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CONTENTS

INTRODUCTION

"Last week one guy was telling his friends that he was going to rape all those girls who denied him before when he was clean. Now he was going to give them this AIDS and show them something."

(Leclerc-Madlala 1997: 372)

"A high school teacher shot dead his wife and mother-in-law and critically wounded his father-in-law before killing himself...a note written on a brown paper which read: "HIV Positive AIDS" was found on top of Mpho's body...According to a relative, the couple...went for an HIV test some two weeks ago...She (the relative) *suspected that Motloung had blamed his wife for contracting the virus."*

(*The Sowetan*, 23 August 2000)

These reports illustrate how two of South Africa's epidemics - violence against women and HIV/AIDS - may be converging in new and lethal ways. Yet current responses to HIV/AIDS and responses to violence against women remain split from one another and typically exist as parallel rather than complementary initiatives. To test this impression, we undertook a national scan to:

- identify and describe current activities by civil society bodies and government departments focussing on the links between violence against women and HIV/AIDS
- identify and describe gaps in current initiatives
- identify and describe current initiatives which can be built on and strengthened

This report documents our findings and argues that, to date, rape-related concerns have driven policy and legislative responses to a far greater degree than concerns about other forms of violence against women. While we can date the first public references to rape and HIV/AIDS to1996, this focus only truly took hold on the public agenda from 1999 onwards. Thus, given the relative newness of this emphasis, organisations have not always thought to link the issues and, when they have, have been unsure how to develop responses integrating the two issues. Until such time as more research and information becomes available, developing comprehensive responses aimed at addressing the links between all forms of violence against women and HIV/AIDS remains difficult.

REVIEWING THE LINKS BETWEEN HIV/AIDS AND VIOLENCE AGAINST WOMEN

Four hypotheses are typically put forward suggesting how the dual epidemics of HIV and gender-specific violence may overlap in women's lives (Maman *et al*, 2000):

- rape may directly increase women's and girls' risk of contracting HIV. Typically, rape does not occur in circumstances where a condom will be used. The violent nature of rape creates a higher risk of genital injury and bleeding (increasing the risk of HIV transmission), while, in cases of gang rape, exposure to multiple assailants may also contribute to the risk of transmission
- abusive relationships (including other forms of abuse besides that of a physical nature) may limit women's ability to negotiate safer sex
- women who have a history of childhood sexual abuse may engage in riskier sexual behaviour as adolescents or adults, increasing their risk of HIV infection
- women who receive HIV counselling and testing may be at risk of partner violence should they disclose their HIV status.

The report opens with a brief discussion contextualising both violence against and HIV/AIDS amongst women in South Africa. We then describe the study and its findings and analyse current attempts to integrate HIV/AIDS and violence against women before concluding with a range of recommendations.

Defining violence against women

The Declaration on the Elimination of Violence Against Women (DEVAW) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering, whether occurring in public or private life, in the family, in the community, or perpetuated or condoned by the State." A crucial weakness of the Declaration is the way it leaves unanswered the question of what defines an act as gender-based (beyond the implication that it is something directed at women). Arguably, as all acts of violence are gender-based at some level, regardless of whether or not such violence occurs between men and women, between men or between women[1], this definition is limited.

This report does not try to settle the conceptual challenges of defining violence against women (or gender-based violence). Instead, for convenience sake we will focus on those acts which in practice, are most often considered violence against women: rape and other forms of coerced sex, domestic violence and

1. See Moore's persuasive argument on this point (1994).

murder (or femicide)[2]. However, we return to some of the problems of definition in section three.

Separating behaviours into groupings termed 'rape', 'domestic violence' and 'femicide' does not imply that these various behaviours are mutually exclusive. Violence within relationships can include sexual assaults and may even culminate in murder, for instance. It is far more useful then, to conceptualise violence against women as existing on a continuum (Kelly, 1988). The idea of a continuum is useful for at least two reasons:

- it identifies the basic characteristic common to the many different forms of violence: namely the *'abuse, intimidation, coercion, intrusion, threat and force men use to control women' (italics original)* (1998:76)
- it enables recognition of the range of abuses, intimidation, threats and force used, while simultaneously recognising that these behaviours cannot be isolated into defined, discrete analytic categories; many overlap and shade into each other.

Finally, as Kelly points out, her use of a continuum does not suggest a linear connection between different events and experiences. Additionally, with the exception of violence resulting in death, there is no attempt to rate the seriousness of the various experiences by placing them at different points on the continuum. As she describes it, the "more or less" aspect of the continuum applies to prevalence: some forms of violence are experienced by most women and likely to be experienced on a number of occasions. These common, everyday experiences are more likely to be tolerated and seen as harmless by society at large.

The incidence of violence against women in South Africa

Police statistics on the incidence of domestic violence are not available because presently there is no crime called 'domestic violence'. However, recent surveys have supplied the following figures:

- A community-based prevalence study conducted in three provinces found that 26.8% of women in the Eastern Cape, 28.4% of women in Mpumalanga and 19.1% of women in the Northern Province had been physically abused in their lifetimes by a current or ex-partner (Jewkes *et al*, 1999). The same study also investigated the prevalence of emotional and financial abuse experienced by women in the year prior to the study. This was found to have affected 51.4% of women in the Eastern Cape, 50% in Mpumalanga and 39.6% in Northern Province *(ibid).*
- In a study of 1 394 men working for three Cape Town municipalities, approximately 44% admitted to abusing their female partners (Abrahams *et al*, 1999).

2. The Human Rights Watch report "Violence Against Women in South Africa" (1995) took rape and domestic violence as the scope of its examination. In addition to these two acts, the National 1994 Women's Health Conference included sexist jokes and pornography within its definition of violence.

- At least one woman in Gauteng is killed by her male partner every six days (Vetten, 1995).

In 1998, 49 280 rapes were reported to the SAPS (SAPS, 1999)[3]. Jewkes *et al's* 1999 study found that the incidence of rape for women aged between 18 - 49 years was 1 300 per 100 000 women.

However, many women do not report being raped out of fear of being disbelieved by members of the criminal justice system (Stanton and Lochrenberg, 1994), fear of reprisal and intimidation, shame and knowing the offender (Camerer *et al,* 1998). The 'Victims of Crime Survey' conducted by Statistics South Africa found that approximately half of all women who admitted to having been raped reported the matter to the police (Hirschowitz *et al*, 2000), while Jewkes *et al's* three province survey found that one quarter of women raped in the year prior to the study reported the matter to the police.

One study of 159 women in the Western Cape found that 2% of the group had experienced marital rape and a further 12% sexual assault at the hands of their partners (Maconachie *et al,* 1994). National statistics supplied by the SAPS National Crime Information Management Centre indicate that approximately 1% of rapes reported during 1996 and 1997 were perpetrated by husbands upon wives (cited in Kottler, 1998).

Thirty-nine percent of young women in South Africa between the ages of 12 - 17 state they have been forced to have sex (LoveLife, 2000). In the same study 33% said they were afraid of saying 'no' to sex, while 55% agreed with the statement "there are times I don't want to have sex but I do because my boy-friend insists on having sex" (2000:19). The study does not record how many of the forced sex experiences were reported to the police.

HIV/AIDS and women in South Africa

By the end of 2000, an estimated 3.8 million adults and children became infected with HIV in sub-Saharan Africa, bringing the total number of people living with HIV/AIDS in the region to 25.3 million, or 70% of the total population worldwide living with HIV/AIDS. In terms of the global HIV/AIDS picture, sub-Saharan Africa is something of an anomaly, with more women than men infected with HIV and dying of AIDS (UNAIDS, 2000). In this region, women account for 55% of HIV-positive adults and are infected primarily through heterosexual transmission.

The most recent sero-prevalence survey of women attending public ante-natal clinics in South Africa indicates that 24.5% are infected with HIV (Department of Health 2001: 8). Increases in infection rates were most significant in the provinces of KwaZulu-Natal and Gauteng. Women in their twenties are consistently showing the highest infection rates while infection rates amongst teenaged girls are thought to be stabilising. The report

3. This is the last year for which figures are available, following the government's declaration of a moratorium on the release of all crime statistics.

estimates that 2.5 million women and 2.2 million men in South Africa between the ages of 15 - 49 are infected with HIV. These findings have not gone unchallenged. Other researchers, while agreeing that the infection rate is slowing, put the national estimate somewhat higher, calculating that between 5.3 - 5.4 million people are HIV-positive (*Weekly Mail and Guardian*, 23 March 2001).

