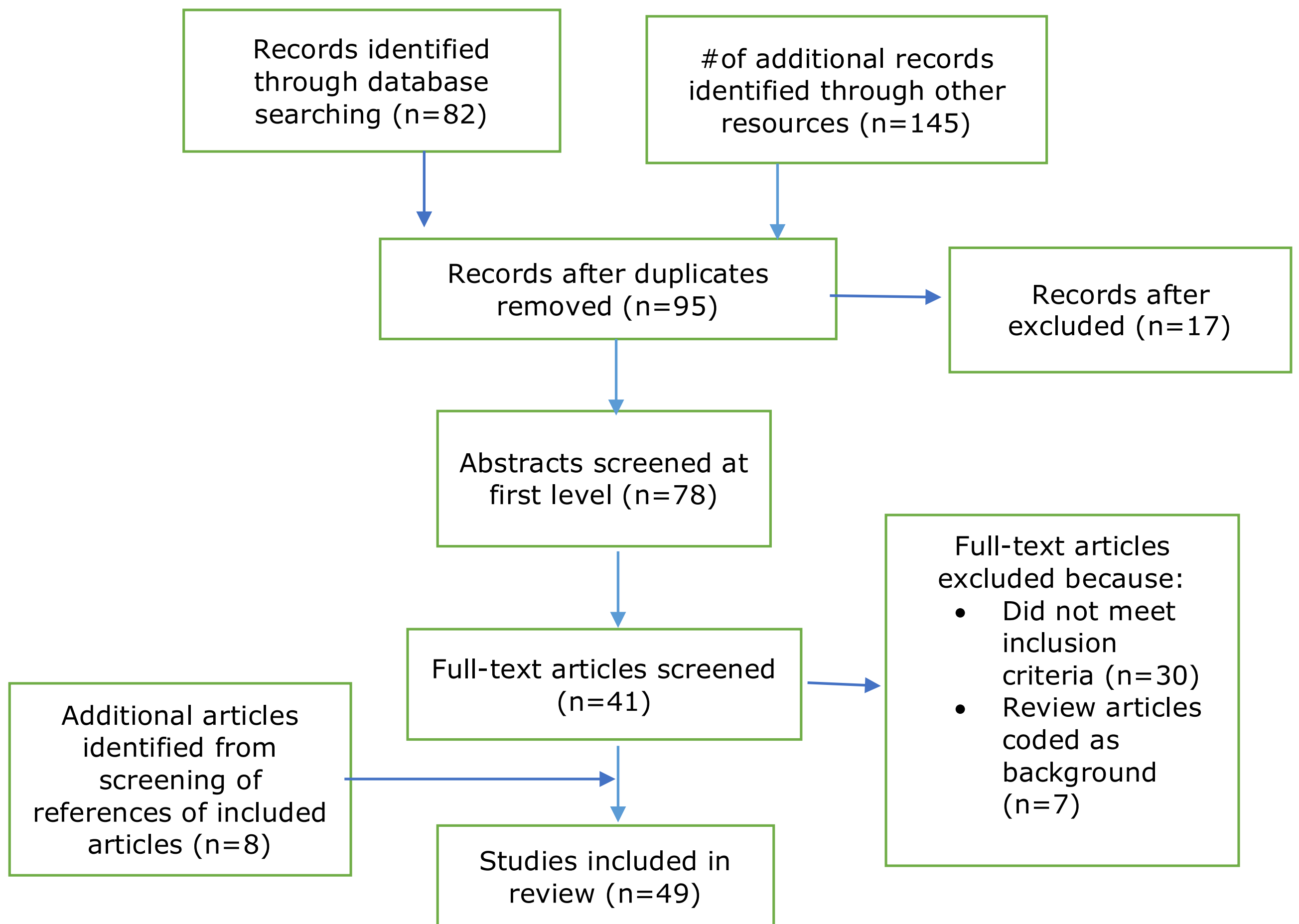
We also searched through Indonesian literature, including the study that has been conducted by Ikatan Perempuan Positif Indonesia (IPPI)-The National Network of WLHIV in Indonesia, or Indonesian researchers. Data on violence against women reported in annual note (CATAHU) of the Indonesia National Commission for Women, MOH and National AIDS Commission reports was also included.

To search for other grey literature, we searched from multilateral and bilateral organisations under the terms "women living with HIV" and violence. We reviewed websites of the following organisation: UNAIDS, WHO, UNWOMEN, UNDP, The International Community of Women Living with HIV (ICW), GNP+, DFID, ICRW, FHI360, OXFAM, The Rutgers in The Netherlands, and the UK HIV NGO, The Terrence Higgins Trust.

2.3.5. Limitations

This thesis has several limitations. There is a bias in language because only articles in English and Indonesian were reviewed in this study. Time constraint is also a challenge; thus, relevant articles may not be included in this study. It is challenging to analyse the causes of current IPV and also, effective interventions to prevent IPV due to limited data, particularly from Indonesia and other Asia countries. This study only relies on articles that have been already published.

Figure 2. Search and screening flowing chart illustration



Chapter 3. Conceptual Framework: Bringing Concepts Together

The gender structure model from Wyrod (2013) and the causes of intimate partner violence framework from Jewkes (2002) were adapted and used to analyse the literature to understand factors contributing to IPV among women living with HIV (fig.1). The Wyrod model consists of three levels of gender structure: intrapersonal, interpersonal and institutional (33). Each level of structure will organise risk factors and prevention for reduction of intimate partner violence model from Jewkes (24).

The two frameworks were chosen because of each has its strengths and weaknesses and complements the other. Combining the two frameworks helps to see how people's behaviour and particularly violent acts among intimate partners is tied to gender structures such as masculinity or gender roles in society which are reinforced from the institutional level to the interpersonal and to the individual level. Therefore, it will guide in developing the study to understand the causes of Intimate partner violence among WLHIV and analyse the best practices to overcome this situation.

3.1. Framework for causes and interventions of IPV among WLHIV

The term gender refers to the broadly accepted norms and agreements that are socially and culturally constructed about appropriate roles, responsibilities and behaviours of women and men within society, and how both sexes should interact (34). Gender is different from sex. WHO (2015) defines sex as "the biological characteristics that define humans as female or male" (35). Although gender is a "culture-specific construct", across society there is always a distinct role between men and women, access to valuable resources and the authority on decision process (34). As cited by Gupta (2000), in general, men are held responsible for working productively outside the house whilst females have responsibilities inside the house such as chores, cooking and caring for children (34). Research on women's roles shows that women still have low access and power over valuable supplies than males such as salary, property, credit, and schooling. Although there are differences in levels and variations from one culture to another, the findings almost always show the same (34).

