



Violence Against Women and HIV/AIDS: Critical Intersections

Information Bulletin Series, Number 1

Intimate Partner Violence and HIV/AIDS

Why focus on violence against women and HIV/AIDS?

"It is impossible to talk about HIV/AIDS without talking about domestic and sexual violence (Peer educator for men, Men as Partners Program, South Africa)".

Today, half or more of the 40 million people infected with HIV in the world are women. Millions of those infected with HIV are young people aged 15-24 years who now account for half of all new infections. And perhaps most disturbing of all, in sub-Saharan Africa, young women (15-24 years) account for 75 % of HIV infections and are approximately three times more likely to be infected than young men of the same age¹. So, what makes women, especially girls and young women so disproportionately vulnerable and why have current AIDS control efforts largely failed to stem the epidemic in women and girls?

The high rates of HIV infection in women have brought into sharp focus the problem of violence against women. There is a growing recognition that women and girls' risk of and vulnerability to HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. Studies conducted in many countries indicate that a substantial proportion of women have experienced violence in some form or another at some point in their life. Studies from Rwanda, Tanzania, and South Africa show up to three fold increases^a in risk of HIV among women who have experienced violence compared to those who have not^{2,3,4}. For millions of women, the experience or fear of violence is a daily reality and increasingly, so is HIV/AIDS.

Violence against women is well recognized as a gross violation of human rights and a public health problem,

an epidemic that often overlaps with the AIDS epidemic. This information bulletin is the first in a series of four, presenting evidence on how violence against women and girls in its different forms increases their risk of HIV infection and undermines AIDS control efforts. It focuses on the links between **intimate partner violence (IPV) and HIV/AIDS**. Subsequent bulletins, will focus on the linkages between HIV/AIDS and a) violence against women in conflict settings; b) violence against sex workers; and c) trafficking of women and girls. In doing so, we hope to spur action at different levels (i.e. donor, policy, community) and across sectors (health, education, legal) to integrate programming for violence against women with HIV prevention and AIDS treatment and care; reduce women and girls' vulnerability to HIV; and protect and promote their right to be healthy and free from violence.

What constitutes intimate partner violence?

Violence perpetrated by an intimate partner^b is widespread globally. It includes:

- Physical violence (e.g. slaps, punches, kicks, assaults with a weapon, homicide);
- Sexual violence (e.g. rape, coercion and abuse includes use of physical force, verbal threats, and harassment to have sex, unwanted touching or physical advances, forced participation in pornography or other degrading acts that often persist over time and are accompanied by threats on part of the perpetrator);
- Psychological violence (e.g. belittling the woman, preventing her from seeing family and friends, intimidation, withholding resources, preventing her from working or confiscating her earnings).

¹ Unless otherwise specified, the odds ratios reported are adjusted for other factors.

² It is also referred to as 'Domestic Violence', 'wife abuse' or 'battering' referring to the fact that for many women it occurs within the context of the home. We use the term intimate partner violence to emphasize that it is perpetrated by any intimate partner or ex-partner regardless of the legal status of the relationship.

Rape is often assumed to occur as a violent attack by strangers. In reality, most forced sex is committed by individuals known to the victim such as the intimate partner, male family members, acquaintances, and individuals in position of authority. For many girls and young women, their first sexual encounter is coerced, with younger girls more likely to experience sexual coercion at initiation than older ones.

The extent of the problem: Prevalence of violence against women and girls

- Globally, between 10 and 69 % of women report physical abuse by an intimate partner at least once in their lives.
- Between 6 and 47 % of adult women worldwide report being sexually assaulted by intimate partners in their lifetime.
- Between 7 and 48 % of girls and young women age 10-24 years report their first sexual encounter as coerced.

Source: WHO 2002; Garcia-Moreno and Watts 2000; Heise et al. 1999

Where and how do intimate partner violence and HIV/AIDS intersect?

The links between intimate partner violence and HIV/AIDS are explained by biological as well as socio-cultural and economic factors. Ways in which the two epidemics intersect are described here with the caveat that pathways, causal or temporal links between violence against women and HIV/AIDS are quite complex and not completely understood.

