A safe sanctuary away from home: Working women's perceptions of power, gender-based violence and HIV-infection risk within intimate relationships

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Abstract

In this manuscript insight about working women's perceptions of power, gender-based violence and HIV-infection risk within intimate relationships in an airline business is provided. The manuscript is based on the findings from a Master of Arts thesis conducted by Ms Rachel Freeman, the main author of this article, in an airline business in Windhoek. Qualitative in design, in-depth face-to-face interviews were conducted with five women employees in an airline business to explore their experience and perceptions of power, gender-based violence and the risk of HIV-infection risk. Such insights formed the backdrop to data gathering, which used a narrative approach in which women were asked to retell their experiences of power, gender-based violence and HIV-infection risk within their intimate relationships, including the significance of the presence of an employee Assistance Program (EAP) in their lives as employees of an airline business; therefore providing them a safe sanctuary away from the chaos of their home environment. This manuscript covers a brief introduction of the study; the aim and objectives; it explores the extent of the problem being investigated; it provides a theoretical perspective as well as looking at the methodology of the study; and data analysis. The manuscript concludes with specific recommendations about the relevancy and importance of workplace programmes to protecting and promoting women's wellbeing and rights.

Introduction

This manuscript presents a brief overview of the findings of a research project undertaken by one of the authors in fulfilment of the requirements for her master studies, which was an exploration of Working Women's Perceptions of Power, Gender-Based Violence and HIV-infection risk within their intimate relationships. It was a qualitative study in which five female participants were sampled, using purposive sampling method. Freeman's (2010) study sought to uncover women's experiences in navigating their personal and work worlds, from "which they can draw personal and external resources in order to shift the balance of control within their own intimate relationships" as explained by Kirkwood (as cited in LaFont & Hubbard, 2007, p. 86). Data was collected using semi-structured and face-to-face interviews, following a narrative approach. Interview data was analysed and interpreted by applying a generalised inductive approach for qualitative data analysis.

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The findings of this study show that all the women in the study experienced power imbalances and GBV in their intimate relationships. All the women reported emotional or psychological abuse. The majority of them reported of being subjected to economic and physical abuses, which posed potential adverse effects to their health, well-being and work productivity. The findings show that the experiences of GBV left an emotional scare on all five interviewees. However, the findings show that the presence of an employee Assistance Program (EAP) in the women's workplace provided a sanctuary away from the chaos of their homes, suggesting the need and importance of workplace interventions, policies and programmes in addressing gender-based violence and power imbalances. Therefore, Freeman's (2010) findings are relevant and important in that they serve the function of informing policy-makers, employers and proponents of Employee Assistance programmes to support the continuation of such workplace initiative for employees in violent intimate relationship.

Increasing gender-based violence and power imbalances are being cited as essential determinants of women's HIV-infection risks, globally and particularly in sub-Saharan Africa (Jewkes, Levin & Penn-Kekana, 2003, p. 1415; WHO, 2004). Globally, according to the United Nations Programme on HIV and AIDS (UNAIDS, 2004), women are disproportionately affected by HIV and AIDS. In Southern Africa statistics have shown that women and girls make up almost 57% of the adult population with HIV and AIDS in sub-Saharan Africa (www.unaids.org). This trend in women being disproportionally affected by HIV and AIDS, according to WHo (2000), suggests that women in most parts of the world face particular risks of HIV infection, because of the interplay between their economic positions and social status. These realities form a social context in which women's abilities to make healthy choices is often diminished. The World Health Organization (2000) states that when a woman is afraid of violent retaliation by her intimate partner, she is less likely to discuss the reduction of HIV-infection risk with him.

Women's relative lack of control over their sexual lives and methods of preventing HIV and other sexually transmitted infections due to violence or fear of violence is one of the main factors behind the spread of HIV (United Nations, 2006). The United Nations (2006, p. 36) states that lack of control is experienced not only by women who are sexually assaulted, but also by those women in relationships where they are unable to negotiate the use of condoms with their partners.

Violence both exposes women to HIV-infection and limits their ability to participate in and benefit from HIV and AIDS prevention methods and treatment. According to the WHO (2004), when women reveal that they are HIV positive they may face real violence (or the threat of violence) and the risk of abandonment by their partners, families, friends and employees or colleagues. WHO (2004) reports that research findings in the United States and sub-Saharan Africa show an increased risk of HIV and AIDS among women victims of gender-based violence and that being HIV positive is an added risk factor for gender-based violence against women.

In this regard, the WHO (2004) identifies four areas in which women's vulnerability to gender-based violence and HIV and AIDS overlap, namely:

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

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

Violence against women is a complex and multidimensional problem, and as Heise, Pitanguy and Germain (as cited in Namibia Ministry of Health and Social Services 2004, p. xi) indicate: "Male violence against adult women is a public problem of enormous magnitude". Strauss et al. (as cited in Namibia Ministry of Health and Social Services, 2004, p. xi) state that Namibia's political history, combined with social values and practices within which inequality between men and women are embedded and condoned, has created an environment where violence against women has flourished. This type of violence has therefore evolved to become the embodiment of unequal power relations between men and women. Brown, Dunkle, Gray, Harlow, Jewkes and McIntyre (2004) demonstrate that women who had less power in their sexual relationship were at elevated risk of HIV infection. These researchers (Brown, et al., 2003) have argued that the high prevalence rates of HIV among females are the results of gender power inequities and violence against women, not forgetting the biological nature of women's reproduction system which also puts them at risk.

Jacobs (2003) has argued that violence against women is both a cause and a consequence of HIV-infection. Brown et al. (2003) have consistently found high prevalence rates of gender-based violence among South African women. It is generally known that human societies make social distinctions based on gender and virtually allocate more power and higher status to men.

Freeman (2010) sought to draw on existing knowledge of and research findings on women's perceptions of power, gender-based violence and HIV-infection risk within their intimate relationships. Such contextual insight formed the backdrop to the data gathering, which used a narrative approach in which a sample of five volunteer women survivors of GBV in an airline were asked to retell their experiences of power, gender-based violence and HIV-infection risks within their intimate relationships.

While the effect of gender power imbalances in constrain women is well documented, its effects on employed women is less studied. DiClemente & Wingood (2000) state that, as power between men and women increases and favours men, women will be more likely to experience adverse health outcomes. Meaning that men's control over women's sexuality, for example men deciding when, where and with whom to have sex greatly contributes to the spread of HIV. DiClemente and Wingood (1997) suggest that gender power imbalances constrain women in negotiating safer sex, while Campbell (2002, p. 1331) states that increased health problems such as Sexually Transmitted Infections (STIs), post-traumatic stress disorder and depression are well documented in research on abused women. In turn, all these personal problems are likely to follow or affect women employees in their workplaces.