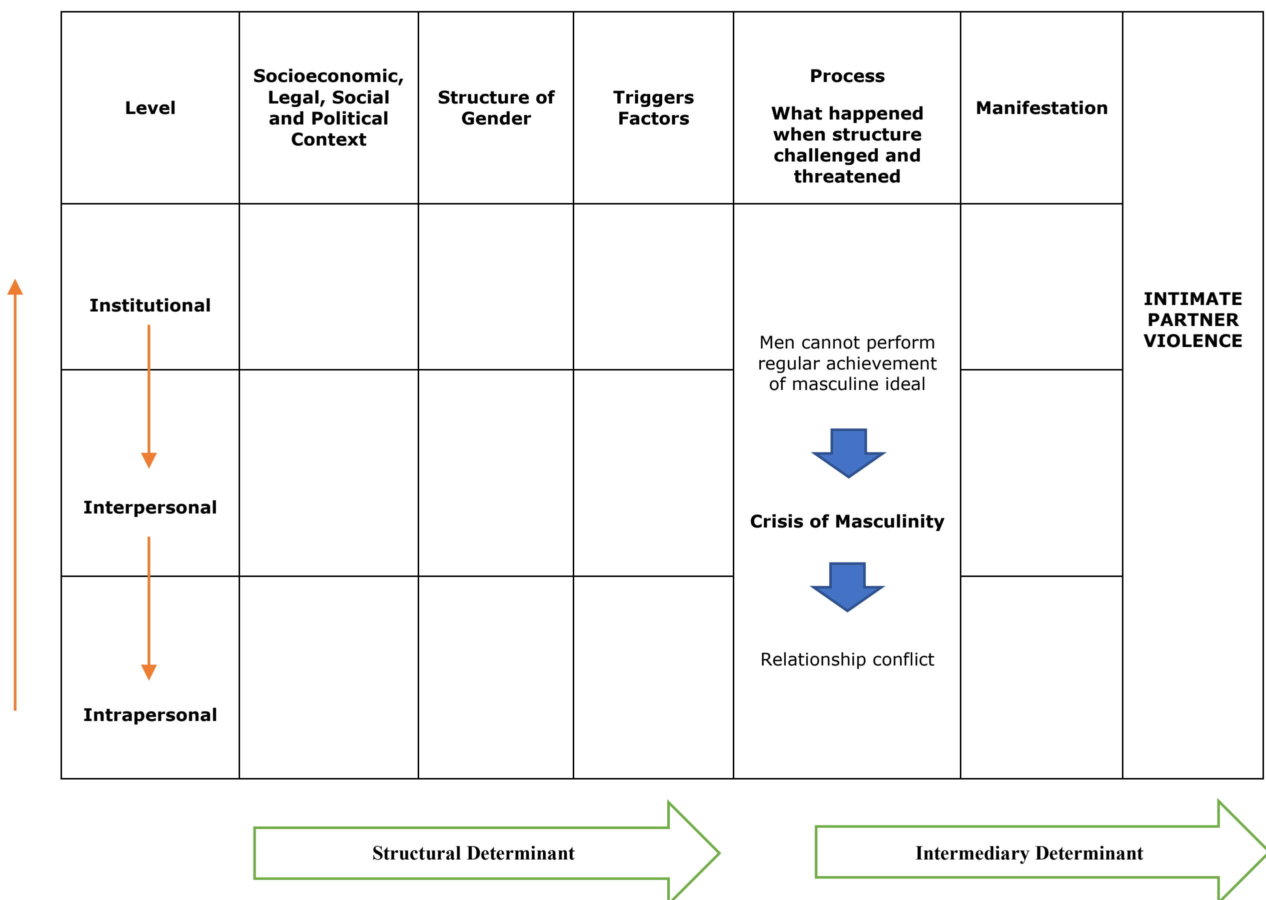
According to Wyrod (2013), gender has a structure and "every society has a gender structure, starting from patriarchal to at least hypothetically egalitarian" (33). As a social structure, gender makes a strong pattern of social interaction especially between men and women (33). These relations show the enactment of power dynamics and also strong, resilient and unequal gender hierarchies (36). Therefore, Wyrod's framework was used to distinguish between three dimensions of the structure of gender: institutional, interpersonal, and individual to understand how gender structure influences violent behaviour against women.

In the institutional level, gender hierarchies are built apparently through the policies, authoritative structures, and allocation of provisions that favour men over women(33). At the interpersonal level, gender structures the daily interactions between people and their community by shaping what is expected of the behaviour of men and women by given society, including in the marital relationship (32). These daily social relationships are then manifested in the hierarchy of gender and inequality (32).

At the intrapersonal level, gender as a social structure works on the individual level through the process which occurs during infancy development or adult socialisation (37). It forms gender identities on each and creates the way people think of themselves as gendered individuals (36). As cited by Wyrod, "this individual dimension is where cultural schemas that reinforce gender inequalities are internalised and how normative gender identities are made to seem natural" (32).

In the original framework, Jewkes (2002) includes level of education, few public roles for women, lack of family and social and legal support for women, lack of economic power for women and lack of economic opportunities for men and inequality with women, alcohol consumption and witnessing and experiencing violent during childhood in the influencing factors of IPV (24). In the processes category, Jewkes illustrates how enforcement of hierarchy and punishment of transgression, crisis of masculinity and crisis resolution of men and relationship conflict shape the manifestations of IPV (24). It was created because of distinct gender roles and hierarchy, male sexual entitlement, low social value and power of women, and ideas of manhood linked to control of women and using violence as a strategy in conflict (24). The framework shows how ideologies of male superiority and culture of violence become key factors causing IPV (24).

Figure 3. Conceptual Framework of causes of IPV against WLHIV



For this thesis, relevant factors, process, manifestation and ideology which cause IPV from Jewkes' (2002) model have been identified for each of the levels referred to the figures 3 above. At the institutional level, it includes larger societal factors such as poverty, economic opportunities, legal support for women, and tolerance or acceptance of violence to resolve the dispute. Although in some of the poor households, women are protected from IPV (24), it is still important to study the relation between poverty and violence (32). This level also comprises gender norms and expected roles between male and female that shape ideas of masculinity (24). At the interpersonal level, the risk factors include relationship conflicts including unequal decision-making and poor communication. At the intrapersonal level, personal experience and witnessing of violence, the level of education, low social status of women and other behavioural factors that increase the possibility to become a victim and perpetrators have been identified.

Additionally, the socioeconomic, legal, social, and political contexts have been added and determined for each of the levels. Trigger factors or conflict arena such as situational triggers: HIV diagnosis, HIV disclosure, infidelity, male drinking, and patriarchal triggers: women transgress behaviour or failure to meet gender role expectations, for example such as women failing to fulfil men's sexual urges or refusing to have sex (19), also have been identified and defined within the framework. The process and manifestation categories helps to explain what happens when structures are challenged and threatened, which will drive the IPV. There are 3 figures built on this framework. The model is the same, figure 3 is about the gap of knowledge, figure 4 is proof of what drives the occurrence of IPV, and figure 5 uses this template to describe what are the evidence of approaches to addressing IPV.

Figure 3 is constructed by bringing in elements from the Jewkes and Wyrod models which allow us to see and explore the causes and contributing factors of IPV against WLHIV. The categories are outlined in the first column and in the first row, and how each of these steps operate and what the literature reveals about this is presented in the findings section. Visually there are at least 12 empty boxes. The empty cells represent the knowledge gap, and these boxes will be populated as the findings are completed. The complete framework joins the literature synthesis presented in discussion section. As a Public Health practitioner, this thesis helps me to understand these knowledge gaps. That's why the cells are empty and I return to it later in the discussion chapter.

Chapter 4. Causes of Intimate Partner Violence Against Women Living With HIV

To best understand the causes of intimate partner violence (IPV) against women living with HIV (WLHIV), it is critical to provide a definition of IPV against WLHIV. Jewkes (2002) defines Intimate Partner Violence as "Physical violence directed against a woman by a current or ex-husband or boyfriend" (24). The term IPV used by Jewkes merely describes physical violence, but IPV often includes sexual violence and psychological abuse which often accompany physical violence (24). Hale and Vazquez (2011) offer a far more specific and interesting definition about violence against women living with HIV as "any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV" (38) (p.13). This definition describes violence against women with HIV although it does not specifically explain violence in intimate relationships.

In defining Intimate partner violence against women living with HIV, the study tried to combine and modify both definitions taking account of the specific experience and context to Indonesia. Therefore, this study defines intimate partner violence as "any act or behaviour, structure or process in which power is used in such a way as to cause physical, sexual, psychological, financial or legal harm by a current or ex-husband or boyfriend of women living with HIV". This definition includes structural violence as it can establish gender-based violence against women in vulnerable social positions such as WLHIV and create conditions in which interpersonal violence occurs (39).

In this section, the causes of IPV against WLHIV from institutional, interpersonal and intrapersonal level describe based on findings from three countries in Asia, 24 from sub-Saharan Africa and three literature items from the global reviews.

4.1. Institutional causes of IPV

4.1.1. Poverty, Lack Economic Opportunities and Poor Living Conditions

Research has shown that lower socioeconomic levels are associated with IPV. Achchappa et al (2017) by using an abuse assessment scale found that the vulnerability to IPV is significantly associated with the low socio-economic level of PLHIV (40). Furthermore, Ezechi et al (2008) confirmed that only the women's socio-economic class and partners' HIV status were indicated to be associated with increased risk of abuse (41).
According to Olowookere et al (2015), poverty and absence of economic opportunities may cause some men to be more likely to engage in alcohol use, which increases the risk of IPV against WLHIV (42).

One study has found on the association between poor living conditions and IPV against WLHIV. Maman et al (2002) reported that in Tanzania, overcrowded living conditions contributed to spousal stress that may eventually lead to partner violence (26). However, the same study also showed that sharing homes was not considerably linked with current spouse violence (26). The existence of other family members at home may discourage the perpetrator's intention to commit violence against his spouse (23).