I) *Direct transmission through sexual violence:*

Forced or coercive sexual intercourse with an HIV infected partner is one of the routes of transmission for HIV and sexually transmitted infections (STI) to women. The biological risk of transmission in a violent sexual encounter is determined by type of sexual exposure (vaginal, anal or oral)^c. HIV transmission risk is also generally higher in presence of other STI and with exposure to sexual secretions and/or blood. Risk of transmission is also increased with the degree of trauma,

vaginal lacerations, and abrasions that occur when force is used. Where sexual violence occurs in girls and young women, risk of transmission is also likely to be higher because girls' vaginal tracts are immature and tear easily during sexual intercourse. Evidence of direct transmission of STI and HIV following sexual violence is difficult to establish. Two studies from the U.S.A suggest that while women who are raped are at high risk for pre-existing STI, sexual assault itself presents a small but substantial additional risk of acquiring STI^{5,6}.

II) *Indirect transmission through sexual risk taking:*

There is growing evidence that the relationship between violence against women and HIV infection in women and girls may be indirectly mediated by HIV risk-taking behaviours. Studies show that women's experience of violence is linked to increased risk-taking including having multiple partners, non-primary partners (or partnerships outside marriage) or engaging in transactional sex^d. For example, one study in South Africa showed that women who experienced intimate partner violence were two to three times more likely to engage in transactional sex than women who did not experience violence. Moreover, women who reported transactional sex and had non-primary partners had 1.5 fold higher odds of being HIV infected than those who did not report transactional sex⁷.

Sexual abuse during childhood and forced sexual initiation during adolescence are also associated with increased HIV risk-taking among women. For example, in the U.S.A, several studies show that experience of childhood sexual assault is associated in adults with early sexual initiation, anal sex, sex with unfamiliar partners, and low rates of condom use⁸. In Nicaragua, one study found that women who were severely sexually abused in their childhood and adolescent years made their sexual debut more than two years earlier and reported a higher number of sexual partners than those who had experienced moderate or no sexual abuse⁹.

III) *Indirect transmission through inability to negotiate condom use:*

While the evidence is not conclusive, research suggests that violence limits women's ability to negotiate condom use. For example, in a study from the U.S.A, African-American women who

^c Transmission of HIV is higher for anal followed by vaginal and oral sex.

^d Transactional sex is defined as exchange of sex with men for material gains and basic survival needs. Women who exchange sex for money may not necessarily identify themselves as sex workers.

had physically abusive partners were four times more likely to be verbally abused and nine times more likely to be threatened with physical abuse when they asked their primary partner to use condoms compared to those who did not have abusive partners¹⁰. In a study from South Africa, women who experienced forced sex were found to be nearly six times more likely to use condoms *inconsistently* than those who did not experience coercion and, in turn, women with inconsistent condom use were 1.6 times more likely to be HIV infected than those who used condoms consistently¹¹. On the other hand, another study from South Africa found that women who were physically abused prior to the past year were 1.5 times more likely to ask their current partners to use condoms than women who were not abused¹². As these have been cross-sectional studies and measures of condom use and violence have differed across studies, it is difficult to draw definite conclusions about how partner violence is linked to condom use. Certainly, qualitative data from studies in Uganda, India, and elsewhere indicate that women find it difficult to suggest or insist on condom use in face of or threat of violence^{13,14}.

Marital violence, condom use, and HIV risk

"My husband hated condom use. He never allowed it. He would beat me often. He used to beat me when I refused to sleep with him. He wouldn't use a condom. He said when we are married, how can we use a condom? It's a wife's duty to have sex with her husband because that is the main reason you come together. But there should be love. When I knew about his girlfriends, I feared that I would get infected with HIV. But he didn't listen to me. I tried to insist on using a condom but he refused. So I gave in because I really feared [him]." (A 31-year-old Ugandan woman)

Source: Human Rights Watch 2003⁽¹⁴⁾

IV) Indirect transmission by partnering with riskier/older men: A review of over 40 studies from sub-Saharan Africa suggests that a significant proportion of adolescent girls have sexual relations with men five to ten years older than themselves^c. While girls are able to initially choose the older sexual partner, once in the relationship, it is the older men who control the sexual

relationship including condom and contraceptive use - in some situations through the use of violence¹⁵. Emerging evidence from a study conducted among young women (16-23 years) in South Africa suggests that women who have partners older than them (i.e. age difference of three or more years) have 1.6 fold higher odds of being HIV infected and young women with older partners are 1.5 times more likely to experience physical and sexual violence than women with partners in the peer age group¹⁶. The researchers suggest that partner violence may be a feature of relationships with older men and that age difference between partners increases young women's HIV risk because older men have a much higher prevalence of HIV¹⁷.