Women's vulnerability to HIV/AIDS

Women's greater susceptibility to HIV infection can be explained as the outcome of both biological and social factors.

Those biological factors facilitating transmission of HIV include:

- the fact that the vagina and labia present larger exposed surface areas than that of the penis
- more susceptible mucosal surfaces are present in the vagina in comparison to the penis
- the presence of other sexually transmitted infections (STIs) (Gupta and Weiss, in Abdool Karim, 1998). STIs are often undetected in women because they are usually hidden inside the genital tract and are asymptomatic. As a result they go unnoticed and untreated, a problem compounded in areas where good health care is inaccessible or too expensive
- additionally, women's genital tissues are easily damaged during sex (especially dry sex), causing cuts and bruises, which provide entry points for the virus (Lawson, 1997)
- younger women's vulnerability is also increased due to their genital tract being less developed.

Also crucial to understanding women's greater vulnerability is an analysis of the nature of heterosexual relationships between men and women, the circumstances under which men and women engage in sex, the kind of sexual practices they engage in, and the reasons why they engage in sex. Here we need to understand how men and women are situated differently in relation to one another. Such gender differentiation structures social relations in a hierarchical fashion, with women subordinate to men. Other factors such as race, age, socio-economic circumstances, geographical location, sexual orientation, religion and culture also intersect with gender to produce complex patterns of dominance and oppression both between women, as well as between women and men.

A full review of the gendered nature of the HIV/AIDS epidemic in South Africa in all its complexity is beyond the scope of this report. However, the impact of HIV/AIDS has been described as a 'triple jeopardy' for women (PANOS, 1990) because of its impact on women as individuals, mothers and caregivers.

'Triple jeopardy' refers to women's vulnerability to HIV infection, as well as the impact of HIV on all women, regardless of HIV status.

Vulnerability at an individual level is determined by personal daily circumstances, with some women being extremely vulnerable to HIV infection. Most women living with HIV/AIDS are denied adequate access to care and treatment due to their personal financial constraints as well as government policies regarding health care for women living with HIV/AIDS.

When most of the information about the epidemic is produced in written form, low levels of literacy amongst women may keep them ignorant about HIV/AIDS. Poverty, as well as women's restricted economic opportunities, also increase the risk of HIV infection by restricting women's access to health information and services (such as STI treatment and condom supplies). Women's limited economic circumstances may also increase the likelihood of their engaging in high-risk behaviour such as commercial sex work, survival sex or transactional sex. These latter two terms describe the range of sexual interactions women may enter into in which sex is 'bartered' in return for desired goods. Webb (1997) describes how divorced women or single mothers with poor or non-existent incomes may have a ring of boyfriends who provide material necessities in times of domestic instability. A second type of survival sex specific to young women is the 'sugar daddy' phenomenon where young women utilise sex as a commodity to obtain presents, food and clothing from older men (Webb, 1997; Adams and Marshall, 1998)[4].

Some South African traditional and cultural practices such as lobola or polygyny may also contribute to women's risk (Pieterse, 2000)[5]. Some men may reinterpret the practice of lobola, or bride wealth, to mean that their wives are now their property, to do with as they please because they have been 'paid' for. Women may thus have less power in sexual decision-making and are not permitted to refuse their husbands sex. Obviously, there is no recognition of marital rape within very traditional societies. Polygyny (marrying more than one wife), which may have fulfilled important social and cultural functions in the past[6], now places all partners in such a marriage at risk of infection. Polygyny also legitimises the notion that men should have access to multiple sexual partners. The migrant labour system has also encouraged a system of 'informal' polygyny, with some men having female partners both in town as well as the rural areas. From men's perspective, this enables them to maintain both their rural properties as well as satisfy their need for sexual partnership (Ulin, 1992).

4. Young girls do not only exchange sex for survival purposes; both Webb (1977) and LoveLife (2000) note that sex is also exchanged for items which confer status, such as brand name clothing.

5. The traditional and cultural practices of South Africa's various communities have not been examined equally. The lack of such comprehensive and representative research may perpetuate the stereotype that it is only the cultural practices of African women and men which promote HIV infection. Polygyny for instance, is also practised by some Muslims.

6. Despite the argument that the practice demeaned the status of women, practically being part of a polygynous household was preferred to being single as it provided women with security they would otherwise not have had, such as access to land and resources as well as lightening their childbearing burden (Pieterse, 2000).

Another practice placing women at risk is 'dry sex.' This involves drying out the vagina with substances such as methylated spirits, vinegar, snuff or powders prepared by traditional healers. Because a moist or lubricated vagina is associated with promiscuity, women resort to these measures to avoid accusations of being 'unclean' or 'loose' (Women's Health Project 1996: 272).

In their role as mothers, women face additional concerns about transmitting the virus to their babies, and face difficult choices. In the absence of anti-retrovirals which could significantly reduce the transmission rate, they may consider termination or take the chance that their babies will be born negative. Women may have to wait for months or even years to find out whether their child is infected or not. Many women have to deal with caring for their HIV-positive children. Older women are also having to care for their grandchildren when one or both parents dies of AIDS. For those women wanting to bear children, the use of condoms as part of safer sex practices prevents conception.

Women may also be excluded from clinical drug trials for HIV/AIDS treatment due to a lack of practical considerations such as childcare provision, and a lack of transport. Fears of the effects of the drugs on a foetus (should women fall pregnant during the course of a study) also lead to women's exclusion from such trials. While women form the population on which sentinel surveys and prevalence studies are based, they are also least likely to be the recipients of HIV/AIDS drugs.

As caregivers, women may be expected to look after other infected people in addition to those they normally take care of (such as their children, male partners and other family members). But when women become ill, few other household members may be willing or able to care for them.

The presence and combination of these various circumstances ensures that the HIV pandemic affects women differently to men. Violence must now be added as yet another factor increasing women's vulnerability to HIV.

Contextualising the links

In the section that follows, we review a range of South African studies and one Tanzanian study providing insight into the overlap between HIV/AIDS and violence against women. We conclude by noting the questions left unanswered by these studies.

Coercive sexual practices in South Africa

Earlier we highlighted how practical difficulties and fear stopped women from laying charges of rape. Equally relevant to understanding the extent of coercive sexual practices, are women's own beliefs about what constitutes 'real' rape. CIETafrica's survey of 8 417 women and 7 826 men living in the Southern Metropolitan area of Greater Johannesburg records 27% of young women and 32% of young men as saying that 'forcing sex with someone you

know is never sexual violence' (2000: 51). Situations in which women are expected to trade sex for jobs or promotions, or, within an educational context, improved marks, may also not be reported as rape (Jewkes and Abrahams, 2000). Vetten and Dladla's research with sex workers in inner city Johannesburg (2000) showed how sex workers who cannot afford bail or admission of guilt fines were expected by police officers to provide sex in exchange for their release.

Insight into how women come to define their experiences as rape comes from Kottler's (1998) investigation of 20 wives' subjective definitions of marital rape (wives in her study referred to women who were living with, or had lived with, male partners, regardless of whether the couple had been married or not).

Women in her study did not define their experiences of sexual violence as falling into the neat categories of 'marital rape' and 'not marital rape'. Instead they defined their experiences in a variety of ways such as 'forced' or 'survival' sex, sexual assault/abuse, 'like rape' and 'pressurised' sex. Defining an experience as rape was based on a number of variables including force, consent, relationship to the rapist, access to information about marital rape, the degree of violence used and the consequent levels of injury and pain caused, and whether they had disclosed their experience of rape. However, 80% of Kottler's interviewees defined at least one of their experiences as rape (1998: 221- 222).