Poverty is a fundamental factor to IPV because it is associated with stress (24). As cited by Jewkes (2002), it has been debated that IPV can stem from stress and this is not just material but also emotional and stress to men's identity, and low-income men have less resources to decrease stress, because poverty is inherently stressful (24). Men are meant to be the main breadwinner in their family, so poverty is a threat to their masculinity and to exert that masculinity, men use violence to control women. In the Indonesian context, among the population of 261 million, more than 28 million Indonesians still live below the poverty line (3). We might assume that this condition increases the susceptibility of HIV-positive women with low socio-economic level to IPV.

4.1.2. Weakness of legal sanctions on violence against women and lack of legal support for women

In many societies including Indonesia, intimate partner violence is seen as a private matter between a man and a woman, husband and wife, and is rarely reported (43). Only through campaigning and politically shifting the discourse on IPV is IPV made a public issue and a policy issue (41).

Sexual coercion or marital rape is the most common form of rape but because impunity remains a challenge on this issue in many countries, offenders are generally not criminalized (44). In Uganda and many other low-middle income countries, sexual violence often is not punished by the justice system (43). Emusu et al (2009) cited, in Uganda cultural beliefs, that a woman is owned by her husband and the inability of authorities to treat sexual violence as a crime discourages allegations of sexual violence and makes leaving violent relationships difficult, thus exacerbating the abuse (43). In Indonesia, marital rape is not a crime in the Penal Code. Marital rape is covered by 'forced sexual intercourse' in the law on the elimination domestic violence and is subject to criminal punishment (45).

Emusu et al (2009) reported that in Uganda, violence is most commonly reported to non-authority figures, such as family, friends, or local NGOs (43). The authors found although most the women living with HIV shared their experience of sexual violence with someone, none reported it to the law enforcement authority. Mkandawire et al (2010) also emphasised that none of the Malawi's HIV-infected women mentioned calling the police or seeking legal recourse as a strategy for addressing the violence perpetrated against them (46). Both studies highlighted the women's lack of confidence in such institutions as the police and the judiciary in Uganda and Malawi.

In Indonesia, only few WLHIV have ever used services for victims of violence (47). The research have been conducted in collaboration NGOs in 2015 reported that only one respondent have ever contacted legal aid to ask for assistance in dealing with violence (47). The research found that the obstacles for this situation were due to limited exposure to information regarding the availability of the services and that they regard violence as something usual and therefore see no need to seek help (40). Additionally, the authors also found that their spouse forbids them to ask for help, or they fear that they will not receive help because of their HIV status and because they do not want people to know her HIV status (47). This weakness of legal sanctions on IPV means women lack legal protection, especially WLHIV and perpetrators of violence retain impunity.

4.1.3. Gender

<u>Acceptance of Violence</u>

In many developing countries, the acceptance of violence against women is considerably high in society. For example, in Swaziland, the Demographic and Health Survey (DHS) reported that 38% of women and 41% of men reporting wife beating being justified under specified scenarios (48). The Zimbabwe DHS also reported that 40% women and a third of men accepting beating in the relationships. Similarly, the Uganda Bureau of Statistics (UBOS) said 70% of women and 60% of men agreed that wife beating was acceptable under certain situations (43). Mkandawire-Valhmu (2010) discovered that wife beating as a result of quarrels within marriage among PLHIV is common and accepted in Malawi (46). The authors also added that among WLHIV, even if the unprotected sex was not physically enforced on them, the women still felt obliged to give in because of traditional gender roles within marriage (46). Maman et al (2002) reported that 41% of WLHIV in Tanzania identified at least one condition in which IPV was acceptable, including disobedience, disloyalty, and non-completion of domestic work in Tanzania (26).

In Asia, a similar situation found by Aryal et al (2012) which found that Violence against Nepalese women is often seen as a usual practice and has gained social acceptance (24).

In Indonesia, the quantitative data from the Indonesia Demographic and Health Survey (IDHS 2012) showed that 34.5% of Indonesian women agree to a husband beating his wife if she makes a mistake (7). In Papua, the form of discipline against women who have violated their specified gender roles is physical punishment. (49). This trend may have further aggravated in the case of violence against HIV-infected women in Nepal (30) and also in Indonesia.

Gender Norms and Masculinity

Gender norms that puts men’s power over women and accept violence against women impede women's ability to protect their self to practice safe sex, make best choices for their reproductive health, and to be open about their health status regarding HIV (50). According to WHO (2012), these are a few findings of social norms and beliefs that support IPV which demonstrate the ideal masculinity: men have a right to rule over women and are considered to be socially superior; men have the right to discipline women because of wrong behaviour; to resolve the conflict in a relationship, physical violence is a viable means; men have the right to demand sexual intercourse in marriage; women should be able to tolerate violence to keep the household intact; sexual intercourse including rape is a sign of male virility; and women are obliged to satisfy men's sexual urges (19). As masculinities defines as “ways of living for men” (44), when men were unable to live up to their ideas of “successful” manhood, they would hit women as appropriate vehicles for confirmation of male power (24).

In Swaziland, gender norms and social expectations, particularly for women’s fertility, require a wife to have children (48). Among WLHIV, Mulrenan et al (2015) found that social norms as a mother, a wife, or a care taker in the family and also being HIV-positive, increase susceptibility to IPV among WLHIV, because HIV reduces her already limited autonomy, such as social stigma, self-esteem problems, fertility issues and financial capacity (48). Moreover, Mulrenan also found that male virility has been identified as central to the conceptualization of Swaziland masculinity including sexual decision making (48). Shamu et al (2014) and Osinde et al (2011) found that disclosure of HIV status (51) and polygamy (52) become strong predictors of IPV due to unequal gender power relations between men and women. Both studies also indicated that social norms and beliefs such as becoming a father are essential for men’s identity (51) and male control of women’s behaviour increases risks of IPV (52).

In Asia, a study conducted in Indonesia found that 98% of Papua men agreed that a man has to be tough as an expression of a male power and masculine identity, and 57% mentioned that men need more sex than women do (49).

4.2. Interpersonal level causes

4.2.1. Relationship conflict and Controlling Behaviour

In Uganda and Kenya, the partner’s controlling habits remained significantly related to IPV among WLHIV (53,54). Moreover, Conroy et al (2016) confirmed that the odds of sexual violence were low among WLHIV who have power in their relationship including high decision-making control in Uganda (55). According to Jewkes (2002), verbal disagreement frequency and high levels of conflict in the relationship are associated with physical violence (24). Conflicts occur due to women's transgression into conservative gender roles or challenges to male privileges, as well as financial matters (24). Factors that trigger a relationship conflict among WLHIV include infidelity, refusing to have sex, drinking alcohol, disclosing HIV status, money problems, and children (26,53,54).

In Papua, Indonesia, one study revealed that nearly 75% of women identified at least one form of behaviour control in intimate relationships (50). The most common form of control behaviour is that women should report where they are at all times (52 percent) and must seek permission from their partners before coming to health services (51 percent) (50).

These findings suggest that women in Papua often experience forms of harassment and control of nonviolent behaviour in intimate relationships, and such harassment is a normal part of intimate relationships (49).

4.2.2. Infidelity

Research has shown that accusation of women's infidelity is causing intimate partner violence against HIV-infected women. Colombini et al (2016) found that in Kenya, some WLHIV experienced direct physical abuse because of the accusations of unfaithfulness and blame for ''bringing the virus'' (54). Similarly, Ezechi et al (2008) found that in the Nigerian community, being HIV-positive is felt to be synonymous with being promiscuous (41). Some studies in Africa also confirmed the beliefs that HIV comes into the relationship or marriage as a result of women disloyalty associated with IPV (42,43,56,57). This stigma persists even though local norms about male's promiscuity on women are constantly being promoted, and their husbands are often responsible for HIV infection to their wives even if they do not know their HIV status (56).

In Togo, Burgos-Soto et al (2014) found the only common determinant linked with IPV against WLHIV was having a male partner who had multiple concurrent partners out of the household (58). Maman et al (2002) also found that in Tanzania, compared to WLHIV who reported that their partners had never been engaged with other women, WLHIV who reported that their partner currently had other affairs were five times more likely to report violence (26).