Several studies also highlight that men's use of violence is linked to their own sexual risk taking and hence, their own as well as their partner's risk of STI and HIV. For example, in India, a study showed that men who had extramarital sex were six times more likely to report sexual abuse of their wives than men who remained faithful. Moreover, men who reported an STI were 2.5 times more likely to report abuse of wives than men who did not report an STI¹⁸. The researchers concluded that abusive men were more likely to engage in extramarital sex, acquire STI, and place their wives at higher risk for STI possibly through sexual abuse. In another study from Cape Town, South Africa, men who reported use of sexual violence against intimate partners were nearly twice as likely to have multiple partners compared to those who did not use sexual violence¹⁹.

V) Violence as a consequence of being HIV

positive: Violence or fear of violence has been implicated as a barrier to women seeking HIV testing. In Uganda, research indicates that women were afraid to ask for money or permission from their husbands to attend HIV/AIDS facilities or seek information and in some cases explicitly forbidden from taking HIV tests²⁰. Violence or fear of violence has also been implicated as a barrier to disclosure of HIV status among those women who do seek testing. Between 16 - 86 % of women in developing countries choose not to disclose their HIV status to their partners. On the other hand, disclosure of HIV status is considered to be important

³ ^c For many adolescent girls, older men provide gifts or offer life chances in terms of education by paying for school fees as part of the sexual exchange. For older men, preference for adolescent girls is partly driven by the belief that the girls may be free of AIDS.

for ensuring that HIV positive individuals are able to access a range of services including prevention of mother to child transmission (pMTCT), anti-retroviral treatment (ART), and psychosocial support²¹. For example, disclosure by HIV positive women to their sexual partners could enable couples to make informed reproductive health choices such as seeking family planning services to reduce unintended pregnancies or it could lead to changes in HIV risk behaviours. Studies on disclosure suggest that for a majority of women, their partners' reaction was sympathetic and understanding. However, between 3 - 15 % women in most studies reported negative reactions including blame, abandonment, anger, and violence. Among those who do not disclose their status, fear of violence is one of the major barriers to disclosure - reported by between 16 - 51 % women in studies from Tanzania, South Africa, and Kenya²².

HIV disclosure and violence

In 2000 Susan Teffo discovered that she was HIV-positive. When she told her husband of her status, he grabbed her and burnt her face over a primus stove. Her four-year old son was also burnt when he tried to stop his father from hurting Susan. Susan laid charge of attempted murder against her husband, but did not plan to leave him. If she divorced him, she would lose access to her husband's medical aid, which provided life-prolonging anti-retroviral drugs.

Source: Vetten and Bhana 2004

What are the opportunities to address intimate partner violence in HIV/AIDS programming?

Programs implemented by women's groups have addressed violence against women for many years. Many of them are on a small scale, often not adequately resourced, operating in isolation, and may not be scaled up easily. A growing number of HIV/AIDS and reproductive health programs are beginning to address violence against women. We describe some interventions with the caveat that they do not cover all types of programs related to violence against women and

HIV/AIDS. Moreover, many of these interventions have not been fully evaluated and, therefore, there is not enough evidence that they work or to qualify them as good practices. However, they provide promising ideas for further intervention research using more rigorous methods.

D) Behaviour change communication strategies (BCC): BCC interventions are recognized for their potential in creating public awareness and challenging individual and collective beliefs and attitudes towards an issue. In the area of violence against women, BCC strategies recognized as having raised public awareness of violence and created an enabling environment for policy changes are: 'Soul City' reaching 16 million South Africans and 'Sexto Sentido' reaching more than half a million young (13-24 years) Nicaraguans. Both these use educational entertainment - i.e. television and/or radio drama and print media - to educate young people about social and health issues including violence and HIV/AIDS.