Other factors also influenced how women described their experiences. The notion that men are entitled to conjugal rights left some women feeling obliged to have sex with their husbands because sex was their duty. A refusal indicated 'frigidity' which then justified the partner's use of force to obtain sex. Some women also saw marital rape as obligatory sex required to pay their husbands back for the food and shelter provided for them and their children. The stereotype that 'real' rape occurs between strangers in traditionally unsafe areas such as dark alleys and involves the use of weapons and violence made it difficult for at least one woman to perceive her experience as rape, since what was happening to her was taking place in the 'safety' of her home within the bounds of a marital relationship.

Re-defining an experience of coercive sex as rape was a gradual process brought about in part through exposure to information about marital rape (from counsellors, and other educational sources) as well as changes to the law - specifically the recognition of marital rape by the Prevention of Family Violence Act of 1993. For some women, changes in the frequency and severity of the violence which crossed the boundaries of the 'normal' led them to define their experience as rape. Women were also more likely to define their experiences as rape if they were injured and experienced pain.

At least a third of the women had not disclosed their experience of rape to anyone. Privately acknowledging having been raped was only part of the process of defining their experience as rape. Describing their experience as

rape to another person was another component women found difficult. Such an admission not only tarnished their public image and relationship to the rapist, but it also impacted upon their self-esteem and prompted fear of being blamed.

Whether experiences defined as 'forced' sex or 'pressurised' sex carry a greater or lesser risk of HIV infection than experiences defined as rape is unknown, as is the risk of HIV infection following rape. Information about women who have become HIV-positive after rape is limited and anecdotal, and often comes from newspaper reports (*Sunday Times*, November 10 1996; *The Star*, 4 June 1997; *Weekly Mail and Guardian*, May 21 1999). Some women will however, already be HIV-positive when they are raped as the age group at greatest risk of being raped[7] overlaps with the age group most likely to be infected with HIV. Some indication of this overlap is provided by Sunninghill Clinic. Twenty-two percent of the approximately 500 rape survivors who have been treated at the Clinic's Albertina Sisulu Rape Crisis Centre were already HIV-positive at the time of the rape (Kim, 2000).

Knowing the incidence of rape is important for planning around the provision of HIV post-exposure prophylaxis (PEP). However, it is clear from the studies reviewed, that many women do not define their experiences as rape and therefore may not see themselves as being at risk of infection. Thus, they are highly unlikely to benefit from HIV PEP for rape survivors. We discuss the implications of these findings further in section three.

HIV infection as a factor leading to rape

This review also identified an additional linkage between violence against women and HIV/AIDS not typically identified in the international literature. This was HIV infection as a factor precipitating sexual assault.

The belief that sex with a virgin[8] (who will usually be a young girl) can cure HIV/AIDS appears to be widely believed in Southern Africa (Kim, 2000; Leclerc-Madlala, 1997) with one in four young South Africans not knowing that this is a myth (LoveLife, 2000)[9]. The choice of younger victims is, perhaps, also a pragmatic one; rapists may be targeting younger girls in the belief that being less sexually active, they are also less likely to be HIV-positive (Leclerc-Madlala, 1997).

"Infect one, infect all" is how Leclerc-Madladla has characterised the response of Zulu-speaking youth to the HIV/AIDS epidemic. Her interviews with 100 Zulu-speaking young men and women uncovered a fear amongst women that men would respond to an HIV-positive diagnosis by raping women more than ever before. One participant, recounting her friend's experience of rape, is quoted as saying:

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7. See Kim's review (2000: 4).

8. In South Africa, virgins have not been the only group of women attributed with powers to cure HIV/AIDS. In 1990 a document appeared calling on African men in the Durban area to acquire the AIDS antibody by raping Indian women. Even though the flyer was believed to be the work of a 'third force' intent on aggravating conflict in and between black communities, it still succeeded in increasing the fear surrounding the disease (Leclerc-Madlala, 1997).

9. This is not unlike beliefs which proliferated in nineteenth century England claiming that sex with a child would cure syphilis (Leclerc-Madlala, 1997).

"She told me he was laughing and told her to relax. He said that everyone had AIDS now so she mustn't cry. Why was she crying? He said he gave it to many of her friends already. She'll join them" (Leclerc-Madlala 1997: 372).

It is impossible to quantify how widespread these beliefs are, as well as to what extent they influence the rate of rape. Leclerc-Madladla herself notes that further empirical research is needed to test this relationship (1996:34). Certainly, no data is currently available recording the HIV status of either convicted or alleged rapists.

Violence and condom usage

"Once you raise the issue of your husband using a condom, there no longer will be peace in the house." (urban woman from Worcester, cited in Booysens *et al,* 2000).

Male co-operation is paramount in safer sex practices such as condom use. But with men traditionally having greater influence over when, where and how sex takes place, this disadvantages women in successfully initiating discussions about safer sex practices or negotiating safer sex. A study of women in a rural and peri-urban setting in KwaZulu-Natal found that most women in marital or permanent relationships accept that their husbands or partners have other sexual partners, but had little power or leverage in the relationship to negotiate safer sex (Abdool Karrim and Mohanty, in Abdool Karrim, 1998).

Varga and Makubalo's 1996 study with 85 young African women attending two ante-natal clinics found that 58% of the girls avoided discussing or requesting the use of condoms out of fear of violence or rejection from their partners. Abdool Karim (1998) notes that sex workers working at truck stops faced violent reactions, loss of clients or as much as a 25% cut in income for insisting on condom use. Vetten and Dladla (2000) found that sex workers in the inner city of Johannesburg were coerced into unsafe sex by clients threatening them with violence, especially if the setting was in the clients' home.

However, it is not only fear but the meanings attached to condom usage which prevents women from using condoms. Married women who request safer sex practices may either be accused of having extra-marital affairs or of accusing their husbands of being unfaithful. Men's suspicions of female infidelity are not to be treated lightly. Vetten and Ngwane's research in progress[10] finds alleged female infidelity to be the most common factor precipitating men's murder of their female partners.

In dating relationships, women requesting condom use are seen as 'loose', 'experienced' or 'sleeping around'. Women themselves may not want to use condoms because condoms are perceived to be used only in casual relationships and with 'casual' women. Alternatively, women may perceive unprotected sex as a symbolic step towards a more meaningful, long-term relationship, or partners may ask it as proof of commitment to a relationship (Campbell *et al,* 1998).

10. This is an analysis of all cases of spousal murder heard between 1994-1998 in three Gauteng courts: Witwatersrand Local Division, Transvaal Provincial Division and Transvaal Regional Division.

Violence following disclosure of HIV status

Anecdotal evidence exists of women who have experienced a range of abuses after disclosing a positive status, ranging from emotional abuse to abandonment and being killed (Maman *et al*, 2000; Sewpaul and Mahlalela, 1998; Mthembu, 1998; *The Sowetan*, 23 August 2000).

Promise Mthembu (1998) recounts how her husband gradually became abusive after she disclosed her HIV-positive status to him - at first blaming her for bringing the virus into their lives, then beating her and forcing her into unprotected sex. Another such example is that of Susan Teffo who was burnt over a primus stove by her husband when she disclosed her HIV-positive status. When her four-year-old son tried to stop his father from burning Susan, he was burnt as well (SABC 3 News, 9 July 2000). Although charges of attempted murder have been laid against Susan's husband, she does not intend leaving him. Doing so would deprive her of the drugs she has access to via her husband's medical aid.

Perhaps the most extreme response to disclosure is murder. From a newspaper report, it seems possible that Mpho Motloung's HIV-positive status may have played a role in her death. According to a relative she and her husband had tested positive some two weeks earlier. After receiving her diagnosis Mpho returned to her parents' home where she was killed, along with her mother. Her father was also critically wounded during the shooting. A note reading "HIV Positive Aids" was found on top of Mpho's body. Mpho's husband committed suicide after the three shootings (*The Sowetan*, 23 August 2000).

Two African studies investigate the consequences of disclosure for women. Sixgashe *et al* (2000) interviewed 28 women who had been diagnosed HIV-positive at least three months prior to the interview. Fifteen of these women had not disclosed their HIV-positive status, mainly out of fear of being rejected by their partners. Of the thirteen women who had disclosed, only seven had disclosed to sex partners. All the women who disclosed to their partners reported previously trusting and loving relationships, with their partners continuing to be supportive after the diagnosis. The number of women in this study who disclosed to their partners is too small to draw meaningful conclusions about the risks of disclosure for women.