4.2.3. Sex and Condom use

Many studies showed that many women living with HIV are beaten or experience sexual violence because they do not want to have sex with their spouses. Moreover, they are also being coerced to have sex without a condom. Murray et al (2006) and Olowookere et al (2015) confirmed that WLHIV are beaten since they refuse to have sex with their partners (42,59). Likewise, some research also confirms that WLHIV experience violence, harsh confrontation, and threats from their husbands because they refuse to have sex without barrier protection (43,46,54,56,60,61). This situation might also be common where HIV is not present. However, among WLHIV this situation may worsen due to HIV stigmatising her as promiscuous women.

Many WLHIV wished to use condoms to prevent pregnancy because of concerns regarding the impact of HIV on the child's health. However, they are being forced to have sex since they (men) say they want children (61). Zunner et al (2015) also stated that husbands were described as resistant to using protection because they wanted to have many children (56). Referred to gender structures, the presence of children showed that men can perform normal achievement of the masculine ideal (51).

4.2.4. Number of Children

The number of children has been reported as the factor associated with IPV against WLHIV in the study in India and Nigeria. Achchappa et al (2017) highlighted that the association between IPV and WLHIV with two or more children were reported to be statistically significant (40). These finding also supported by Ezeanochie et al (2011). The authors said that HIV-positive multiparous pregnant women reported experiencing significantly more IPV as compared with nulliparous women (62). Similarly, respondents with an HIV-positive child were also nine times more likely to experience IPV than those without an HIV-infected child (62). Increasing family size puts additional pressure in the household on the prevailing socioeconomic conditions, especially in the households with poor living conditions (62).

4.2.5. HIV as a Trigger Factor

Research has shown that women's HIV status, and that of their partners and children is associated with intimate partner violence.

Ezechi et al. (2008), Shamu et al. (2008) and Orza et al (2015) found that HIV status of women is associated with IPV (41,51,63). Aryal et al (2012) findings also supported that HIV status per se is the high-risk factor for violence among women in Nepal (30). Furthermore, the authors found that as women are often tested earlier than men, Nepalese women are more likely to be accused of transmitting HIV into the family, and blamed for disloyalty (30).

HIV serostatus disclosure has been associated with adverse outcomes including partner's violence (64). A qualitative study by Mulrenan et al (2017) found that among WLHIV in Swaziland, serodisclosure, caused emotional and physical abuse from male partners which was often gendered asymmetrically (with only one partner disclosing HIV status) (48). Some studies in Africa also showed that HIV disclosure by WLHIV led to conflict or even to divorce (51,54,59,60,65). Despite the reality that most women were also infected, the adverse consequences included blame for infidelity, rejection, and verbal violence (48).

Nevertheless, a previous study in Tanzania found that among women who disclosed their HIV status, HIV was not significantly associated with IPV (26). The authors discovered interesting findings that woman who do not disclose, the history of experiencing IPV was higher for HIV-infected women as compared with HIV-uninfected women (26). Similarly, a systematic review in sub-Saharan Africa and Asia even reported that the majority of the literature showed positive consequences associated to disclosure (66). Women reported receiving affection, understanding, or acceptance following disclosure in three of the studies. A significant finding is telling that HIV status was not associated with the break-up of relationships including marriages (66).

Studies reported that HIV-positive women in sero-discordant couples (relationships where one partner is living with HIV and the other is not) were at high risk for IPV. Emusu et al (2009) and Ezechi et al (2008) confirmed that among some couples who did not have a history of abuse before, violence against women by the men occurred after they learn that the women are infected by HIV (41,43). Aligned with Emusu, Shuaib et al (2012) and Colombini et al (2016) found that violence against HIV-positive women stopped once the partner also found his positive results (54,67).

A recent study by Mulrenan et al (2017) reported that HIV diagnosis of children was the trigger of IPV against WLHIV (48). The authors found that while WLHIV's husbands started to accept her condition and his seropositive status, discovering HIV infection to their baby retriggered IPV (48). These findings confirm the Ezeanochi et al (2011) study which stated that among HIV positive Nigerian women, the history of IPV was significantly high among those with an HIV-positive child (62). Psychological stress in couples associated with HIV infection can be exacerbated by the presence of an infected child and this tension may trigger violence against women (52).

4.3. Intrapersonal level causes

4.3.1. Age, Level of Education and Social Status of Women

According to Jewkes (2002), intermittently, age as a risk factor has been found in some studies on violence against women (24). A study by Maman et al (2002) showed that WLHIV under 30 years old were ten times more likely to report violence than HIV-uninfected women (26). Olowookere et al (2015) supported this finding and showed that the younger WLHIV are more likely to experience IPV than the older respondents, although this is not statistically significant (42). In contrast to Maman and Olowookere, Burgos-Soto et al (2014) argued that age was a risk factor to physical violence only for HIV-uninfected women 33 years old or bellow in Togo (58).

Maman et al (2002) also reported that older women, regardless their HIV status were significantly more likely to report violence than were HIV-uninfected adolescent women (OR=11.66 and 9.59, respectively) (26). Likewise, Burgos-Soto et al (2014) also confirmed that age was associated with physical violence for HIV-positive women who are older than 33 years (58).

Research has shown that level of education had the highest factor associated with IPV against WLHIV. Maman et al (2002) highlighted that the odds of reporting violence were five times higher among women who had a secondary school education or less than among those with a post–secondary school education (26). These result aligned with Ezeanochi's findings, which found that respondents with the primary level of education in Nigeria were significantly more frequent among women who experienced IPV and women whose partners had post-secondary education experienced significantly less IPV (62). Conversely, Olowookere et al (2015) reported that IPV was lower among HIV-positive women without formal education compared with educated women. Osinde et al (2011) confirmed these findings. The authors found that WLHIV whose spouses had no formal education reported less experience of IPV (52).

Achchappa et al (2017) found that IPV was associated with WLHIV who were divorced (p=0.001). Olowookere et al (2015) also stated that other significant predictors of IPV against HIV-positive women included not being currently married. However, in contrast, Maman et al (2002) reported that women who did not live with spouse and unmarried were significantly less likely to report physical abuse (26).

4.3.2. Witnessing and experience violence in childhood

Maman et al (2002) found that from the 245 surveyed HIV-positive women, 8.5% reported that they had experienced sexual abuse by someone adult at least once before the age of 12 (26). In the same vein, Shamu et al (2014) noted that IPV was associated with WLHIV who had experienced violence during their childhood (51). The authors also found that partners with histories of violence with other people were associated with IPV among HIV-positive women (51). Burgos-Soto et al (2014) claimed that the incidence of sexual abuse among adolescent girls before 15 years old during childhood was higher among HIV-infected compared to HIV-uninfected women and also having spouses who had experienced fights with other males (58).

In Indonesia, a study of gender-based violence conducted in Jakarta and Papua province found that most of the participants, both women and men who experienced violence cited previous experiences with violence during childhood (66). They saw violence directed at his or her mother, being on the receiving end of violence from the first husband/boyfriend, and then by the second husband/boyfriend (68).

4.3.3. Alcohol use

As cited by Jewkes (2002), alcohol drinking increased the risk of all practices of violence against women (24). Emusu et al (2009) found that alcohol intoxication was described as a major contributing factor to sexual violence against WLHIV in Uganda (43). This study is supported by a study in Zambia (Murray et al, 2006) which reported that women whose husbands drank alcohol experienced domestic violence (59). Likewise, a study in Nigeria (Olowookere et al, 2015) found that IPV was significantly associated with partners' alcohol use (42).

Brittain et al (2017) suggested among 580 WLHIV, 40% reported alcohol use during the year before pregnancy, with alcohol consumption characterised by binge drinking and associated with their single relationship status and the experience of the intimate partner violence (IPV) (69). This study confirmed previous research done by Wilson et al (2015) which compared women who did not drink with women with higher alcohol use who had a

greater likelihood of IPV in the past year, although only the severe alcohol consumption category remained statistically significant (53).

4.3.4. Early starting sexual life and transactional sex

Shuaib et al (2012) reported that early age at sexual debut was associated with two times increased risk of reporting a history of sexual abuse among WLHIV (67). However, Burgos-Soto et al (2014) found that early sexual debut among women below 18 years old was the only risk factor to intimate partner sexual violence regardless of the women's HIV status (58). It can then be concluded that early starting sexual life was associated with IPV among both HIV-infected and uninfected women (58).