In order to promote the health and well-being of employees, the airline business (Air Namibia) in 2007 introduced an Employee Health and Wellness Workplace Programme and other referral services to assist its employees in resolving their personal problems and

productivity issues such as mental health, alcohol and drug abuse, marital problems, family problems, stress, depression and other emotional issues.

Generally, workplace Employee Assistance programmes are offered free of charge and confidential to all employees in a particular employment setting. They cover a range of issues affecting employees such as mental health problems, stress, addiction to alcohol and drugs, HIV and AIDS, and other chronic diseases. Also evident from the findings, is the role of power imbalances which placed women at increased risk of GBV and becoming HIV-infected. Power imbalance manifested in this, however, despite the seemingly power imbalances, only one of the five women interviewed was HIV-positive. This perhaps could be due to the fact that working women are more likely to be educated and therefore more aware about their rights in terms of demanding their spouses/partners to use condoms. This by implication suggests that employment and education have positive impacts on the empowerment of women when it comes to sexual reproduction and health.

Freeman (2010) shows that the airline business' Employee Assistance Programme activities such as Volunteer Counselling and Testing (VCT) and the use of condoms are essential efforts in the prevention of HIV-infections and therefore this needs to be encouraged at all levels of society. This manuscript explains its purpose and objectives and further explores the problem which is followed by a discussion about the theoretical framework and methodological approach. The rest of the paper discusses data analysis and interpretation, ethical considerations and then concludes with specific recommendations for policy direction and implementation of workplace programmes.

The Purpose of the Study

The purpose of this manuscript is to demonstrate the significance of an employee Assistance Program (EAP) in providing a safe sanctuary away from the chaos of their home environments, for working women in risk intimate relationship due to power imbalances, GBV and HIV-infection. The insight of the study was drawn from the experiences, perceptions and perspectives of five women in an airline business as part of a Master of Arts thesis conducted by the main author of this article.

An airline business is a fast-paced working environment; therefore may poses, considering women's vulnerability due to power imbalances, GBV and HIV-infection, a threat of stress to the detrimental of the health and wellbeing of employees. A growing body of research suggests that intersection between personal and work-related problems present an adverse effect to the health, well-being and work productivity of employees (DiClemente & Wingood, 2000). In the current environment of prevailing GBV in Namibia, the findings of the study by Freeman (2010), are of utmost importance, because they contribute to the understanding of the "web of abuse, personal and external resources" from which women in abusive relationship can draw strengths to "shift the balance of control within such relationships", as explained by Kirkwood (as cited in LaFont & Hubbard, 2007, p. 86).

Freeman (2010) shows that there are benefits in providing a workplace employee Assistance Program (EAP) in that it provides a sanctuary to workers caught up in a web of abuse at home, suggesting the need and importance of workplace interventions, policies and programmes in addressing gender-based violence and power imbalances.

Objectives

The following were the objectives that the study explored:

- Working women's perceptions and experiences of power imbalances and gender-based violence in the workplace and homes. Women routinely face power imbalance at every level of the society, including at work and homes, which often put them at risk of gender-based violence and HIV infection. Due to the prevalence of power

imbalances (psychologically, physically and economically), women sometimes lack a voice and resources to respond to their repressive situations therefore ending up trapped in a cycle of violence.

- Hence, it is the objective of this paper to explore the avenues and how an employee assistance program is a double-edged sword in combating domestic and workplace violence against women.

Exploring the problem in a Namibian Context

In 2008 Freman, one of the authors of this paper, under the auspices of the *Namibian Voices for Development* launched the "I"-stories booklet that chronicled real life stories of Namibian women who spoke out against gender-based violence during the *Sixteen Days of Activism Campaign against Violence against Women*. The theme of the "I"-stories booklet was: *Healing through the Power of the Pen*. This was a series of first-hand accounts of women who have experienced gender-based violence, and included themes such as domestic violence, rape, child abuse, poverty, and HIV-infection after a sexual assault.

The aim of the "I"-stories project was to create a safe and supportive platform where women could gain emotional healing in the telling and writing of their personal accounts. For the writers it was empowering to tell their stories, because it formed part of a transition from victim to survivor (*Namibian Voices for Development*, 2008). It was during the *Sixteen Days of Activism* campaign and after receiving copies of the "I"-stories booklet, that five women employed in an airline business in Namibia approached Freeman and voiced their need to be given an opportunity to share their perceptions of gender power, gender-based violence and HIV-infection risks both in their intimate relationships and at the workplace.

For the purpose of Freeman's (2010) research, understanding the challenges working women experience in balancing what's happening in their intimate relationships and work is important in the fight against GBV. This rationale is supported by the recommendation of the Beijing Platform for Action (as cited in Namibia Ministry of Health and Social Services, 2004, p. 1), for the promotion of:

"… research and data collection on the prevalence of different forms of violence against women, especially domestic violence and research into the causes, nature and consequences of violence against women".

Thus, the central research problem of Freeman's (2010) study was to explore from the narratives of working women, how they cope with the web of abuse in their intimate and personal relationships and workplace, and what help in the form of external resources, and personal strengths, to shift the balance of control within such relationship.

LaFont and Hubbard (2007, pp. 100-101) state that Namibia is frequently applauded for being signatory to the United Nation's Conventions and the Southern African Development Community (SADC) Protocol on Gender and Development (2008) with no reservations – a wholehearted degree of commitment which is rare amongst the countries of the world. According to LaFont and Hubbard (2007, pp. 4 & 100), Namibia in its years of independence, has made remarkable progress in fighting gender-based violence and HIV and AIDS by establishing enabling environments through well-defined laws, policies and programs. LaFont and Hubbard (2007, pp. 4 & 104) state that there is a legal framework for gender-based violence which includes the Married Persons Equality Act (as cited in LaFont & Hubbard 2007, p. 104), which eliminated the discriminatory Roman-Dutch Law concept of marital power previously applicable to civil marriages in Namibia, and which grants women equal legal status in their household. Yet in reality, most women do not seem to enjoy equality in their domestic spheres. The Combating of Rape Act (as cited in LaFont & Hubbard 2007, p. 106) outlaws rape within the marriage and is one of the most

progressive laws on rape in the world; yet, most men still believe that their wives are under an obligation to provide them with sex whenever they demand it.