Maman *et al's* study conducted in Tanzania (2001) followed up 245 women three months after receiving their HIV test results. The results of this study provide little evidence to support the hypothesis that sero-status disclosure *per se* leads to an increase in physical violence against women. But for the small proportion of women who do experience negative outcomes, these can be severe. Negative outcomes did not result only when women disclosed a positive status; women who disclosed a negative result were also assaulted and/or told to leave the house or abandoned (2001: 21).

The most significant aspect of this study is its finding of an association between physical violence and HIV infection within the study population. HIV-positive women were 2.68 times more likely than HIV-negative women to have

experienced a violent episode perpetrated by their current partner. HIV-positive women were also significantly more likely to have had a physically violent partner in their lifetime and to have experienced an episode of physical and sexual violence with a current partner. HIV-positive women under 30 were ten times more likely to report violence than their HIV-negative peers of the same age. The strong, consistently positive relationship between a prior history of violence and HIV infection lends support to the theory that violence may play a role in women's risk for HIV infection (2001: 30).

Earlier studies suggest how violence and HIV may interact. Martin *et al* (in Maman *et al,* 2001) found that Indian men who physically and sexually abused their wives were more likely to engage in extra-marital affairs and have STIs - so placing their wives at risk of contracting STIs and HIV. Others have suggested that women's experience of violence limits their ability to take preventive health action, thereby placing them at risk of HIV infection and limiting their access to care and support services.

Another important study finding was that women's decision to be tested for HIV was frustrated by violence or threats of violence by their partners. Women's fear of their partners' reaction emerged as the major barrier to HIV testing (2001: 30). This is a link between violence and HIV/AIDS which does not appear to have been raised before.

Maman *et al* conclude that it is the imbalance of power between women and their partners which places women at risk for violence and limits women's ability to take preventive health measures.

Childhood abuse

The hypothesis that women who have a history of childhood sexual abuse are at greater risk of HIV infection because they may engage in riskier sexual behaviour has not been well researched in South Africa. Although Russell's (1995) interviews with 20 self-selected white incest survivors finds that 30% of her sample's behaviour could be characterised as 'sexual promiscuity, sexual preoccupation and compulsive sexual behaviour; prostitute-like behaviour/becoming a prostitute' (1995: 64), she also found that 40% of this group described themselves as having an aversion to sex, or avoiding and abstaining from sexual activity as a result of their experiences. More in-depth research is needed to investigate this link.

Although these various linkages have been suggested, little research has been completed examining the causal pathways leading to women's increased risk of HIV infection and/or violence. Samples are generally small, making it difficult to generalise their findings. Further, these studies all focus on violence as a precursor to infection, or violence as a consequence of infection, but do not consider the impact of violence upon the progression of HIV and the care and treatment of infected women. In conclusion we offer the story of Grace, whose experience highlights the many complexities of the intersection between domestic violence and HIV/AIDS.

CASE STUDY

Grace is a 37-year old mother of four children. Ten years ago she married "Thomas", the father of the three younger children.

Thomas has abused Grace throughout their marriage and in 1995 she obtained an interdict against him in terms of the Prevention of Family Violence Act. The relationship deteriorated further when Grace discovered that Thomas was involved in an extra-marital affair. Thomas subsequently left Grace to move in with his mistress. When Thomas sent police officers to fetch his clothes from the marital home, Grace refused to give them the clothing, which led to them assaulting her. Grace laid charges against the officers concerned and refused to drop them even after being threatened. Thomas reappeared again, saying that he had ended the affair and that his life was also being threatened as a result of the charges she had laid. Grace forgave him and took him back as he also promised to buy a house. However, these circumstances affected her health and she has been treated for depression ever since. Thomas also continued abusing Grace - even threatening to shoot her on occasion. In 1999, Grace applied for a protection order in terms of the Domestic Violence Act.

In 1997 Thomas was diagnosed HIV-positive but kept his status secret from Grace. He sought treatment from an inyanga in Mpumalanga. It appears Thomas' family were aware of his HIV status as one of his sister's contacted Grace to tell her that Thomas was being treated by an inyanga and to ask if Grace was also being treated. When a puzzled Grace asked Thomas what he was being treated for, he replied that he had ulcers. She left the matter at that.

In 1999 Grace was told by one of Thomas' colleagues that Thomas was infected with HIV. She then contacted a service organisation to arrange for an HIV test. The counsellors advised her to bring Thomas so that they could both be tested. They were both diagnosed HIV-positive.

Grace did not consider leaving Thomas. She was unemployed and also had four children to look after. She worried that if she left Thomas, no-one else would want her now that she was HIV-positive. She also hoped that they would act as a mutual support to one another.

Thomas left Grace again in 1999, claiming that he had found accommodation closer to his place of employment. He moved in with his mistress instead. Grace discovered the affair when she made a surprise visit to Thomas on Father's Day and found his mistress in his room. During the ensuing confrontation Thomas' neighbours beat Grace.

Thomas continued visiting the children but stopped paying maintenance. Grace saw Thomas for the last time in November 2000 when she traced him to his new girl-friend's home to ask for money for one of the children who

was ill in hospital. Grace also asked the woman if she was aware of Thomas' positive status. An angry Thomas then assaulted Grace for disclosing his status.

Very soon after this incident Grace phoned the medical aid to find out about the options and types of treatment available to her. She was told that she was no longer included in the medical aid because she and Thomas had been divorced. This came as a shock to her because she had not signed any divorce papers. Late in 2000, Grace was forced to leave the house when Thomas stopped paying both the rent and electricity bills. She currently lives in a garage with the youngest child while the older three children live with her sister.

Thomas, who feared the reaction of community members once they discovered his HIV status, has moved out of the area altogether. He pays a total of R600 per month maintenance towards the children who also remain on his medical aid. He justifies his abandonment of Grace on the grounds that she disclosed his HIV status to his mistress but states that he will remain with his mistress because he feels some responsibility towards her for having infected her.

Grace is currently testifying in the court case arising from Thomas' assault of her in violation of the protection order. She is also attempting to have the circumstances of her divorce investigated and the protection order amended so that it will order Thomas to place her on his medical aid. The first legal agency she approached for help mislaid her file for three of the six months during which they handled her matter. A second legal agency specialising in HIV-related matters was unsure whether her case was a domestic violence matter or an HIV matter and so were uncertain about whether the case fell within their brief. During her most recent appearance in the maintenance court, the magistrate referred the case to the High Court. Because Grace is HIV-positive, unemployed, and has no home of her own, the magistrate recommended that Thomas be given custody of the children.

Grace's story illustrates some of the complexities of the lives of HIV-positive women living with abusive partners. Her HIV status seems to have been a reason for remaining with Thomas, rather than leaving him. Her fear that no-one else would want a relationship with her now that she is HIV-positive, and that an abusive relationship is better than no relationship at all is not unusual; Zierler (1997) records similar fears amongst women living in the USA. Staying for Grace was also an economic necessity to ensure that the children would be taken care of, and that she would have access to Thomas' medical aid. Finally, there was her hope that she and Thomas could support one another as HIV-positive people. This raises broader questions: How does living in relationships which are emotionally and physically stressful affect susceptibility to HIV-related illnesses? Are women more or less likely to tolerate abuse in the context of HIV infection? How might ongoing battles with the legal system affect stress levels? As for the magistrate's perception that Grace's HIV status precludes her from caring for her children adequately, is this an isolated

perception, or does it signal the emergence of a broader trend around custody decisions?

Thomas' behaviour also prompts questions around how men respond to their partner's HIV status. How does a positive diagnosis affect a relationship over time? Are abusive men more likely than non-abusive men to have extra-marital affairs? What effect does being diagnosed HIV-positive have on an abusive man? Might such a diagnosis increase, decrease or change the nature of his violence? What prompts abandonment? Is it possible to identify which men are more likely than others to abuse and/or abandon their female partners? If yes, what might such signs include?

Finally, what kinds of social support are necessary to assist HIV-positive women who are experiencing domestic violence?