Soul City

In 'Soul City', a series of television and radio drama episodes and informational booklets highlighted domestic violence, sexual harassment, date rape and HIV/AIDS. 'Soul City' also established a partnership with the South Africa's National Network on Violence against Women to convey information on women's rights, connect its audiences to needed services, create training materials on violence against women, and push for legislative changes. Evaluation of this series showed a decrease in tolerance towards violence against women and an increase in interpersonal communication about violence. The series also encouraged the implementation of a national legislation on domestic violence by mobilizing funds for training service providers and educating communities.

Source: Guedes 2004⁽²⁵⁾

II) Role of health services in addressing violence against women: Health services including those focused on AIDS provide an important and potential entry point for identifying and responding to women who experience violence. Cross-training those working

on HIV counselling and those working on domestic violence may be an effective strategy to sensitize providers on the dynamics of both epidemics. For example, providers can facilitate women to receive care for their physical injuries, treatment for sexual and reproductive health problems that are associated with violence (e.g. STI, pelvic pain, unwanted pregnancies), and get referrals to other services that they may need. In voluntary counselling and testing (VCT) clinics, identification of women experiencing violence may enable counselors to offer appropriate advice on disclosure to HIV positive women. One strategy for addressing violence in the VCT context is couple testing and counselling followed by mediated disclosure as a potential way of reducing tensions between partners and adverse consequences for women²³. It is important that health services develop context specific responses to violence against women based on existing resources, level of staff training, referral options, and availability of other services.

III) Programs targeting gender attitudes and norms: Gender and sexual norms related to masculinity and femininity play a central role in contributing to violence against women. In many societies, manhood or notions of an ideal man are defined in terms of providing for the family, honour, respect, and being sexually controlling whereas, notions of an ideal woman are defined in terms of being submissive, disciplined, respectful, and sexually passive. Men use violence against women as a way of disciplining women for transgressions of traditional female roles or when they perceive challenges to their masculinity. Several programs have used principles and methods from adult education to target gender and sexual norms underlying violence against women. Examples of such strategies include the Men as Partners (MAP) program in South Africa, and the Stepping Stones intervention implemented in a number of African countries^{24,25}. These strategies involve working in depth with peer groups to explore ideas, attitudes, behaviours and values related to sexuality and gender relations as well as STI, HIV and reproductive health problems.

Stepping Stones program

Stepping Stones is a participatory training program developed for HIV prevention in rural communities that aims to improve participants' control over their sexual relationships by challenging gender norms and encouraging gender egalitarian relationships. It is based on the principles that the best prevention strategies are those developed by community members themselves and behavior change will be more effective and sustained when all members of the community are involved. It consists of 14 sessions of 2-3 hours covering topics such as relations between men and women, sex, sexual and reproductive health problems, love, HIV, STI, gender-based violence, why we behave in ways we do, grief/loss and dying, and negotiation and assertiveness skills. Stepping Stones has been used and adapted for many settings. An evaluation of a Stepping Stones pilot study in four villages in Gambia found that publicly witnessed intimate partner violence completely stopped after the intervention and this was sustained three years later.

Source: Welbourn 1995⁽²⁴⁾; Shaw and Jawo 2000

Efforts such as the MAP program have particularly focused on youth, as there is increasing recognition that young people are experiencing high levels of coercion and that equitable gender and sexual norms need to be promoted at an early age before they become deeply ingrained. A few youth programs for those in and out of school not only provide young people with the information, skills and services for HIV/AIDS and reproductive health, but also address violence against women. Examples of such programs include an in-school guardian program linked to the TANESA HIV/AIDS control project in the Mwanza region of Tanzania; the Guy-to-Guy project by Instituto PROMUNDO in Brazil with young men on sexual and reproductive health and gender violence; and the SiHLE (Sistas Informing, Healing, Living and Empowering) project with African-American adolescent girls who have been sexually abused^{26,27}.

Multi-sectoral approaches to address intimate partner violence and HIV/AIDS

Program responses to address violence against women have also been implemented through sectors other than health. These include public awareness campaigns, policy initiatives and advocacy efforts at the global level and in countries. On the other hand, HIV/AIDS programs have largely been implemented as health interventions. A few opportunities where both violence against women and HIV/AIDS can be synergistically addressed through multi-sectoral approaches are described here.