Studies showed that recent IPV was prevalent among HIV-infected female sex workers. In a Zimbabwe study, WLHIV who were sex workers had higher risk of facing many acts of IPV after being open about their HIV status to male partners, not clients (51). A recent study in Kenya also reported that compared to those who had first engaged in commercial sex less than five years previously, women who became sex workers 10 or more years earlier had a lower likelihood of recent IPV (53). According to WHO, "Stigmatization of sex work may lead partners or family members to think it acceptable to use violence to "punish" a woman who has sex with other men" (70), and among HIV positive sex workers, IPV is exacerbated by HIV stigmatisation.

Chapter 5. Interventions addressing IPV among Women Living with HIV

In the eyes of public health, the approach of IPV intervention consists of primary, secondary, and tertiary prevention. Primary prevention strives to prevent violence before it begins and decrease the level of IPV at the community level. Secondary prevention focuses on reducing the level of violence among victims or those who had previously experienced violence. One example of secondary prevention is a program designed to screen and to provide psychological counselling for women who had experience with IPV in health care settings. The aim is to identify victims early to prevent recurrent violence. Tertiary prevention aims to reduce the adverse impact of violence that has occurred among victims.

This thesis reviews the evidence for interventions in low-middle income countries (LMIC) which concentrate on primary prevention to prevent and reduce overall levels of intimate partner violence in both medium and long-term impacts. The study also focused on secondary prevention of IPV. This thesis does not review interventions that are only intended to meet the immediate needs of victims and do not evaluate services for victims of violence.

The study does not only prioritise programs that have been evaluated through rigorous scientific research. The problem that dealing with male-to-female IPV and the appropriate intervention to tackle the problem are complex (24). In addition, only a few studies specifically evaluate the intervention to prevent and reduce of IPV against HIV-positive women. Because of its complexity and the scarcity of literature, the evidence is understood from a broader perspective judgement of the applicability of the evidence for the context of Indonesia. For this review, building on the figure 3, this section looks at best strategies, and the best evidence of ways and means to address the various drives that have been identified.

5.1. Socio-economic, Political and Legal Approach

The research has shown that combining economic and social approaches to tackling IPV is associated with reduction of violence against women in some settings.
This thesis identified three studies which combined economic and social approaches:

1. Intervention with Microfinance for AIDS and Gender Equity, IMAGE, which combined microfinance and gender training, in South Africa (71);
2. The Stepping Stones program in South Africa, which combined income generating training (creating futures) and sexual health training (72,73);
3. The Women's Income Generating Support, WINGS, which combined gender and couples training (Women Plus) with cash transfers and micro enterprise training, in post-conflict Uganda (74)

IMAGE, a participatory training and microfinance program, was associated with risk reduction of sexual and physical violence (71). The multicomponent program provided by Stepping Stones was associated with IPV reduction related sexual and physical abuse among women over time (71). However, Stepping Stones did not report significant associations for any IPV indicators (72).

No significant effect was shown to a component of the intervention program with some comparator. Although cash transfer and micro enterprise training facilitated by WINGS was associated with reduced IPV, the combination with the Women Plus program is not associated with a reduction of IPV (74). Instead, the IMAGE program was associated with a decreased risk of physical or sexual IPV compared to last year, but a separate study showed no significant effect of the intervention when compared with the IMAGE micro-finance program alone (71).

This thesis has not managed to find studies from developing countries that are attempting to estimate the potential deterrent effect of the law on offender recidivism or at the level of partner violence in the overall population. Moreover, there is no evaluation available from low-income countries that assesses whether and to what extent a protective order to help reduce the risk of women against violence in the future.

5.2. Gender Structure Approach

This study also identified four interventions which focuses on changing gender norms that support IPV against women by multi-component approaches. The interventions are:

1. The SASA! Project; a community-based mobilisation intervention focused on critical analysis and discussion of power inequities among men and women, HIV-related risks and unequal relationships in urban Uganda (75,76);
2. The SHARE, focused on changing attitudes and gender-related norms that contribute to the risk of partner violence and HIV transmission through community-based mobilisation in rural Uganda (77–79);
3. The IMAGE intervention implemented a microfinance-based poverty mitigation program combined with capacity building on improving knowledge and awareness on gender norms, sexuality, HIV infection, and domestic violence in South Africa (71).
4. The PREPARE, a multi-faceted program in South Africa with school-based HIV prevention intervention. It aimed to delay early starting sexual life, increase condom use and decrease intimate partner violence (IPV) among teenagers (80).

The result of the SASA! project showed that the reported improved equal decision-making, better communication, collaboration in household works, and gratitude to their partner's work were more likely in men in the intervention groups than in men in the control groups (75). The ability to refuse sex, better communication, and equal decision-making were more often reported by women in the intervention groups than women in the control groups (76). The study showed that the intervention was associated with significantly lower social acceptance of IPV among women and less acceptance among men. It is also reported that more than half of the women (52%) had fewer experience of physical abuse and lower levels of sexual coercion in the past year (76). However, both findings were not statistically significant. Women experiencing abuse in the intervention groups were more likely to receive supportive responses from the community (75). Qualitative interviews found that "shifts operated through broader improvements in relationships, including increased trust and cooperation, participants' greater awareness of the connections between HIV and IPV and their resultant desire to improve their relationships" (76).

SHARE interventions showed that the reported physical abuse was considerably lower among women in the intervention groups than in the control groups at 35 months among all participants, although, there was no difference at 16 months (77–79). Similarly, reported sexual coercion and sex abuse were significantly lower among intervention groups than control groups at 36 months, but not different at 16 months (77–79). The incidence of emotional IPV at 16 or 25 months did not differ between the two groups. The study also showed that the program did not affect men-reported partner violence enactment (77–79).

The IMAGE program outcome showed that compared to women in the control group, a more progressive attitude toward IPV is more indicated by the intervention group (71). There are improvements in nine indicators of women's empowerment and financial welfare indicators, including:

- Improvements in decision-making autonomy
- Improved self-confidence and better economic situation in the households
- Improved attitude toward gender norms
- Better relationship with partners

- The financial contribution to the household makes the male's partners give great appreciation
- Meaningful participation in collective action (71).

Qualitative data found that this multi-component approach "to enable[d] women to challenge the acceptability of violence, expect and receive better treatment from partners, leave violent relationships, give material and moral support to those experiencing abuse, mobilise new and existing community groups, and raise public awareness about the need to address both gender-based violence and HIV infection" (p.5) (71).

The school-based program, PREPARE, showed that 55% of 6244 participants in the intervention group were less likely to report IPV victimisation, indicating the PREPARE shaped intimate relationships into safer ones, and potentially decreasing the risk for HIV (80). However, there were no differences in sexual risk behaviours between two groups at 12 months (80).

5.3. Trigger Factors Approach

5.3.1. Safer Disclosure of HIV status

Training of community counsellors in routine HIV testing and counselling (HTC) policy using specific training module was held from June – November 2005 in Zimbabwe (81). The intervention showed that 88% of 221 participants had disclosed their HIV status to their husbands. Among those who disclosed their status, 92% did not experience violence and their relationship continued. Violence from their partners due to disclosure was experienced by 8% or 16 women (14 HIV-positive and 2 HIV-negative) (81). The 11% who had not disclosed their HIV status mentioned their reasons not to disclose were due to fear of violence, divorce and stigma (81). Eighty-nine percent of participants stated that routine HIV testing program as other blood tests during pregnancy is very helpful. This program has been empowering women so that they can exercise their rights and responsibilities, particularly in accessing the appropriate information about PMTCT including infant feeding (81).

The Safe Homes and Respect for Everyone (SHARE) project conducted the program through screening and rapid intervention in HIV testing and counselling to prevent violence related to HIV status disclosure (77). The program trained counsellors to screen women who experienced IPV and refer those affected (78,79). Counsellors are also trained to assist WLHIV to develop a safe HIV disclosure plan and to help abused women on practising safe sex negotiation skills (78,79). The study showed that the disclosure of HIV status among all women to their partners was considerably higher in the intervention groups rather than the control groups at 36 months (78,79). However, there was no difference at 16 months. Particularly among women living with HIV, the disclosure of HIV serostatus to their partners was also higher although it was not statistically significant between two groups either at 16 or 35 months (78,79). The study showed a decrease in the incidence of physical and sexual IPV among all women but there was no difference in emotional abuse (78,79). Despite a decrease in IPV incidence (other than emotional IPV), there was no report that a decrease in the incidence of IPV occurred in a group of women living with HIV.