THE STUDY

Methodology

A combination of purposive and snowball sampling was used to gather information. We identified a first set of informants through the "National Directory of Services on Violence Against Women" (CSVR, 2000), the "South African AIDS Directory" (Department of Health, 2000), media reports and articles, and two issues of *Agenda* devoted to HIV/AIDS. We also drew on our involvement with health and violence against women networks to identify further interviewees. This first set of informants was then asked to identify other individuals or organisations who they thought would have information about the area under study. Interviewing continued until we reached the point where interviewees were no longer providing us with new names.

A structured interview schedule was drawn up which aimed to elicit general information about the organisations and their activities. More specifically, we asked interviewees to describe on the basis of their work experience what, if any, links they were noting between violence against women and the transmission of HIV, as well as the care and treatment of people living with HIV or AIDS. If organisations were running projects or activities that attempted to address these links, they were also asked to detail these initiatives. Finally interviewees were asked to outline the kinds of programmes or activities they thought necessary to address the links between violence against women and HIV/AIDS.

A review of research reports, information packages, and policy documents was also undertaken (sometimes in lieu of an interview) to supplement the interview findings.

Limitations of the findings

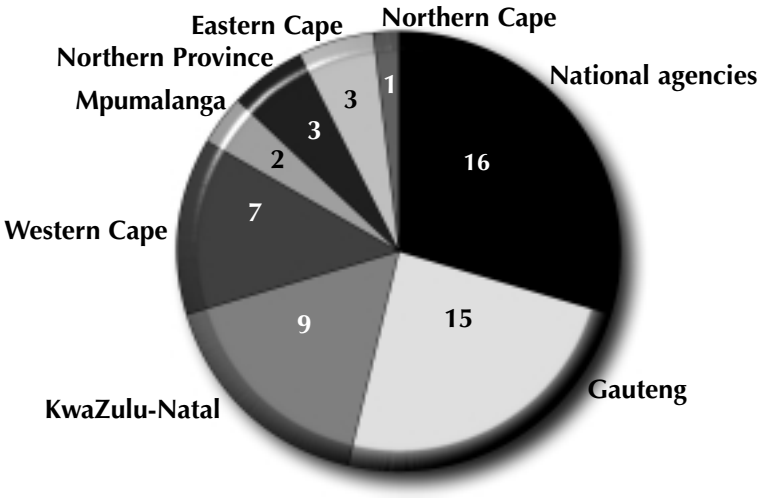
Our sampling approach assumes that organisations doing similar work are in contact with one another and sharing information around their activities. It is entirely possible that such networking is not taking place consistently and that we may have excluded some activities drawing together the links between violence against women and HIV/AIDS. Further exclusions of nine organisations occurred on the basis of non-response to requests for an interview, which may also have resulted in some activities not being identified by the scan.

Geographically, the sample is biased towards Gauteng and does not include information about activities in either the Free State or North West Province - despite efforts to identify organisations in these areas.

Description of the sample

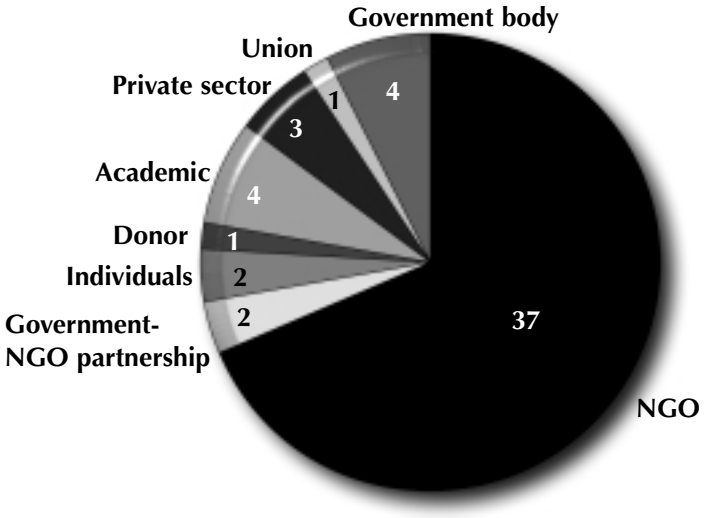
Representatives of fifty-two organisations and two individuals were interviewed, while written information was received from a further three agencies. The bulk of those interviewed were located within the NGO sector generally and either engaged in work around HIV/AIDS, or were attempting to develop intersections between violence against women and HIV/AIDS. A somewhat smaller sub-sector consisted of organisations focussing on gender in one form or another, in particular violence against women. The remainder were drawn from the health sector generally, the organised labour movement and the development sector.

Geographic distribution of interviewees



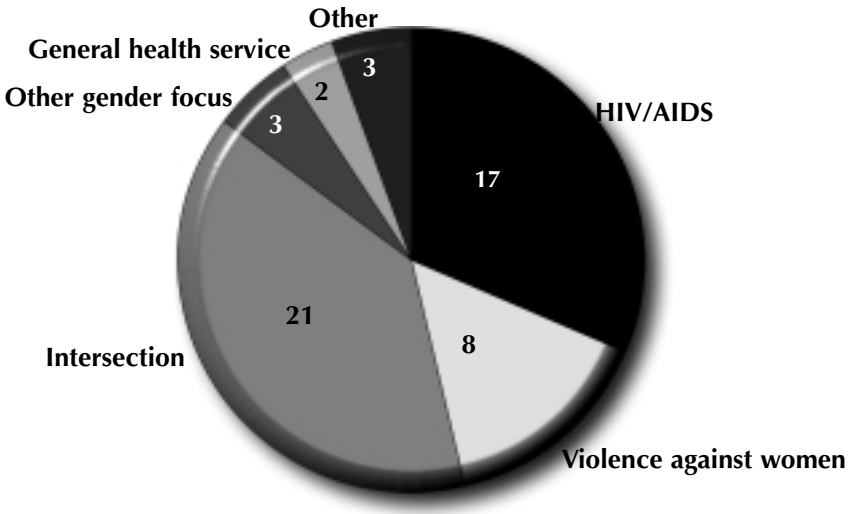
TOTAL 54

Type of organisation



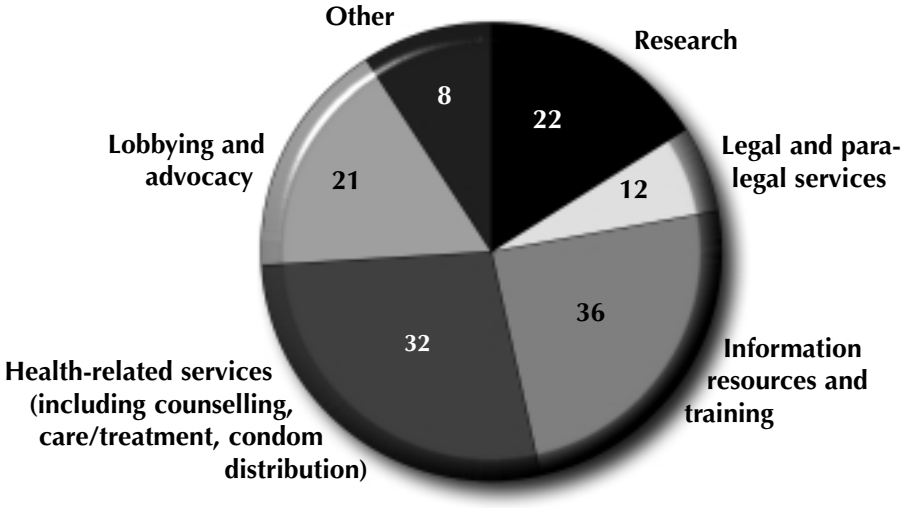
TOTAL 54

Organisational/programme emphasis



TOTAL 54

Range of activities engaged in



STUDY FINDINGS

What links between violence against women and HIV/AIDS do interviewees report?

Most of the linkages described by interviewees echo the literature review and will not be repeated here. While most participants had no difficulty in identifying the links between rape and HIV transmission, few were able to identify the links between domestic violence and HIV/AIDS. A third of interviewees made no specific links at all between violence against women and HIV/AIDS. Instead they spoke broadly of how gender inequality within society and subordination within relationships makes women vulnerable to HIV.