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

We are in agreement that these acts are all progressive pieces of legislations that sought to outlaw and discourage gender-based violence and HIV and AIDS, but we strongly charge that they lack in implementation, therefore lag behind in combating gender-based violence. LaFont and Hubbard (2007, p. 108), report that Namibia has one of the highest rates of sexual violence in the world, with the vast majority of rapes in Namibia – at least 67% involve persons known to the victim, about one fourth (25%) involve spouses or intimate partners, including past partners. The researchers (LaFont & Hubbard, 2007) furthermore state that the country's HIV prevalence rate ranks fifth in the world. The situation of women in Namibia can partly be equated with what Ipinge and Le Beau (as cited in LaFont & Hubbard, 2007, p. 108), suggested about women in Southern Africa, namely that they remain a vulnerable, marginalised group that do not yet enjoy equal status with men or have equitable access to services and resources. According to the Namibia Ministry of Health & Social Services (2008c, p. 1), women are found to disproportionally account for those living in poverty, those who are illiterate and those who are landless or living in rural areas where facilities are scarce. We are, thus arguing that there are still many challenges in achieving gender equality in Namibia, especially in the view of persistent gender stereotypes among many Namibian communities, due to cultural traditions and social believes.

The SADC Protocol on Gender and Development (2008), defines gender stereotypes as "beliefs held about characteristics, traits and activity domains that are deemed appropriate for women, men, girls and boys based on their conventional roles both domestic and socially". However, a simplified definition of gender stereotypes to denote the way men, women, girls and boys behave and think as a result of socialisation is how we are operationalizing the definition in this study. From birth, gender stereotypes are embedded in the way boys and girls behave, think and act. It is through this socialisation process that men, women, girls and boys learn to behave and act differently when it comes towards what is appropriate and improper for both genders at every societal level, including workplace. The lack of gender-sensitive (here meaning inclusive definitions of gender roles, sexuality and relationships), workplace policies and programmes to address power imbalances warrants further research into gender-based violence and HIV-infection risks.

The SADC Protocol on Gender and Development (2008) defines gender equality, "as the equal enjoyment of rights and the access to opportunities and outcomes, including resources by women, men, girls and boys". In this regard, equality does not imply for men and women to become the same or to be treated in exactly the same way, but that individuals' rights, responsibilities and opportunities will not depend on whether they are born male or female (LaFont & Hubbard 2007, p. 91). In the study by LaFont & Hubbard

(2007, p. 91) equality means treating people who are in similar situations in a similar way. It implies that the interests, needs and priorities of both men and women are taken into consideration, recognising the diversity of different groups of women and men.

According to the Namibian National Planning Commission's Report on the Millennium Development Goals (2004, p. 13), gender equality is about extending freedoms, choices and opportunities to both women and men. The Namibian National Planning Commission (2004, p. 13) states that, "although Namibian women are doing relatively well in terms of educational achievement, the picture is less encouraging when it comes to translating education into good jobs and overall changes in society." While Namibian women hold more than half of all professional jobs in general, they account for just one third of higher level positions such as legislators, senior officials and managers.

Moreover, only nine per cent of seats in the Namibian National Assembly were occupied by women in 1990. This has gradually increased since, but is still only at 19 per cent. SADC (2008) recommends that the number of women politicians and decision-makers should be at least 30 per cent by 2005. Edwards (as cited in Cupido, Edwards & Jauch, 2009, p. 32) states that the disparities in income, employment and access to resources according to gender in Namibia are glaringly obvious. Of the economically inactive sector in the Namibian population, 43,1 per cent is classified as homemakers, with women accounting for 70 per cent of this figure. Women form the bulk of caregivers, yet are considerably under-represented in the formal economy, especially at managerial level. Female-headed households, which are some 40 per cent of the total, have a per capita income of N$7528, in contrast to male-headed households with a per capita income of N$12 248. According to the Namibian National Planning Commission (2004), these figures point to a large number of single mothers and to the continued economic marginalisation of women in the Namibian society. Edwards (as cited in Cupido, et. al., 2009, p. 32) states that under conditions of poverty there is a demographic transition towards older and female household heads. This partially explains why there are so many poor, matrifocal families in Namibia.

Theoretical Perspective

The theory of Gender and Power was used as a theoretical framework in Freeman (2010) to answer the research questions. The theory of gender and power, as conceptualised by Connell (1987) and reworked by Wingood and DiClemente (1998), posits that three major structures typify gendered relationships: 1) The sexual division of labour; 2) The sexual division of power; and 3) The structure of cathexis. DiClemente & Wingwood (2000) state that the three structures serve to explain the cultural bound gender roles assumed by men and women. The above structures are said to exist at two different levels, that is, the societal and institutional level. The highest level in which the structures are embedded is the societal level. Furthermore, the three structures are rooted in society through abstract, historical and socio-political forces that consistently segregate power and ascribe social norms based on gender-determined roles. The structures remain intact even though the society is changing (DiClemente & Wingwood, 2000).

The three structures are also evident at social institutions that include: schools, worksites or industries, families, relationships, religious institutions, the medical system, the media etc. In the social institutions the three structures are maintain, for example, through unequal pay for comparable work where women doing the same work as men but are paid less than men: the imbalances of control within relationships and at places of work. According to Mauthner and Doucet (2003, p. 422), "… human beings are viewed as interdependent and as embedded in a complex web of intimate and larger social relations". This ontological view of things emphasizes the issue of social relation which also shape people the way they make decisions. Mauther and Doucet (2003) state that they have appreciated and

interrogate the epistemological and ontological assumptions of subjects and subjectivities that informed both their research and the data analysis method they used. Mauther and Doucet (2003, p. 424) argue that research "which relies on the interpretation of subject's accounts can only make sense with a high degree of reflexivity and awareness about epistemology, theoretical and ontological conceptions of subjects and subjectivities that bear on their research practices and analytical processes".

Methodology

A qualitative approach was chosen, because the nature of the research problem and the stated objectives demanded an idiographic, case-based approach (Denzin & Lincoln, 2003, p. 28). Denzin and Lincoln (2003), note that as qualitative researchers seek answers to questions that stress how social experiences are created and given meaning, their research is value-laden. This approach enabled Freeman (2010) to gain a better understanding of working women's perceptions of power, GBV and HIV-infection risk in their intimate relationships. The chosen qualitative approach also offered Freeman (2010) the opportunity to seek an in-depth understanding of complex human experiences (Lietz, Langer & Furman, 2006, p. 445). For the purpose of the study by Freeman (2010), semi-structured, individual, face-to-face interviews were conducted following a narrative approach. The face-to-face interviews were used as a primary data collection technique for the study and were conducted on a dyad basis (one interviewer and one respondent) as described by Warren and Karner (2010, p. 2).