5.3.2. Reducing Harm Alcohol Use

Alcohol interventions are generally divided into four categories (82):

1. Brief interventions that detect and intervene with problem drinkers before the problem is increasing.

2. Intervention structural emphasis on laws and policies to make alcohol more expensive and limit supply. This includes access restrictions for young people and shipping regulations and promotion.
3. Community-based interventions that attempt to reshape the drinking environment through social norms campaign, school education, and public dialogue on the costs and benefits of alcohol.
4. Medical support and self-help systems such as Alcoholics Anonymous.

Until now, most programs based on this strategy have been implemented and evaluated in high-income countries (82).

This thesis only identified one intervention to reduce harmful alcohol use from LMICs in India. RISHTA is a community-based program with multi-component activities to reduce harmful use of alcohol in Mumbai, India (83). Initially, RISHTA prioritised sexual health concerns of men, but the use of alcohol appeared when the study highlighted the rate at which alcohol was associated with male involvement in sex outside marriage and relationship conflicts (83). The project included a combination of better services, community drama and group reflection (83). The results of the program showed that the overall alcohol use in the intervention group was significantly reduced, although, the study did not involve the control group. Also, men in the intervention group who were drinkers at baseline but not at the end of the line reported reduced sex outside marriage and began to apply gender equality attitudes (83).

Chapter 6. Discussion and Conclusion

Through this review of existing literature, I have addressed the research questions I set out the answer in this study:

1. What are the most specific causes and risk factors of intimate partner violence among WLHIV?
2. What are the effective interventions that have been implemented to prevent and reduce intimate partner violence among WLHIV, and how well are they working?

The thesis has found the causes and risk factors of IPV against WLHIV are based on the institutional, interpersonal and intrapersonal levels. At the institutional level, the causes of IPV are gender-related norms including acceptance of violence and concept of masculinity; poverty and lack of economic opportunities and lack of legal support regarding violence. At the interpersonal level, relationship conflict and controlling behaviour, poor living conditions, infidelity, sex and condom use, the number of children, and HIV status are the causes of IPV among HIV-positive women. Finally, at the intrapersonal level, the level of education, witnessing and experience violence during childhood, alcohol use, and transactional are the causes and risk factors of IPV.

The thesis also reviewed the effective intervention to prevent and to reduce IPV against WLHIV, and it has found some multi-component programmes in sub-Sahara Africa and Asia. The IMAGE, Stepping Stones and PREPARE in South Africa, and the SHARE, WINGs and the SASA! projects in Uganda, counsellor training in Zimbabwe and RISHTA program in India are evidence-based programs which may be adapted to the Indonesia context.

The empty boxes of the framework have finally been completed based on findings from this study, as shown in figure 4 and 5. In this section, certain key themes, which cut across the level of the boxes, and dominantly influence and shape are discussed. For each theme after discussing it, conclusions are arrived then.

6.1. Knowledge Gap

The study reveals the lack of literature on causes of IPV against WLHIV, not only for Indonesia but also in Asia, sub-Saharan Africa and Latin America. Research focusing solely on the causes of IPV for women with HIV including those who work as sex workers, or are drug users, housewives, migrant workers, disabled, or young women, is insufficient. Research involving spouses or perpetrators of violence as respondents on the cause of IPV is also hardly found. Interventions focused on preventing and reducing IPV in households or relationships with political and legal approaches, reducing harmful alcohol use, or childhood interventions to prevent future aggression are other important areas for which no evidence is found.

The absence of proof is the sign of neglecting; it signals the denial of government, academia, and society, in fact everybody. It is also understandable, and this issue is very hidden because the stigmatisation of HIV itself has made the victims silent, reluctant to report because of fear and shame, as if very few women with HIV who experience it. Thus, IPV is not currently a concern of the Indonesian government and has not been adequately addressed by the health care and other related sectors in Indonesia. Despite these limitations, the data convinced me that IPV for women with HIV is indeed a social and public health problem in Indonesia. This social phenomenon occurs because IPV is a form of structural violence that successfully perpetuates the ideology of male power over women, nourishes masculinity, and maintains a culture of violence, affecting the attitude and behaviour of society, spouses, and individuals.

In conclusion, research that focuses only on the causes and effects of interventions on IPV against WLHIV in Indonesia is insufficient. The willingness and abilities of various parties, including governments, funding agencies, academia, NGOs and other stakeholders to

study this issue has become a challenge for developing countries, including Indonesia. This neglect has fuelled violence as a part of women's lives, especially women with HIV. It takes commitment and strong support from various parties, especially the government, to prevent the occurrence of IPV and protect those who experience it, especially women with HIV.

6.2. The Vicious Cycle of HIV and Impoverishment

Poverty and lack of economic opportunities have caused women with HIV to be vulnerable to IPV. The surveys conducted by the IPPI found that economic factors were the reason for couples to vent anger through violence among WLHIV (21). When the high patriarchal culture is deeply rooted in the society, and the man are charged as the backbone of the family, poverty led to the crisis of masculinity in men. Poverty makes men feel weak and having lost power in their households and communities. The ideology of masculinity and culture that legalises violence in the society places women as a vehicle on whom to vent the anger due to inability to fulfil a man’s role. This is exacerbated by the widespread stigma and discrimination caused by HIV in the community. The consequences of stigma and discrimination due to HIV can make people with HIV lose income and livelihoods, end marriage and childbearing options, receive poor care within the health sector and also experience the loss of hope and feelings of worthlessness. If one family member is infected with HIV, it can cause a severe financial crisis. When someone is in a state of AIDS, it takes a lot of medical expenses, especially expensive treatment for opportunistic infections. In addition, when men are infected with HIV and in sickness, they become unproductive and unable to work to make money and to support their families. Especially in the poor households, HIV causes impoverishment. Conflicts within relationships can also occur due to the presence of children in the household. Children have many needs that must be met, and when men are unable to act as bread winners, then the target of their anger and despair turns to women.

It follows that patriarchal culture demands men to be successful, wealthy, able to meet the needs of the household and to show their power over women. Poverty due to HIV can shift men's confidence and make them feel that they are failing to maintain their existence as a "successful" man. Due to this crisis in confidence and power, women become the right vehicle to vent their anger on through violence. The idea of masculinity, coupled with the presence of HIV and poverty, was a strong blend of conflict that led to violence.

6.3. Gender Inequalities

Intimate partner violence is closely related to the feminine and masculine concepts as the gender indicators that exist in most societies in the world including Indonesia. The feminine concept identifies women as emotional, weak, of limited-ability, and as figures who must be helped and protected because of their limitations. While the masculine concept gives the identity of men as rational, dominant, and strong characters physically, it gives privilege to men to be the decision makers and even have the right to control of women. When women are unable to carry out the role demanded by their spouses and fail to meet the norms expected by the society, it can lead to conflict within the household. Therefore, violence acts as the conflict resolution effort has chosen to discipline women, including women living with HIV.

Violence is a strategy used in conflict resolution and to control transgressive women by men in a relationship. When women are disobedient to their spouses, financial crisis due to HIV in the households, infidelity, refusal to have sex and condom use, the number of children, and HIV status can lead to a crisis of masculinity in men which then leads to conflict within relationships. HIV status and infidelity affect each other and cause conflicts within a relationship. Women with HIV are labelled as immoral, unfaithful, promiscuous women, and this violates community norms and deserves them to be blamed. So, when they disclose their HIV status to their partners, they are vulnerable to violence especially

if their partner is not aware of their HIV status or not infected by HIV, whereas in fact many women are infected with HIV in monogamous relationships due to infection from their HIV partners. Additionally, when a WLHIV chooses not to give birth for fear of spreading HIV to her babies or giving birth to HIV-infected infants, or if they work as sex workers, this condition will make them more vulnerable to violence.

Women with HIV who refuse to have sex or require the use of condoms during sex are also vulnerable to violence by their partners. In the culture of patriarchy and Islamic culture, women are generally responsible for meeting their partner's sexual needs, so if they resist, conflict is inevitable. The problem of condom use also occurs because it is considered to reduce the pleasure during sex for men, and they want to have children to demonstrate their masculinity.

Given the above one can conclude, the violence experienced by WLHIV is a reflection of women's problems in general, a result of gender inequalities. But, HIV has exposed women to violence in the new situation. HIV acts as a determining factor of violence as it pushes women further, falling into a power hierarchy. Gender inequalities continue to foster violence against women committed by their partners.