Rape was identified as the strongest link (33) between HIV transmission and violence against women. The majority of interviewees focussed on stranger and gang rapes as the types of rape that made women vulnerable to HIV infection and only a small minority (3) included marital rape and date rape as equal risk factors. A limited number (4) of interviewees made the link between `coercive' sexual practices and HIV/AIDS as distinct from rape. Two interviewees suggested that violent or dysfunctional family lives might lead women to engage in high risk behaviour such as sex work.

When the link between HIV/AIDS and domestic violence was made, it was identified in relation to women's relative powerlessness to negotiate safer sex practices (12), either out of fear of partner violence (6); or the connotations

attached to condom use (3). A limited number of interviewees thought domestic violence resulted in women having poor self-esteem or being depressed (5), which compounded being unable to negotiate safer sexual practices. One interviewee made the link between a form of domestic abuse ie. isolating women from their support networks as well as limiting the type and amount of information which she may have access to. Under these circumstances women may not have knowledge about HIV/AIDS and safer sex practices, as well as being unable to access support or information from others. Nine interviewees described how women would tolerate coercive sexual practices, infidelity and violence because they were dependent on men for their own as well as their children's survival.

Consequences of (non)disclosure

Interviewees stated that women who disclosed a positive HIV status to their partners faced physical abuse of some sort (3), being blamed for acquiring the virus (4) or abandonment (14) (sometimes being thrown out of their homes). Because women felt afraid to disclose their status, they often did not seek medical treatment (1). In addition, women continued either reinfecting or being reinfected by their partner because they could not raise the matter of safer sex practices without giving a valid reason (1) or because requesting such practices made them vulnerable to violence (4). Non-disclosure was seen to have further implications for the vertical transmission of HIV from mother to child. Three interviewees said that where women have not disclosed their status they may continue having children and by so doing, increase the likelihood of spreading the virus to their children. Additionally, they may be forced to continue breastfeeding (2), which further exposes an infant to HIV/AIDS. One interviewee thought that women who kept their positive status secret experienced stress and guilt arising from the knowledge that their partners were at risk of being infected. She thought this might lead to a quicker progression in the illness, as stress is known to exacerbate HIV progression.

New linkages not made in the research literature

The widely-held belief that HIV/AIDS can be cured through sexual intercourse with a child virgin has led the AIDS Legal Network (ALN) to identify virginity testing as a form of violence against women on the grounds that:

- it is targeted primarily at women
- it stigmatises young women who are not virgins
- young girls may be forced to attend such examinations by their peers or parents (although this may not be achieved through violence)
- it invades the girl's privacy
- it is a form of sexual abuse because it involves touching girls' genitalia
- very young children may be tested without understanding the reason for the examination (Barrett Grant *et al*, 1999: 42).

The ALN also suggests that women living with HIV and AIDS are particularly vulnerable to violence from people other than their intimate partners. As examples of such violence they highlight:

- assaults by members of the community
- violence at the hands of the medical profession - assaults in the form of blood being drawn without consent and disclosure of HIV status without knowledge or agreement
- being evicted from their homes
- being dispossessed of their property by family members after a partner's death because the family blames the woman for the man's illness (Barrett Grant *et al*, 1999: 45).

Also mentioned is the case of Gugu Dlamini who was stoned to death in 1998 after disclosing her HIV-positive status. Although it is not known with complete certainty why she was killed, newspaper reports state that neighbours accused her of shaming her community by revealing her HIV status (*The Sunday Independent*, 14 August 1999). The ALN suggests that it is unlikely that a man who was open about his HIV status would have attracted such hostility.

Gugu Dlamini's murder appears to be the only case where public disclosure has resulted in death. However, HIV-positive people who disclose their status are exposed to a range of other negative community reactions. Further research is needed to understand how community responses to people who are open about their HIV status may be gendered[11].

Finally, the refusal by government to provide anti-retroviral therapy to women where there is a risk of mother-to-child transmission (MTCT), as well as in the case of rape, is seen as violence against women (10). Since the care and treatment of people living with HIV and AIDS (PWLAs) in South Africa is generally limited, further investigation is needed to understand how it may also be gendered. These were some of the gendered dimensions to treatment suggested by interviewees. Women are tested for HIV more often because they use state services more often than men. They may often be tested without their consent and given their results without receiving counselling (1). One interviewee thought that there was a greater likelihood of women being refused treatment once their HIV-positive status was known. Staff (both nurses and doctors) in government health care facilities were said to stigmatise women (2) who have HIV/AIDS and not afford them proper care and dignity because they are perceived to be dying anyway. This is illustrated by the attitude towards women with different lifestyles such as sex workers, who may be perceived as infectors and spreaders of the disease not meriting care. However health care workers often cannot provide proper medication, either because it is not available (1) or because it is of limited efficacy (1).

11. Webb (1997) states that community responses towards HIV-positive people reveal attitudes generated by fear. Community members suggest that HIV-positive people should either be killed or isolated to communities exclusively comprised of HIV-positive people to prevent the spread of the virus. This has been a universal response to the epidemic. In Britain in the mid-1980s, overt homophobia often resulted in 'hysterical' press articles advocating the killing of people with AIDS and the isolation of homosexuals (Webb, 1997).

Description of civil society projects addressing some of these links

While a number of agencies indicated that they addressed the links as they come up[12], 21 projects state that they are currently involved in projects or activities which, in varying ways, are attempting to integrate violence against women and HIV/AIDS[13]. These interventions range from counselling and legal services, to research and the provision of PEP.

Services providing HIV PEP

The Greater Nelspruit Rape Intervention Project (GRIP) is a rape crisis service located in Mpumalanga province. Over and above providing counselling and court support services for rape survivors (both adults and children), it also appears to be the only NGO which makes PEP an explicit and routine part of its services. These services are provided free of charge.

Until recently, the organisation was based in the Rob Ferreira Hospital and Themba Hospital. In October 2000, prompted by President Mbeki's publicly expressed doubts about the efficacy of AZT, GRIP's services were shut down by the Mpumalanga Heath Department for breaching government policy. The Department claimed that GRIP had not received permission to be based at the hospitals and was thus squatting illegally (*Cape Times*, 16 October 2000). GRIP was subsequently allowed back into the hospital when the Department did not serve it with an eviction order. Very soon thereafter, five senior members of hospital management were suspended from their posts at Rob Ferreira Hospital and charged with misconduct. Recently all five were reinstated and charges against them dropped (*Lowvelder*, 6 March 2001).

The Department of Forensic Medicine and Toxicology has instituted PEP for rape survivors at both Groote Schuur Hospital and Thuthuzela Centre in the Western Cape. This has been accompanied by the development of protocols outlining the treatment of rape survivors, as well as criteria guiding the provision of HIV PEP. Groote Schuur Hospital has now been providing PEP for the past two years to those rape survivors presenting within 72 hours of being raped.

Thuthuzela Centre (based at the G.F. Jooste Hospital in the Western Cape) is run in conjunction with the Bureau for Justice Assistance and the National Directorate of Public Prosecutions. It attempts to combine counselling, health and policing facilities under one roof. With the exception of those able to afford the treatment, PEP is offered free to rape survivors who present within 72 hours.

The Sunninghill, Garden City and Milpark Clinics based in Gauteng belong to the Netcare group of private clinics. Rape survivors presenting at any of these clinics within 72 hours of the assault are given a free emergency dose of PEP and provided with the medication at cost price thereafter. Sunninghill also provides a counselling service for rape survivors.

12. This mainly includes addressing questions about the links should they come up during presentations or training sessions, or sending counsellors to information session around HIV/AIDS.

13. It is likely that this number will increase during the next year, given current donor interests. The United Nations Theme Group on HIV/AIDS is in the process of defining a three-year Flagship Programme on violence against women and HIV/AIDS in South Africa to run from 1 April 2001-31 March 2003. A further expression of interest is being signalled by the Donor Network on Women who have organised a seminar for April 2001 entitled 'Women and HIV/AIDS: Challenges for Donors'.

HIV PEP offered at these various facilities usually includes an emergency dose of anti-retroviral therapy (ART) – typically AZT – sometimes prescribed in conjunction with 3TC and Crixivan. ART is offered within 72 hours following rape, in conjunction with baseline HIV tests, emergency contraception and follow-up health care. If women decline a baseline HIV test, or the test indicates a positive sero-status, the remainder of the four-week course is not provided. Priority is given to emergency treatment and voluntary counselling, with testing deferred until a later stage in the process.