In-depth, face-to- face interviews

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

According to Adler and Clark (2008, p. 271), qualitative interviews can vary from unstructured to semi-structured interactions. Semi-structured interviews are described by these researchers as designed ahead of time but modified as appropriate for each individual participant. Patton (1990, p. 278) argues that at the root of interviewing is an interest in understanding the experiences of other people and the meaning they make of those experiences. In the in-depth face-to-face interviews, the researcher did not only ask questions, but also recorded and systematically documented the participant's responses, coupled with intense probing in order to obtain deeper understanding of the responses. All of the interviews were conducted in English. The semi-structured interview schedule was prepared in advance, but Freeman (2010) allowed the interview to flow naturally based on information gathered from the participant. The interview schedule, developed on the basis of the literature review, comprised eight main sections and 62 questions. The interview schedule included Pulerwitz, Gortmaker and DeJong's (2000) Sexual Relationship Power Scale. An expert was interviewed to pre-test the interview schedule. She holds a Master's Degree in Social Work. The goal was to test the interview schedule in order to ensure clarity of the research instrument, as well as to establish the time to be taken in answering the questions. The expert commented positively on the interview schedule and on the way the interview was conducted. The expert reported that she found the questions of the interview schedule relevant and clear. She suggested the inclusion of a question on the sharing of an HIV positive status, by asking the participants on how they might react if they found out that their partner was HIV positive.

Freeman (2010) began each interview by introducing herself and explaining what her study was about, emphasising the importance of the data that the participant would give her by answering the questions she asked. The researcher made it very clear that she was not there to judge, but simply to understand the research participants, so that she could interpret what their perceptions and experiences of gender power, GBV and HIV-infection risks were. Freeman (2010) gave the participants the informed consent forms to read and highlighted the fact that the she would be happy to answer any question that the participant may have relating to the written text. As some of the participants were well educated women with some research experience, it was easy to conduct the interviews with them. Freeman (2010) guided the participants through the conversation until all the important issues on the interview schedule were explored. She then listened attentively and very patiently to what the participants had to say, because she wanted to let the participants say as much as possible about any particular theme she was trying to probe. As a result, Freeman (2010) did not get to the end of the interviews quickly. Some interviews took an hour and ten minutes, but the researcher found that the participants were forthcoming in the re-telling of their stories. One of the participants even regarded the interview as cathartic and said: "*Even if my life story can just change one life, I will be happy.*" (Freeman, 2010, p. 40)

Another participant thanked Freeman for including her in the research, because she was desperately looking for some donor who could fund a book about her personal life story. Two of the participants indicated that they were currently in the process of writing up their own life stories. All of the participants felt grateful for the opportunity to tell an outsider about their perceptions and experiences.

Freeman (2010 tape-recorded the interviews. None of the participants objected to this as they understood how important accuracy was for the credibility of the findings. The interviews took place in the researcher's office – an arrangement preferred by all of the participants. In addition to the interviews, the participants were encouraged to write down further narratives about the issues discussed. A deadline was agreed upon for submission of their narratives.

This was two weeks after the individual interviews were conducted. The narratives were used to complement the in-depth interview transcripts.

Choosing a narrative approach

According to Overcash (2003, p. 179), narrative research can be defined as collecting and analysing people's accounts of experiences and their interpretations of those experiences. Narrative research enables the exploration of personal experiences beyond the boundaries of a questionnaire, providing insight into decisions and actions. A narrative account details someone's unique experiences and perceptions. The reason Freeman (2010) wished to follow a narrative approach in her study was because, she wished to examine the central issues from the perspective of women, to access their stories, to "tap into their usual ways of expressing themselves", and "to incorporate the context and chronology of events while imparting meaning and relaying larger cultural themes and values" (Ismail, Berman & Ward-Griffin 2007, p. 461). Freeman's experiences with women's talk about abuse and violence gained her familiarity with the potential of narration in the voices of the narrators, with contextualising unique experiences, and with offering insights into the dynamics of GBV and women's vulnerability to HIV.

Recruitment, Sampling and Inclusion Criteria

Adler and Clark (2008, p. 121) believe that, for exploratory studies and qualitative research, purposive sampling is desirable. The participants were recruited on a voluntary basis, using a purposive sampling technique. The target population consisted of working

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

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

Freeman approached those women who indicated in 2008 that they would like to participate in a study to share their personal experiences of GBV for their participation in this study. An information letter and informed consent form were handed to the eligible participants.

Data Analysis and Interpretation

Data analysis and interpretation, as described by Liamputtong and *Ezzy* (2005, p. 257), is the process through which the researchers intentionally immerse themselves in data by reading and rereading the data. In this regard, as pointed out by Du Plessis (2009, p. 2), researchers have to order and reduce data according to the objectives and topics of discussion. The data was analysed and interpreted by applying a generalised inductive approach for qualitative data analysis. Such an approach, according to Thomas (2003, p. 2), is a systematic procedure for analysing qualitative data, guided by specific objectives. Shortly after each interview, Freeman transcribed each qualitative interview from the audio-tape recording.

The researcher (Freeman, 2010), studied all the interview transcripts, narratives and her field notes. She read and reread the interviews several times in order to understand and highlight commonalities. Linkages and expressions were later grouped into themes. Such themes were used as codes to organise the data by coding sections of text.

Issues of Reliability and Validity

According to Neuman (2007, p. 120), "… qualitative researchers are more interested in authenticity than validity. Authenticity means giving a fair, honest and balanced account of social life from the viewpoint of someone who lives it every day." Freeman (2010) found it imperative to understand the experiences of the participants from their point of view.

The credibility of the data-generation process was enhanced and protected through immersion in the narration of the research participants. In this regard, Neuman (2007, p. 249), explains that "field researchers depend on what members tell them. This makes the credibility of members and their statements part of reliability … field researchers takes subjectivity and context into account as they evaluate credibility". The open-endedness of narrative research is the strength of the method, and there is no primary method for assessment of validity and reliability (Overcash, 2003). Narrative methods lend themselves to a holistic view of human experience.

Overcash (2003, p. 182) states that, as with all research, one final test of validity exists, namely the ability of the researcher to determine whether there is something abnormal or generally wrong with the data. By critically reviewing the research conclusions, questions may present themselves concerning the population, method of analysis or general procedures. In qualitative research, consistency tends to be a foremost element to collecting and analysing the data. Consistency has been achieved in the interviews by using the interview schedule, the use of a secure setting in which the interviews were

conducted and the use of the participants' own writing. Rolfe (2006, p. 305) emphasises the trustworthiness of qualitative work, which encompasses:

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

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

Ethical Considerations

The ethical principles of confidentiality and respect are especially relevant in the research field of GBV, due to the traumatic and sensitive nature of the subject material (Heise, Ellsberg & Gottemoeller, 1999). Freeman (2010) thus carefully considered the issues of confidentiality, disclosure and the need to ensure adequate and informed consent.