6.4. The Cycle of Violence

Acceptance of violence deeply rooted in the society and born from patriarchal culture also makes WLHIV vulnerable to IPV. Findings from LMICs including Indonesia shows that the culture of violence is widely accepted by the society. The incorrect understanding of religious teachings that assumes men may dominate and exert violence against women has also perpetuated IPV and exacerbated this situation.

Children who are witnessing and experience violence during childhood are prone to violent behaviour when they become adults. Public acceptance of the concept of violence affects children. Children learn to accept violence from both parents, and may even have become victims of violence in the household. This cycle of violence often continues so that when children grow up, they simply accept and commit violence against their partners or others due to their assumption that violence is a common and permissible practice.

The inclusion of alcohol exacerbates the vicious style of violence. Women with HIV who drink alcohol get a double stigma as an "immoral" because, in addition to being infected with HIV, they also drink alcohol that is not allowed for women. For men, alcohol is a symbol of masculinity. As cited by Jewkes, men do not feel that they will be held responsible for acting violently when they drunk (25).

Weak of legal enforcement and lack of legal support also can perpetuate spousal violence against women with HIV. Domestic violence is usually regarded as a private domain between men and women, husbands and wives, and not the authorities' business. This assumption makes law enforcement to tackle the cases related to intimate partner violence impossible to be done optimally. With the absence of a strong law enforcement to impose sanctions against the perpetrators of violence, men feel that violence against women is not a criminal act. Lack of legal support also makes WLHIV reluctant to report their case to the legal authority. They fear that they will face discrimination and their HIV status will be revealed by law enforcement.

Overall, violence has been considered as a common practice in everyone's life. Violence is learnt from childhood, adolescence, and in adulthood. In fact, the state as the supreme institution that should protect all its citizens sees IPV as a natural thing for women in relationships or households. The use of harmful alcohol and weak law enforcement of perpetrators increases the vulnerability of WLHIV to IPV.

6.5. The lifecycle and Characteristics of Women

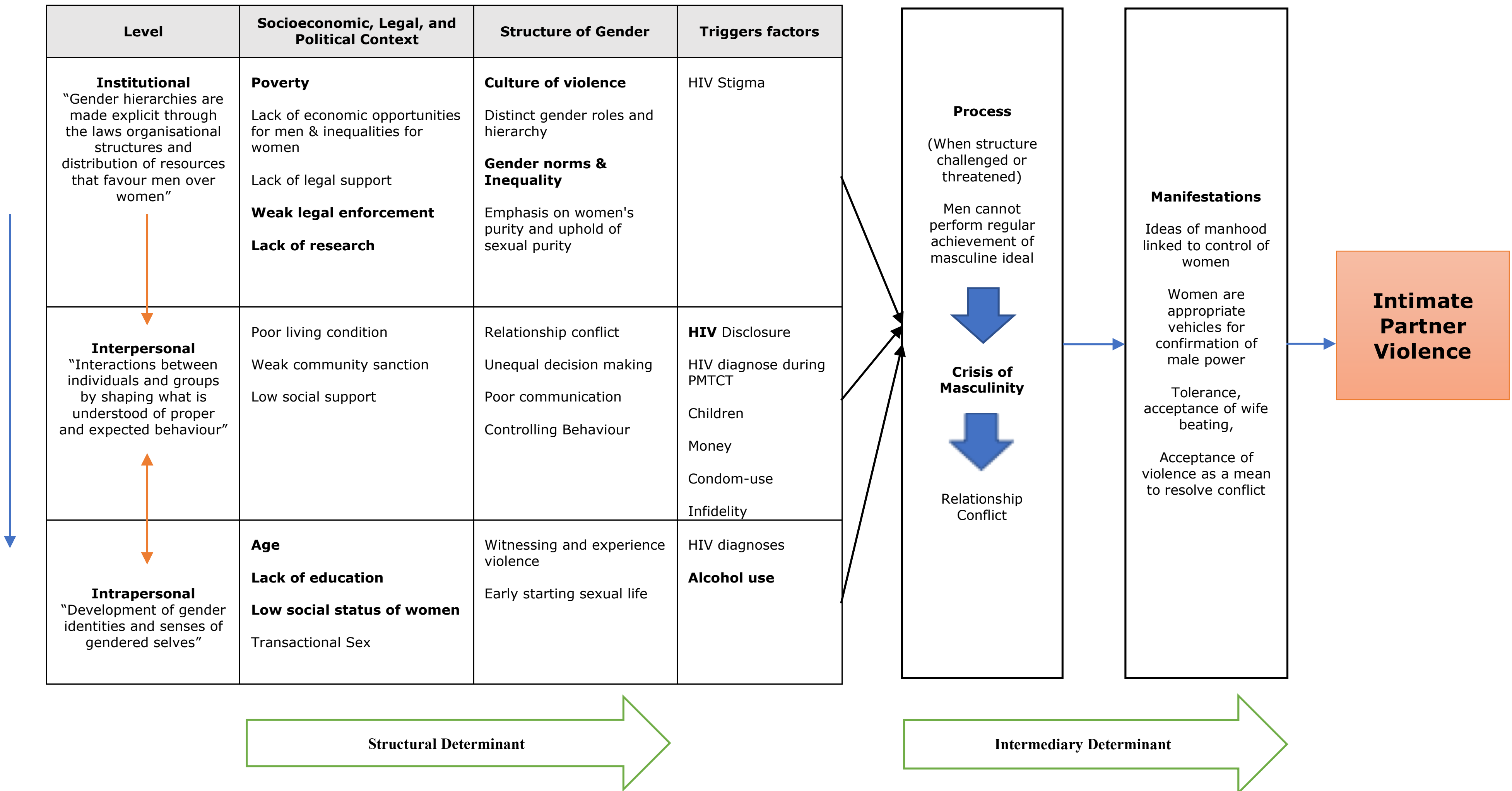
Age is a risk factor for IPV against women including women living with HIV. Younger women are more vulnerable since they have less power and are less educated. Low levels of education can affect a person's level of confidence and communication skills; therefore, violence may occur due to the inability to convey anger or a sense of disappointment well. However, very low education is a protective factor for violence. They may not know how to report the violence that they are experiencing, or may not realise that they are experiencing violence.

Findings also reveal that older women are susceptible to IPV. Older women might have better knowledge, married or have a relationship with their male partners and know how to report the abuse. Higher levels of women's education compared to their partner's educational attainment can be a threat in a relationship. Women with higher education will have better self-confidence and possibly higher income compared to their spouse. This discrepancy can lead to a crisis of masculinity in men. Conversely, the very high level of education becomes a protective factor because they have the self-confidence and autonomy over their bodies and courage or opportunity to leave their spouses. Jewkes describes the phenomenon of this relationship with an inverted U-shape (25).

In the high patriarchy culture and religious society, people still emphasises the purity of women and upholds sexual purity. Therefore, HIV-infected widows or women with HIV who are not married, because they are considered to have had previous experience in sex, have a high risk of experiencing violence. They are judged to have committed wrongdoing and violate the norms prevailing in the society that causes them to become infected with HIV.

The conclusion that can be drawn is age, level of education and social status of women become risk factors of IPV against WLHIV. Violence experienced by WLHIV, either sexual, physical, psychological and economic, also occurs from time to time, from their childhood, adolescence, and while marriage, having children, being a widow, in their old age, and when they become infected with HIV

Figure 4. Conceptual Framework of Causes of IPV Against WLHIV (Complete)