Counselling services

Siyophila is a newly established NGO based in Gauteng. While focussing on HIV counselling, the organisation also provides rape, and domestic violence crisis counselling but refers clients needing more than emergency assistance to organisations specialising in these areas.

The Centre for Criminal Justice in KwaZulu-Natal provides legal advice and counselling around rape and domestic violence. Rape survivors are referred for pre- and post-test HIV counselling.

Phagameng in the Northern province undertakes a range of HIV-related activities. When counselling rape survivors, they advise on HIV testing and refer women to testing centres.

Finally, the Peri-Natal Research Unit based at Chris Hani Baragwaneth Hospital in Gauteng, has developed a module on Voluntary Counselling and Testing (VCT) which is currently being replicated elsewhere. Concerns around domestic violence are dealt with as and when women bring them up.

Research

The Extension of Micro-credit Programme is a project developed by the Health Systems Development Unit (HSDU) of the Department of Community Health at Wits University to explore the impact of economic empowerment upon women in abusive relationships. Specifically, the project is also investigating the risk of HIV transmission to women in abusive relationships.

Research questions include:

- whether participating in an extended micro-credit programme (EMP) increases women's bargaining power in a relationship
- whether participating in an EMP is associated with improvements in relative well-being
- whether participating in an EMP is associated with a decreased risk of HIV infection
- whether participating in an EMP is associated with a decreased risk of gender-based violence and if so, how
- whether being in a violent relationship is associated with a risk of HIV infection

The Women's Health Project (WHP) is currently completing a national audit to identify who is working on the provision of HIV PEP after rape. The audit is likely to become available by June 2001.

Lobbying and advocacy around HIV PEP

Although journalists had been writing about individual rape survivors who contracted HIV from their assailants as early as 1996 and 1997 (*The Sunday Times*, 10 November 1996; *The Star*, 4 March 1997; *The Star*, 4 June 1997), it took the rape of journalist Charlene Smith in 1999 to place the issue of HIV PEP for rape survivors firmly on the public agenda. Through articles describing both her experiences, as well as those of other rape survivors, she gave further impetus to the issue (*Weekly Mail and Guardian*, 9 April 1999; *Weekly Mail and Guardian*, 16 April 1999; *Weekly Mail and Guardian*, 21 May 1999; *Weekly Mail and Guardian*, 15 October 1999).

In the same year, the organisation People Opposing Women Abuse (POWA) circulated a petition entitled 'The million-signature campaign' which called on the government to provide PEP for rape survivors[14]. The petition was widely-circulated via e-mail as well as by the national chain-store Clicks and collected 741 536 signatures. Although the signature campaign did not succeed, it placed further pressure on the government to consider providing anti-retrovirals to rape survivors.

Smith continues to advocate for the provision of PEP to rape survivors[15], as does GRIP and the ALN. In August 2000 ALN distributed a lobbying update focussing on rape and HIV/AIDS (Lobbying Update No 2). The update identifies ten areas of action which, if implemented, would contribute to securing women's rights to equality, dignity, freedom and security of the person as well as access to health care.

The Sexual Rights Campaign

The Sexual Rights Campaign initiated in 1999 by WHP is an "advocacy and community mobilisation process to put sexual rights at the centre of a human rights approach to reconstruction in South Africa" (WHP 2000: 28). Its purpose is the achievement of "a commitment to and understanding of rights to sexual health services and decision-making amongst people in civil society across South Africa" (WHP Newsletter 2000: 16). The notion of sexual rights[16] was developed as a means of impacting on policies and programming in three core areas: violence against women, HIV/AIDS and teenage sexual health.

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14 Other calls to the government included the development of a victim's charter.

15. Charlene Smith has a website for rape survivors: www.speakout.co.za

16. These include "the human right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (WHP 1998:1). On a T-shirt produced by WHP in support of the campaign this has been translated to mean the right to pleasurable and safe sex, equality and mutual respect, and to choose if, when, with whom and how to have sex.

This led to the formation of a Process Committee comprising the Young People's Network, the National Association of People Living with AIDS (NAPWA), the National AIDS Convention of South Africa (NACOSA), the National Network on Violence Against Women, the PPASA, WHP and the Young Men's Christian Association (YMCA) (*ibid*).

The bulk of the Campaign is driven through a national training programme and will culminate in the development of a Sexual Rights Charter to be finalised at a conference in June 2001.

Training and education programmes

Over and above their involvement in the Sexual Rights Campaign, PPASA also runs a 'Men as Partners' (MAP) training programme. Included in its component on HIV/AIDS and gender, is a brief focus on violence against women.

The Traditional Healers' Association, founded in 1970, offers a number of programmes to its members, one of which includes the training programme forming part of the Sexual Rights Campaign. Two such workshops have been run to date to mixed responses. The programme has been challenging for men who find it difficult to include their wives in sexual decision-making because this is seen as giving women power to control them. Traditional healers believe that they have received ancestral sanction to have multiple partners; linking HIV and practices such as polygyny and inheriting wives is experienced as disempowering by this group.

Empilisweni in the Eastern Cape was originally conceived as an HIV prevention project. However, when a needs assessment conducted among the local women found HIV/AIDS to be 13th on the women's list of priorities (with poverty and crime considered far more pressing issues), the project then emphasised job creation instead. Education around HIV/AIDS is now built into the various income generating schemes. Workshops begin by exploring women's human rights, emphasising the rights to respect and sexual autonomy (which includes being able to say 'no' to sex, as well as negotiate safer sex).

The ALN "is a national network of concerned organisations and individuals committed to the promotion and advancement of the principles of non-discrimination, equality and rights in relation to all persons affected by HIV and AIDS, through lobbying, advocacy, training and litigation undertaken by affiliates at a national and provincial level." The Network provides four categories of service: networking, lobbying and advocacy, training and awareness-raising and client services.[17]

Over and above their advocacy priorities referred to earlier, ALN offers a training programme that looks specifically at using the law to reduce women's vulnerability to HIV. A training manual and resource manual have been produced as part of the programme, designed to be run over one or two days. The workshop programme lists four objectives:

17. *All information taken from an undated foldout poster/leaflet entitled "AIDS Legal Network South Africa."*

- to develop an understanding of the nature and forms of violence against women
- to provide trainers with a resource manual on violence against women which can be used by NGOs and other service organisations
- to draw links between violence against women and their vulnerability to HIV
- to develop the capacity of civil society organisations to deal with legal issues around rape, domestic violence, virginity testing and violence against women living with HIV/AIDS (Barrett Grant *et al,* 1999: 1).

The Reproductive Rights Alliance (RRA) was formed in 1996 to advocate for the implementation of the Termination of Pregnancy Act. During the course of 2001 RRA staff will be conducting training and education programmes linking reproductive rights, awareness around HIV/AIDS and violence against women. Training content includes information around the Domestic Violence Act, the Sexual Offences Bill, the Choice on the Termination of Pregnancy Act, and reproductive rights.

Finally, NACOSA states that issues of gender, violence and HIV/AIDS are incorporated into all their training programmes. Not having seen the programmes, it is difficult to describe how the two issues are integrated.

Networking to integrate violence against women and HIV/AIDS

In October 2000, Tshwaranang Legal Advocacy Centre convened a national two-day seminar on violence against women and HIV/AIDS with the aim of discussing and developing an advocacy response to the HIV/AIDS epidemic from a women's rights perspective.

The seminar resulted in the formation of a National Forum including representatives from the Treatment Action Campaign, National Network on Violence Against Women, RRA, Gender AIDS Forum, AIDS Consortium, as well as an AIDS activist. The Forum's terms of reference were defined as follows:

- collaborating to integrate HIV/AIDS and violence against women
- strengthening existing campaigns
- sharing information by developing a document/position paper on the link between HIV/AIDS and violence against women
- facilitating capacity building within the HIV/AIDS and violence against women sectors to increase understanding of HIV/AIDS so that organisations are able to participate in and inform debates in this area
- acting as a civil society lobbying group

The Forum has been unable to meet again and is currently awaiting further funding to enable its work to continue.