Confidentiality

In order to protect the privacy of the participants, Freeman (2010) ensured that interviews took place at a venue away from the public eye and that no unnecessary disturbances occurred. The researcher set up an informed consent form in which she undertook to protect the confidentiality of the participants and their data. Furthermore, Freeman (2010) pledged to keep all participants' responses strictly confidential. In order to protect the identity of the participant, Freeman (2010) used pseudonyms in the field notes and transcripts of the interviews. She also ensured that the data was kept locked in a safe and secure place to protect the confidentiality of the information from others, until it can be destroyed.

Voluntary, informed consent

Neuman (2000, p. 96), points out that a researcher must never coerce anyone into participating. In this regard, Freeman (2010) ensured voluntary participation by all the participants by asking them to sign a statement of 'informed consent'. Each participant was given a full explanation of the purpose of the study. They were informed that their information was for the purposes of academic research only.

The participants were reminded that their participation was voluntary and that they could withdraw at any time without any threat to their families or themselves. Two of the participants withdrew from the study prior to the in-depth, face-to-face interviews. One of the two was in an abusive marital relationship and had since registered a divorce case. The other woman withdrew her participation, explaining that she felt that she would betray her husband by participating in the study. She explained that she really wanted to tell her story, but despite the abuse she suffered in her marriage, she did not feel confident or safe to participate. Both the participants' withdrawals were respected and they were referred to external psychologists and therapists. All of the participants signed the consent forms in duplicate (one was for the researcher and the other for the participant). A guarantee of

confidentiality of records and the protection of the identity of the participant was included in the written informed consent statement. This helped the participants to build trust and confidence amongst themselves as well as with Freeman.

Provision of debriefing, counselling and additional information

Considering the potential emotional strain the participants might experience, Freeman (2010) made sure that provision was made for participants to debrief at the end of each interview in order to make sure that no one went home feeling distressed. Freeman further offered all participants with referral information for local support services specialising in violence against women and HIV and AIDS. Contact details for additional information, debriefing or counselling were provided.

Findings

Women's Perceptions of Power

The women's different perceptions of power became the central theme emerging from the data, which is in line with the first and second research objectives. The majority of the women perceived power, at every societal level in Namibia, including workplace, as favouring men and as rendering women particularly vulnerable to GBV and HIV infection. For example, Faith told the researcher:

> *"Uh … to me, I understand that the power is on men's side, because many men use power against women according to my experience." (Freeman, 2010, p. 55)*

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

Childhood perceptions of power of control

For the majority of the women interviewed, their childhood perceptions of power of control in their families of orientation were tainted by memories of conflict between their parents. The women narrated how their mothers often held power as the persons in charge of the households while their husbands were away at work or when the husbands were incapacitated by alcohol. By virtue of being men, when these fathers were at home, however, they automatically held the position of power of control and the mothers became submissive. In this regard, their power of control comes from socialisation in their families of orientation, which regard women as naturally submissive to men. This power of control held by men also include sexual power in which men exercise control over their wives or partners when and how to engage in intimate and sexual activities, which perpetuate women's risk to GBV.

Women interviewed felt that in their own intimate relationships, the men were socialised to be in control of the household. Two of the women learnt from the negative experiences of GBV from their mothers, who had been exposed to alcohol abuse and physical abuse, not to be silent about violence. In their case, the experience of observing how their parent behaved at home, made them become self-assertive and learn not to tolerate GBV. Both women later in life would use the lessons from their parents' relationship to their own situation when both were exposed to violence in their own intimate relationship by leaving such relationships.

Women's Perceived influences of relationships on working lives of the respondents

All five women reported that power imbalances and GBV negatively affected every aspect of their personal health, well-being and working lives, which are similar to the findings of Manfrin-Ledet and Porche (2003). The women perceived the influences of power and GBV relationships on their working lives as barriers to their economic development, because GBV negatively affected their concentration levels at work, making them less productive in the workplace. Sandra said, for example:

> *"… the emotional abuse affected my working life in the sense that I lost concentration on my work. My partner regarded my work as less important. There were times that I had to stay away from work, because of a situation (physical fight), that had arisen at home the previous day. The unhappiness made me as an individual not being able to concentrate at work." (Freeman, 2010, p. 59)*

Sharing the same sentiment one of the women, Faith, stated:

> *"… when we sometimes had differences with each other at home, then that made me very unhappy. When I reached work, I am not feeling good. I feel stressed. Sometimes I feel emotional. Sometimes I even cry at home and when I come to work that is not good. I am suffering at work, because outside I look okay but inside I am struggling, I am not fine." (Freeman, 2010, pp. 59-60)*

The majority of the women experienced that GBV in its different forms contributed to their physical tiredness in the workplace, which in turn contributed to them encountering backlogs in their workload.

This expanded the cycle of GBV back to their homes where they in turn had stressful outburst towards their own children. In Freeman (2010, p. 60) Lina, one of the women puts it this way:

> *"I am the one who takes the lead in the house; my husband does not support me at all. This has an influence on me as a mother and a working woman. It imposes too much pressure and stress on me. It is really affecting me in my workplace, because most of the times when I come to work I am tired. The tiredness contributes to some backlog in my work and performance … the thing is, I am already tired, so when I reach work then there is also another type of stress awaiting me. So when I go back home I am still tired and it then causes me to stress with my family at home, which also affects my children."*

Women's Perceived influences of relationships on the health of the respondents

Sandra, one of the participants in Freeman (2010), narrated her experience as follows:

"Unfortunately, it happened on a very emotional level, because I was a bit inexperienced and unexposed to relationships. The fact that I was very young and my boyfriend six years older than me, contributed to me not being in a position of power to take decisions to protect myself from compromising my health. My boyfriend used to drink a lot and had a lot of other sexual partners. When I found out that our relationship was not confined to only the two of us, but that there were other people involved, I went for an HIV test and discovered that I was HIV-positive." (p. 60).

Sandra's experience of the perceived influence that her relationship had on her health was similar to what DiClemente and Wingood (2000) found, namely that as power between men and women increases and favours men, women will be more likely to experience

adverse health outcomes. Meaning that men's control over women's sexuality, for example men deciding when, where and with whom to have sex, greatly contributes to the spread of HIV. This woman perceived power inequalities between men and women to play a key role in putting women at risk of HIV-infection.