I) **Public Awareness:** Mass media and public education campaigns to raise awareness of violence against women and HIV/AIDS have been undertaken separately at the global and country levels. Their impact on changes at the community level is arguably more limited. Nonetheless, public awareness campaigns create an overall favourable environment in which other activities on violence and HIV/AIDS can be undertaken by giving visibility to the issues and mobilizing public and political support. Public education campaigns on violence against women include UNIFEM's 'Picturing a Life Free of Violence' campaign, the 'White Ribbon' campaign encouraging men to take action on violence against women, Amnesty International's 'Stop Violence Against Women' campaign, and the '16 Days of Activism' campaign to end violence against women^{28,29,30}.

II) **Economic empowerment of women:** Micro-finance and micro-credit interventions to improve household poverty and women's access to resources, opportunities and choices employ a system of group-based lending to enable women to start small businesses. Evaluation of micro-credit programs suggest that they empower women by improving their decision-making in the household and have health benefits such as improved nutrition, child health and contraceptive use. There is also evidence from a study in Bangladesh that micro-credit interventions may reduce partner violence³¹. In South Africa, the Intervention with Micro-finance for AIDS and Gender Equity (IMAGE) is being evaluated to assess whether micro-finance activities targeted to poor women combined with participatory

training in violence, gender roles, HIV prevention, sexuality, and relationships reduce women's risk for HIV³².

III) **Strengthening laws and policies:** Policies on domestic violence and related gender issues at the level of international treaties, national laws and legislations, and institutions play an important role in addressing violence against women and reducing women's vulnerability to HIV/AIDS. At the international level, the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW 1979) and the declaration of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS 2001) highlight the importance of violence against women for reducing HIV transmission and providing treatment and care for AIDS, and call on governments to develop and monitor legislations and related programs. Such agreements are being used to hold signatory governments accountable for addressing HIV/AIDS and gender equality in their respective countries through monitoring and advocacy. At the national level, networks of women's groups have pushed for better domestic violence laws and their enforcement in countries. For example, in Nicaragua, the Network of Women Against Violence focused its activities on reforming the justice system by drafting a domestic violence bill³³.

Conclusions and key messages

There is a compelling case to end intimate partner violence both in its own right as well as to reduce women and girls vulnerability to HIV/AIDS. The evidence on the linkages between violence against women and HIV/AIDS highlights that there are direct and indirect mechanisms by which the two interact.

- Coercive sex poses a direct biological risk for HIV infection resulting from vaginal trauma and lacerations;
- Intimate partner violence poses indirect risk for HIV infection in several ways:
 - Women with a history of violence may not be able to negotiate condom use;

- Childhood sexual abuse, coerced sexual initiation and current partner violence may increase sexual risk taking (e.g. having multiple partners, engaging in transactional sex);
- Women who experience violence may be in partnerships with older/riskier men who have a higher likelihood of being infected with STI and HIV; and
- Violence or fear of violence may deter women from seeking HIV testing, prevent disclosure of their status, and delay their access to AIDS treatment and other services.

Additional research is needed to clarify the causal and temporal links between partner violence and risk for HIV. For example, is violence triggered by women's demands for condom use or does a history of violence prevent women from demanding condom use? Does a history of partner violence prevent women from testing and disclosing or is violence triggered by a positive status and disclosure?

At the same time, given the magnitude of both problems and their devastating consequences on women, there is an urgent need to move forward on identifying, developing and scaling up interventions that jointly address violence against women and HIV/AIDS in women and girls. Several approaches for integrating violence against women and HIV/AIDS programming have been tried and these need to be further evaluated. These include:

- Behaviour change communication strategies
- Responding to violence against women through health services
- Programs targeting gender attitudes and norms
- Micro-credit interventions for economic empowerment of women
- Strengthening laws and policies related to domestic violence and gender equality

This information bulletin highlights the need to expand the scope of HIV/AIDS interventions and policies to make gender inequalities, intimate partner violence in particular, a central component in the fight against AIDS. And this requires sustained commitment, resources and political will among donors and policy-makers.

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