6.6. The Applicability of the evidence of Interventions for Indonesia

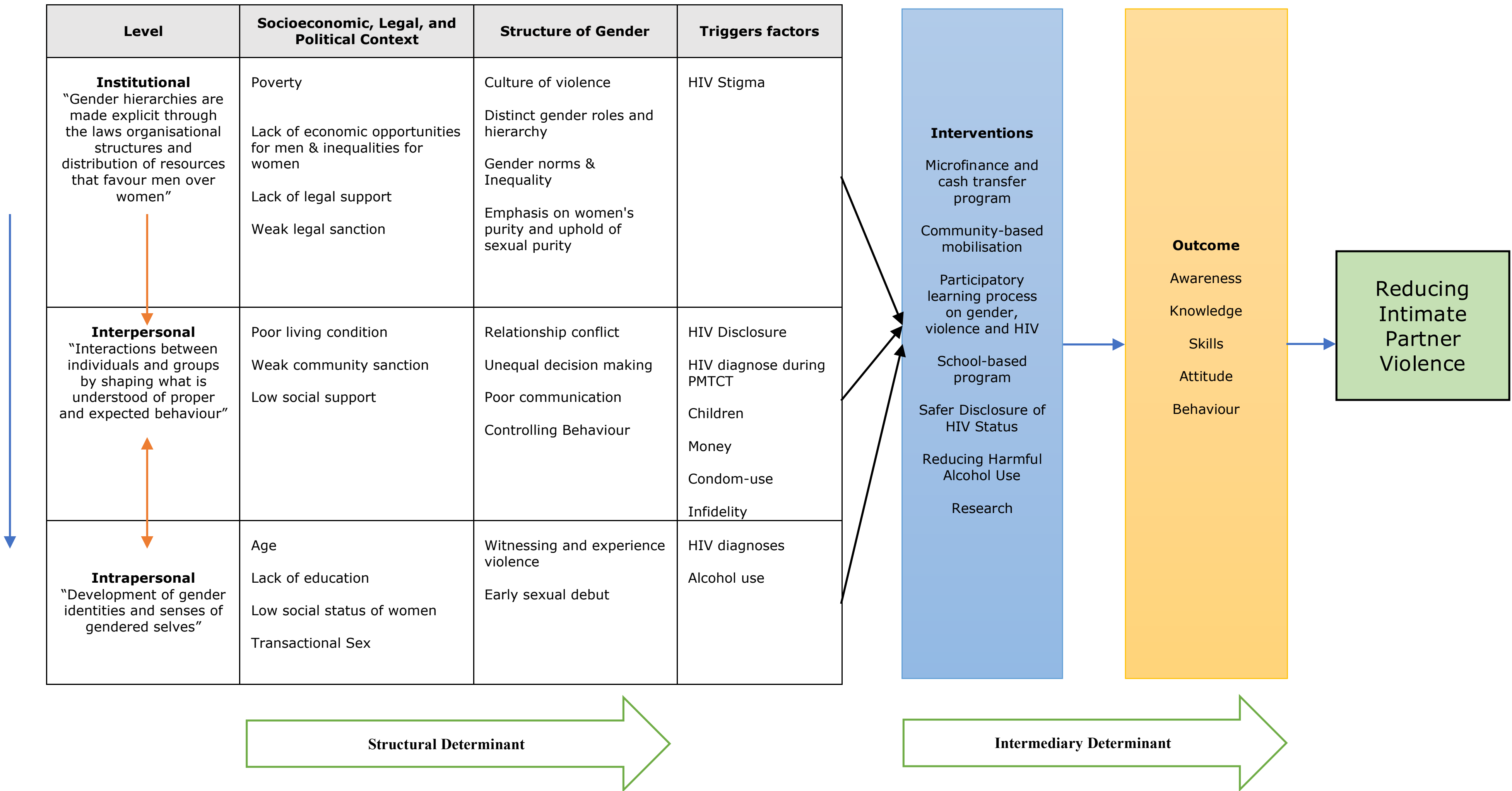
The findings reveal multiple interventions to tackle IPV against women that have been implemented in some countries as shown in figure 5, although there are only a few programs which have been focused on WLHIV. These implementations seem to be comprehensive while addressing the drivers of the institutional, interpersonal and intrapersonal levels.

However, evidence shows that while outcomes from the social and economic, gender structure approaches and safer disclosure of HIV status strategy are visible, measurable and significant, nothing that be seen at the political and legal approach. IPV against WLHIV is not a sexy issue for policymakers because it is associated with HIV and HIV is a moral issue. Policymakers are generally from political parties and they want to continue to maintain their power. Bringing moral issues can reduce their electability, especially if it violates religious, social and community norms. In addition, policymakers want populist programs that can deliver results in the short term, while changes in these issues require an extended period of time. And this certainly does not bring benefits to them. The political and legal approach involves many parties and requires a strong commitment from the government, but until now IPV is still not a priority for governments, particularly in Indonesia. This approach also requires a lot of funds and research. To be able to see the changes that take place, time constraint and resources should be considered.

Because of this knowledge gap, most of the interventions that have been implemented by agencies did not keep up the view on political and legal approach. They prefer to apply a program whose result can be seen at the interpersonal and the intrapersonal level. The difficulty to assess the political and legal approach outcome is understandable.

In short, interventions that can be applied in Indonesia should be a comprehensive response and be sustained by involving multi-sector, from the grassroots to the highest level. Integration between anti-violence against women and HIV intervention programs can be an effective program when combined with programs to empower women and vigorous law enforcement efforts to protect them. On top of these initiatives, the government's commitment and availability of resources including data become the most important thing, although it remains a challenge because IPV against HIV is still seen as a moral issue.

Figure 5. Conceptual Framework of Interventions of IPV Against WLHIV



Level	Socioeconomic, Legal, and Political Context	Structure of Gender	Triggers factors
Institutional "Gender hierarchies are made explicit through the laws organisational structures and distribution of resources that favour men over women"	Poverty Lack of economic opportunities for men & inequalities for women Lack of legal support Weak legal sanction	Culture of violence Distinct gender roles and hierarchy Gender norms & Inequality Emphasis on women's purity and uphold of sexual purity	HIV Stigma
Interpersonal "Interactions between individuals and groups by shaping what is understood of proper and expected behaviour"	Poor living condition Weak community sanction Low social support	Relationship conflict Unequal decision making Poor communication Controlling Behaviour	HIV Disclosure HIV diagnose during PMTCT Children Money Condom-use Infidelity
Intrapersonal "Development of gender identities and senses of gendered selves"	Age Lack of education Low social status of women Transactional Sex	Witnessing and experience violence Early sexual debut	HIV diagnoses Alcohol use

Chapter 7. Recommendations

These recommendations speak to the findings and particularly to the conclusion that has been made. They draw upon evidence that has been presented in the previous chapter, that the vicious cycle of HIV and violence, gender inequalities, knowledge gap on IPV literature, and sociodemographic characteristics may cause IPV against WLHIV. These recommendations are presented with a view for them to be applied to the context of Indonesia. They are, however, ambitious. Recommendations are presented where appropriate concerning what can be done in the short term and what should be done in the medium and the long term. Where possible, recommendations are specifically directed to who could and should be doing them.

1. IPV is an area that suffers from policy neglect. IPV is an area that is neglected by health, social welfare and gender, and also academia. Based on the findings here it is recommended that the inter-ministerial groups, with representation of WLHIV and legal people, be established to define and identify areas that will be the problems where action is needed to prepare the road map, and this can be done immediately.
2. The number of WLHIVs experiencing IPV, where they live, how IPV affects their lives, factors that might protect them from IPV, and any strategies or services that can be exploited for IPV against WLHIV, are ambitious and urgent research questions to be answered for Indonesia. Therefore, hastening research is essential to become the basis for policy development and project development strategy to address IPV against WLHIV. Research can be done either in short, medium or long term.
3. A culture of silence resulting from HIV and violence has fuelled violence against women in society. Women with HIV are required to solve their own problems. They need support to address the problems they face. Building self-confidence, increasing knowledge and awareness about HIV, gender, and violence through training or workshops is essential for WLHIV to have the capacity to utilise services and know how to seek help.
4. Voice is one of the strengths of the community in conveying its aspirations and becoming an agent of change in society. Involving women's organisations with HIV becomes necessary to voice IPV and HIV-related needs. WLHIV organisations in Indonesia are still quite premature and require a lot of support from various parties. Strengthening WLHIV organisations through capacity building, financial support, and technical assistance is important so that they can become strong alliances able to collaborate with different parties in resolving IPV issues.
5. Anti-violence against women programs should consider HIV as a cause and consequence of violence. Similarly, a national HIV program should include a component of violence services for women with HIV or women who are considered vulnerable to HIV transmission. To that end, the government together with other stakeholders needs to build a user-friendly integration of services for women including WLHIV to prevent and protect those who experience violence.
6. By law, the government is responsible for protecting the welfare of every citizen, including women with HIV. Inevitably, high political and substantial funding commitments become the primary needs for bringing about all the recommendations submitted to protect the WLHIV from violence. Good intentions are not enough; concrete actions through sufficient funding allocations for research, strategies, and programs to resolve IPV issues are central, and currently urgently needed to be implemented in Indonesia.

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