In this regard, the woman's perception and experience of the perceived influence that her relationship had on her health resonated with the research findings by Pettifor, Measham, Rees and Padian (2004, p. 1996), stating that gender power imbalances play a key role in the HIV epidemic. This participant perceived her lack of sexual and decision-making powers in her intimate relationship as constraining, because it decreased the likelihood of consistent condom use and increased her risk of becoming infected with HIV. Her perception and experiences clearly reflected gender power imbalances, which are similar to the findings by several other researchers (DiClemente & Wingood, 1997) who suggested that gender power imbalances constrain women in negotiating safer sex. Sandra's experience is an example of a woman who was a victim of power imbalances and GBV, and as a result, she became infected by HIV. One of the participants' experiences resonate with research findings by Brown et al., (2003), where it is evident that the experiences she did not have were, amongst others, the communication and assertiveness skills to cope with gender power imbalances and GBV. Her low self-efficacy resulted in a lack of power and control in her intimate relationship, which contributed to her being less likely to negotiate safer sex with her partner – and that is just some of the many reasons for her to have become HIV positive.

Campbell (2002, p. 1331) states that increased health problems such as Sexually Transmitted Infections (STIs), post-traumatic stress disorder and depression are well documented in research on abused women. Meghan, one of the women in the study by Freeman (2010), reported:

> *"When I was still married I did not take care of my whole self: of my physical, my spiritual and my mental side. I went through a very deep dark hole of stress and depression, and at the end I was suicidal. The whole relationship really impacted my life and my health in a big way. I did not eat properly, I did not exercise properly. I really neglected myself." It is evident from Meghan's experience that she experienced self-reported gastro-intestinal symptoms (for example, loss of appetite, eating disorders) and diagnosed functional mental health effects such as depression and post-traumatic stress disorder" (p. 62).*

Perceptions of Gender-based Violence

All of the women interviewed in the study by Freeman (2010), had in line with other researchers (Dunkle, Jewkes, Brown, Gray, McIntyre & Harlow, 2004), correctly defined GBV as not limited to acts of physical abuse, sexual abuse or psychological abuse by intimate partners, dating partners or family members; childhood sexual assault of girls and rape. In the section to follow, we discuss findings on emotional abuse or psychological abuse, physical abuse, sexual abuse and economic abuse as per the participants' perceptions and experiences.

Women perceived Emotional of psychological abuse

For all women, exposure to emotional abuse in the form of insults, belittlement and humiliation by male partners in the presence of other people, invariably led to stress disorders and depression-related diseases. Meghan, in Freeman (2010), stated:

> *"I felt emotionally abused, because most of the times in our relationship and in my marriage he made me feel like I am nothing. He made me feel as if I do not have any*

> *brains. This is why I am quiet in his company. He has a high profile job and when we were invited to high profile meetings and parties, he would just look at me when I had to say something. When I had a conversation with someone, he always looked at me in a very intimidating manner. It was as if I had to count my words. So I think that is emotional or psychological abuse. He made me think that I am unable to converse with people … I am a dumb blonde. When I had to speak I felt small and it felt like I really did not have brains. And that is one of the main reasons why I divorced my husband. He abused me emotionally and psychologically causing me to suffer from depression." (p. 69)*

Physical abuse

Three of the women suffered physical abuse at the hands of their male partners, while the other two women never experienced physical violence. What is significant about two of the women's experiences of physical violence are that they managed to break the cycle of violence. They both left the abusive relationships and never returned. One of the participants in the study by Freeman (2010), Sandra narrated:

> *"My partner used to slap me in the face. At some stage my partner kept me hostage; he did not want me to go out. And because of the controlling powers he had by locking me up in the house I was not able to go anywhere … When my partner and I would not agree on an issue it resulted in a beating or a slap…It was then that I realised that something was wrong. I had allowed the situation to happen. I decided to do something. It was then that I stood up and ended the relationship." (p. 70)*

In the study by Freeman (2010), Meghan responded:

> *"Yes, through our 17 years of marriage, once or twice I got a slap or two, and that was usually because of certain decisions I made or for the fact that I was who I was." (p. 70)*

What is significant about two of the participant's experiences of physical violence are that they managed to break the cycle of violence. They both left the abusive relationships and never returned. Carien (in Freeman, 2010) narrated her experience of physical violence as follows:

> *"My ex-husband on several occasions, while I was breastfeeding the two baby boys respectively, physically beat me with broomsticks. He was so upset and didn't even care about the babies…He always used to beat me in front of the children…The next day I would call work, informing them that I was not feeling well and that I would not go to work. However, after two days, when I got to work the blue eyes were not gone permanently. I would then cover it with make-up, and lied to my colleagues that I had bumped into a cupboard. I always feared Kevin. I thought it was love, but it was actually fear, hatred and anxiety." (p. 71)*

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

Sexual Abuse

In Freeman (2010), two of the women, Carien and Sandra, reported alleged sexual abuse. Carien said:

> *"With my previous partner (ex-husband), he had forced sex on me. I can still recall … I remember that day when I was drinking the tablets, wanting to commit suicide. All I remember was that he dragged me into the lounge, where he turned me onto my stomach and had anal sex with me against my will. I do not know whether I felt it. I was not myself." (p. 71)*

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

Economic abuse

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

> *"My partner had different sexual partners who also had financial needs, and he would spend his part of the income with the outside partners, which was supposed to be shared by the household. At times I would compromise, and spend money on him. I would provide him with money to spend with his friends and entertain them, or buy him expensive clothing … My partner prevented me from selling, he would prefer me to stay in an Environment where he knows the people I am interacting with, and probably also to keep an eye on what I am doing. He tried to prevent me from socialising with others outside our relationship." (pp. 72-73)*

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

> *"My husband many times failed to provide money to run the household or to look after the children, but then he had money to spend on alcohol. For example, my husband will just go to the bank to withdraw N$1000 and then go to the shebeen. When he comes home he will have nothing, not even ten dollars … imagine. Then the next morning he will go to the cash loan, where he leaves the bank card. Then he uses that money from the cash loan to go and drink, and when he comes home he has nothing." (Freeman, 2010, p. 73)*

Meghan said:

> *"Yes, it was once, he was so cross, we had a fight and he wanted me to stop flying. I asked him where I am going to get a job tomorrow! … So at times he distrusted me and he wanted me to stop flying. So he once prevented me. He took my car and I could not get to work. I had to take a taxi." (Freeman, 2010, p. 73)*

Carien explained:

> *"I was working at the University of Namibia for 12 years. I had a very good job. He made me resign. He forced me to resign because he said that I was sleeping with other men … He one day came into my office and said, 'Today you are going to resign.' He wanted my pension money. So I resigned from the University of Namibia. After I received my pension money he was the one in charge of my money. I then got another job at the Namibian National Broadcasting Corporation. I also worked there for 12 years, but he once again forced me to resign, accusing me of sleeping around with other men. This time I was so afraid and shy – thinking that people knew what happened before – so I was forced to resign again. I took my pension money and we went to South Africa." (Freeman, 2010, pp. 73-74)*

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

The Consequences of GBV for Working Women

In the study by Freeman (2010), Meghan stated that she resigned from a job due to GBV. Another woman also resigned twice from previous jobs due to her experience of GBV. The following excerpts show how GBV impacted on working women's lives where Meghan said:

> *"Due to depression, I could not cope and concentrate when I had to get to my work. GBV really had an impact on my decision-making, because by then I worked in a highly safety-conscious environment on the aircraft. I could not make decisions – that is the reason why my psychologist advised me not to go to work or to fly. She grounded me for treatment of depression for a certain period of time until I got my confidence back and had a balance. So, yes of course it greatly impacted on my thinking and my decision-making and my normal progress and working environment." (Freeman, 2010, p. 74)*

Meghan's excerpt highlights working women's experiences as victims of GBV, which are similar to findings by Anderson et al., (2008, p. 75), who state that it includes 'choice disability', reduced self-esteem, lack of coping skills, or psychopathology such as depression. Carien's experience as a victim of GBV and a working woman is illustrated in the following narrative:

> *"Yes, GBV affected me a lot as a working woman because I was always afraid. I was stressed. I sometimes even took my stress out on my colleagues, which was not good. I could not concentrate at work. In the morning I would feel fresh and happy, but when it came to lunch time and by five o'clock I was in fear, because I had to go home. I knew that I was going to be beaten up. I knew that we were going to have arguments. I knew it all. When I arrive home I am tired and if I am not in a mood to perform sexual activities then I face violence." (Freeman 2010, pp. 74-75)*

The majority of the women confirmed that women working in aviation are at risk of GBV due to the nature of their jobs. This is because the aviation business often demands shift work or being away from home for some time. In this regard Meghan said:

> *"He once wanted me to quit my job. We had a fight and he wanted me to stop flying. At times he distrusted me and he wanted me to stop flying. He once even prevented me from getting to work. He took my car and I could not get to work. I had to take a taxi. The emotional and psychological abuse in my marriage was one of the main reasons why I divorced my husband." (Freeman, 2010, p. 75)*

Carien said:

> *"In my case I am working shifts, and let me say working shifts is a problem. I know that I am going to be beaten if I refuse sex. I know all the … I know, I know, I know…" (Freeman, 2010, p. 75)*

Sandra's perception is, that:

> *"…women are most at risk of GBV at home, because home is an environment where man is protected from the outside, where the outside might not see what happens in the inside of the home … Men might have the power at home where they will lock you up, because they may be scared that if you as the wife go out, you maybe go the police and they fear the authorities." (Freeman, 2010, p. 75)*

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

Perceived relationship between GBV and HIV

All of the women had heard of HIV and AIDS. All of them were able to correctly identify how HIV is transmitted. The majority of them learned about HIV and AIDS at school, via the media (mainly the radio, television and newspapers), at the workplace and through other people. However, according to the Namibia Demographic and Health Survey (as cited in the Namibia Ministry of Health and Social Services, 2008a), despite high levels of knowledge about modes of HIV transmission and prevention many women in Namibia lack control over their own reproductive health.

In the study a number of the participants faced challenges in negotiating safer sex. All of the women interviewed felt personally at risk to become infected with HIV. All five knew about VCT, had gone for testing and knew their HIV status. Four of them also knew their husband's/partner's HIV status. Moreover, all five women perceived that there was a link between GBV and HIV. In this regard, Sandra said:

> *"Women in relationships do not really have a lot of say. They do not have the power to decide in a relationship. The male partner will always be the one to initiate the sexual activities … And above the fact that you as a woman know, especially in a situation whereby there are multiple concurrent partners involved, you will not say much out of fear that the man will get violent. Based on my personal experience, as a woman I found it difficult to get out of that relationship. I pretend to accept the abuse ... I had to settle for this abusive relationship where my partner was involved in multiple concurrent relationships, abused alcohol … in which I became infected with HIV as well. I said it is okay, he will come back tomorrow. The violence just never stopped … I always felt a victim." (Freeman, 2010, p. 76)*

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

Faith also confirmed that she perceived a link between GBV and HIV:

> *"Yes, I do see a relationship between these two, because…to me some people are difficult to talk to when it comes to the part of sex. You want to ask the person to use a condom, but you are afraid he will not want to use a condom and then it causes you to be infected by HIV." (Freeman, 2010, p. 77)*

Sandra said:

> *"The socio-cultural challenges are such a pity, because the cultural norms are withholding women from exercising their rights, we women do not have a choice on whether to be infected or not infected." (Freeman, 2010, p. 77)*

Sandra's narration is supported by Strebel, Crawford, Shefer, Cloete, Henda and Kaufman (2006), as they state that culturally-sanctioned gender roles are intimately connected with both GBV and HIV-infection risk.

Condom use

The majority of the women confirmed that they were able to negotiate condom use with their partners. One of the participants' husbands is HIV positive, whereas she has been HIV negative at the time the study was conducted. They are using condoms as a protective measure. However, one of the participants' experiences at the hands of a controlling partner resulted in her being HIV positive. This finding that the majority of the women reported that they were able to insist or negotiate for condom use is different from most of the findings by other researchers such as Ipinge et al., (as cited in LaFont & Hubbard, 2007, p. 222). Although this warrants further investigation, the researchers speculate that, because the five women had high levels of education and, because the use of condoms could be construed as protecting the males in these relationships, most of these women found condom use less problematic than what is usually reported to be the case with women who are disempowered, because of GBV.

Participant's Suggestions on how to address GBV at the Workplace

The women experienced GBV exclusively behind closed doors in their homes and at the hands of their husbands or male partners (and in one case of a grandfather). They did not experience GBV at the workplace – **in fact, the workplace was a safe sanctuary away from the chaos of their homes**. Thus, their suggestions pertained to how the workplace might extend its influence to address problems experienced by women in their domestic and familial spheres. One such suggestion was that workplaces could conduct educational sessions on signs, possible causes, and prevention of GBV and HIV-infection. The women suggested that workplaces should employ trained professionals, (such as Social Workers) in whom the staff can confide to get assistance for GBV. This was seen as preferable to women going to the police, as many women are too fearful to report abuse to the police. The women suggested the investigation of granting special family leave for women facing GBV to get the help that they need and to address their domestic problems. The women identified the need for workplaces to train all managers and supervisors in maintaining confidentiality, non-discrimination and in the handling of disclosure. They also suggested the establishment of workplace support groups for women facing GBV. Other suggestions were to have gender-specific activities for women and men separately, to educate them on issues of GBV.

Discussion: Summary and Interpretation

The findings of the study by Freeman (2010), does support the aim and objectives of this manuscript in providing a backdrop for research within which the authors demonstrate the significance of the presence of an employee Assistance Program (EAP) in the women's workplace, providing a safe sanctuary away from the chaos of their homes. Freeman's (2010), findings support the theoretical perspective that our understanding of power in relationships be viewed from a contextualized gender lens. It generates evidence that showed that all of the participants experienced power imbalances and different forms of GBV in their personal relationships with males. From the analysis of the experiences of these women, it is apparent that there are some commonalities in their experiences of power

imbalances and GBV. The majority of women in the study perceived power imbalances in their intimate relationships as one of the determinants putting them at increased risk of GBV and HIV-infection.

Power imbalances were perceived as constraining women in negotiating safer sex. They all experienced constrained decision-making powers. Overall, Freeman (2010) suggests that power imbalances by controlling men who commit GBV against their female partners have negative outcomes for the emotional, psychological, physical and economic well-being of the women.

In terms of challenges experienced by working women regarding power imbalances and GBV, evidence showed that all of the women experienced such challenges – not only in their workplaces, but also, and more often, in their homes. To the majority of the women, the workplace's Employee Assistance Programme (EAP) represented a space in which they could learn coping skills to address gender power imbalances and GBV. The workplace, through its interventions such as EAP and access to a social worker, enabled the majority of the women to forge new identities as women who have survived and conquered GBV. The women made use of workplace-related support structures such as earning a salary to make them financially independent to some extent, access to EAP and to on-site VCT and risk prevention (in the form of free condom distribution). Freeman (2010) found that the workplace EAP provided a safe and supportive platform where women gained emotional healing.

The research findings showed unexpected results on how power imbalances and GBV put working women at risk of HIV-infection. The findings as reported showed that working women can negotiate their HIV-infection risk well, because they earn a salary which makes them financially self-sufficient to some extent. Having access to EAP, and learning about VCT and risk prevention in the workplace has enabled the majority of the women in the study to avoid risks. Thus, being working women, the respondents were able to turn their GBV experiences into positive outcomes for themselves. However, this should also be seen in the light of the possibility that the women who had volunteered to participate in the study probably self-selected as those who have already dealt with the immediate physical dangers of GBV.

Recommendations

We believe that the study by Freeman (2010), through its literature review had successfully filled the gap that other researchers in the field have not focused on namely, to focus on working women's perceptions of power, GBV and HIV-infection risk. Secondly, the study has also filled some of the gaps in the society's understanding of working women's perceptions and experiences of power, GBV and HIV-infection risk in an airline business. To the majority of the women, the workplace's Employee Assistance Programme (EAP) represented a space in which they could learn coping skills to address gender power imbalances and GBV. The workplace, through its interventions such as EAP and access to a social worker, enabled the majority of the women to forge new identities as women who have survived and conquered GBV. The women made use of workplace-related support structures such as earning a salary to make them financially independent to some extent, access to EAP and to on-site VCT and risk prevention (in the form of free condom distribution). Freeman (2010) found that the workplace EAP provided a safe and supportive platform where women gained emotional healing. We are recommending that this understanding be used for practical purposes in terms of policy and practice.

In conclusion, the following recommendations are made:

Personal level

To reduce the prevalence and incidences of power, GBV and HIV-infection risk among female employees in an airline business in Namibia, behavioural change approaches such as cultural re-orientation and socialisation are recommended at a personal level. This will help with changing attitudes and norms. Therefore we recommend the development of Behavioural Change Communication strategies in the airline business that creates public awareness and challenge individual and collective beliefs, attitudes and general mind sets in the elimination of power imbalances, GBV, and HIV and AIDS at a personal level.

Company/Institutional level

At company level, the airline business in Namibia should expand and continuously support efforts such as access to EAP access, VCT as well as the promotion of correct and consistent use of condoms, which are found to be key elements of HIV prevention in this study. It is imperative that professionals in the airline business, working with women who experience power imbalances, GBV and HIV-infection risk, remain sensitive as possible whenever they interact with their clients or patients. Expanded airline business HIV workplace prevention programmes in Namibia should include discussions on gender roles and expectations, relationships and sexuality for both men and women. Men as essential stakeholders in the airline business in Namibia should be engaged in HIV prevention efforts in the enhancement of women's sexual decision-making powers. The values of the airline business regarding power, GBV and HIV-infection risk must be made explicit through the implementation of company policies and programmes.

Community level

At the level of community, we recommend educational and training programs, targeting views, values and norms that consider women as inferior and equality as undesirable or impossible. In this way, ordinary people in Namibia can be made conscious and encouraged to question negative social norms and believes that perpetuate GBV, injustice and inequality.

Government level

For the government of Namibia, we strongly recommend legislation that carries enforcement weight. This means that we should not only have well-defined laws passed, but we also should have mechanisms to implement and enforce, especially these laws which recognize women's legal rights and those that punish offenders.

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

Conclusion

The study by Freeman (2010) argues that power imbalances, GBV and HIV-infection risk have existed for decades, and have been perpetuated and sustained by the belief that perpetuates men's power and control over women. Therefore, we are concluding this manuscript with the finding and understanding that to the majority of the women, the workplace's Employee Assistance Programme (EAP) represented a space in which they could learn coping skills to address gender power imbalances and GBV. The workplace, through its interventions such as EAP and access to a social worker, enabled the majority of the women to forge new identities as women who have survived and conquered GBV. The women made use of workplace-related support structures such as earning a salary to make them financially independent to some extent, access to EAP and to on-site VCT and risk prevention (in the form of free condom distribution).

Freeman (2010) found that the workplace EAP provided a safe and supportive platform where women gained emotional healing. In an attempt to successfully address the problems of power imbalances, GBV and HIV-infection risk, Brown et al. (2003, p. 1420) stated that community and societal transformation which defies societal/cultural are needed.

In conclusion, this manuscript attempts to provide you with a backdrop for research within which the authors demonstrate the significance of the presence of an employee Assistance Program (EAP) in the women's workplace, providing a safe sanctuary away from the chaos of their homes. We want to leave you with a statement from the United Nations former Secretary-General Mr Kofi Annan (as cited in Pettifor, Measham, Rees & Padian, 2004, p. 2003) addressed to all those partners involved in the prevention and combating of GBV in the world, stating that:

> Empowerment of women and girls must be made a priority focus area for HIV prevention to protect themselves against the virus … What is needed is positive change that will give more power and confidence to women and girls. Change that will transform relations between women and men at all levels of society.

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