At its Biennial Conference held in 2000, the National Network on Violence Against Women took a decision to investigate the links between violence against women and HIV/AIDS. They have not, as yet, embarked on any activities.

Insuring against rape

In October 1999 CGU Insurance Company launched its "Rape Survivor Policy," the first such policy in the world (*Cape Argus*, 12 October 1999). CGU described the initiative as a 'compassionate' response in line with the National Crime Prevention Strategy, which called for inter-sectoral co-operation, and initiatives to fill gaps in services (*The Star*, 12 October 1999). The policy provides all survivors of rape (including men) with HIV PEP, HIV testing and medical treatment. Both the survivor and his/her partner and family members are also offered psychological and psychiatric care (*The Star*, 12 October 1999). The policy operates via a 24-hour crisis line and claims must be made within 72 hours. Benefits are not dependent on reporting the rape to police, although this is recommended.

Organisations working in the sector of violence against women were critical of the CGU policy, branding it an 'opportunistic', 'money-making' venture (*The Star*, 12 October, 199; *Cape Argus*, 12 October, 1999).Organisations also expressed doubts about the policy's affordability to poor or unemployed women, and thus its potential to further entrench inequity. Nonetheless, response to the CGU policy was initially overwhelming (*The Star*, 3 November 1999). However, CGU has since been taken over by the Mutual and Federal group of insurers and the policy is no longer actively marketed. No further details about the future of the policy were available from the company.[18]

Shortly after the introduction of CGU's policy, Life Sense Medical Insurance group announced the launch of its rape policy, the Life Sense Rape Care Programme. For the cost of R11 per month rape survivors would receive medical and psychological care and special cover to upgrade security at their homes (South African Press Association, 3 November 1999).

The company's decision to introduce the policy grew out of observations made by its Disease Management component (which manages the medical treatment of HIV/AIDS) who noted that a number of clients had contracted HIV/AIDS after rape. The policy is still being actively marketed and claims between 50 000 - 80 000 members. Payment rates have dropped from the initial R11 per month to R9,93 per month and cover is now provided for an entire family.[19]

As our interviews highlight, organisations hold different understandings of what addressing the links between violence against women and HIV/AIDS entails. For some, addressing the links means answering questions from clients or training groups if they should arise, while for others it implies running projects which focus explicitly on the overlaps. Arguably only 11 projects are addressing the links in an ongoing and explicit manner. When projects focussing in some way on access to HIV PEP are excluded, this number shrinks

18. Personal communication, Di Jarvis, March 2001

19. Personal communication, Audrey Potter, March 2001.

further to four (the Sexual Rights Campaign, the Extension of Micro-credit Programme, the ALN training programme, and the RRA training programme).

Government responses to violence against women and HIV/AIDS

This overview is based on scrutiny of documents received from the South African Law Commission, and the Department of Health.

The South African Law Commission

"(M)ounting public concern and pressure on the authorities to take appropriate action with regard to the deliberate transmission of HIV infection....largely in response to a number of widely publicised incidents of deliberate transmission of HIV, accompanied by the very real concern that it is in the most part women and young girls who are being exposed to HIV infection in this manner" (SALC, 2000: vii), led the SALC to develop two reports focussing on the relationship between violence against women and HIV/AIDS.

Fourth Interim Report on Aspects of the Law Relating to AIDS

The Bill "Compulsory HIV Testing of Persons Arrested in Sexual Offences" was presented to the Minister for Justice and Constitutional Development, Penuell Maduna, in November 2000. It has yet to be enacted.

According to the SALC, the Bill is justified by women's vulnerability to sexual violence within a country combining both high levels of sexual violence and a national epidemic of HIV.

Should the Bill come into effect, it will permit a rape survivor (or person acting on their behalf) who has reported the attack to the police, to apply to a court to have the alleged rapist tested for HIV. The application should be brought within fifty days of the rape having taken place. The results of the test may only be made known to the survivor and alleged perpetrator and cannot be used as evidence in either civil or criminal matters arising from the rape. It will not be necessary for the rape survivor to appear in court for the application, nor will the arrested person be permitted to attend the hearing or give evidence.

The SALC claims that this process will benefit rape survivors in at least two ways. Not only might this knowledge give women some peace of mind about their attackers' HIV status, but it should also assist them to make important choices around the use of anti-retroviral drugs, and safer sex practices (2000: ix).

The SALC states that it had considered, but rejected, other possible legal or policy interventions in finalising the draft Bill. One of the interventions rejected included "(D)eveloping a governmental response (eg in the form of policy and practical guidelines) that answers the very real concerns of victims of sexual offences and provides them with comprehensive health and social services (including HIV testing and the provision of prophylaxis) in dealing with the possibility of HIV infection" (2000: xi).

In rejecting this route, a piece of law has been produced that is symbolic rather than practical. Symbolic laws certainly have their place, being useful in pushing for further change, as well as indicating that a problem is considered serious enough to warrant legislation. However, over and above the fact that it will not assist the many women who do not report being raped, it is probable that less than half of all women who report being raped will benefit from the Bill's provisions. According to statistics supplied by the Minister of Safety and Security, the police in Northwest Province, Mpumalanga and Gauteng make arrests in less than 40% of rape cases, while Northern Cape and Western Cape appear to have the best arrest records of all (58% and 56% respectively)[20].

Although some individual hospitals have set up guidelines on how to deal with rape and HIV, no national protocol is yet in place to guide health workers. Some health workers tell women about anti-retroviral drugs, others do not. Some women have access to these drugs, either through private medical aid schemes and rape insurance policies, while the vast majority do not. As the state shows no sign of making such treatment available to rape survivors, this group of women remains neglected.

The Bill highlights the need to develop law that incorporates and addresses South Africa's social context, as well as the need to avoid addressing complex issues in a piecemeal fashion.

Fifth Interim Report on Aspects of the Law Relating to AIDS

The SALC is currently finalising its fifth interim report on aspects of the law relating to AIDS entitled "The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour". The initial discussion paper was released for comment in 1999 but without draft legislation as the Commission was unable to come to any firm conclusion around the need to create such a statute.

Much of the debate in the discussion paper is technical in nature, arguing whether or not existing common law crimes such as murder or culpable homicide can be stretched to include harmful HIV-related behaviour. Legislative reform which has resulted in some kind of criminalisation in the states of Tennessee, Montana and Florida in the United States, the Australian state of South Australia and Zimbabwe is also considered. An additional question is whether or not exposure to the virus should also be criminalised, regardless of whether or not transmission occurs.

This is a complex area of law and it is beyond the scope of this report to explore questions of intentionality, liability and causality (just some of the legal issues under consideration). However, while some discussions around criminalising harmful HIV-related behaviour emphasise the benefits to women affected by violence, its potentially negative impact upon the self-same group of women must also be considered. Perhaps a law that punishes those who knowingly infect (or expose) others with HIV may act as a deterrent to such behaviour. However, it is necessary to consider the flip side to this scenario: the prosecution of women living with abusive partners. Given that HIV testing at

20. *Hansard* 'Interpellations, Questions and Replies of the National Assembly' *15 November 1999 col 1808*

ante-natal clinics is currently the main means of charting the prevalence of the disease, it is likely that more women than men will know their HIV status. However, if women are frightened to disclose their status to their abusive partners out of fear of their reaction, will this legislation pave the way for the prosecution of such women? Such a step may then lead to arguments about who infected who first and so ultimately lead nowhere in terms of prosecution and conviction. Still, the possibility of being charged with a crime is one more worry that should not be added to abused women's lives.

The Department of Health

The Department of Health released its "HIV/AIDS Strategic Plan for South Africa 2000 - 2005" in January 2000. Its stated purpose is "to guide the country's response to the epidemic...(*And act*) as a basis (*for government departments, organisations and stakeholders*) to develop their own strategic plans so that all our initiatives as a country can be harmonised to maximise efficiency and effectiveness" (2000: 1).

The document states as one of its guiding principles "(T)he vulnerable position of women in society shall be addressed to ensure that they do not suffer discrimination, nor remain unable to take effective measures to prevent infection" (2000: 11). We selectively review the document in relation to how it integrates violence against women and HIV/AIDS as one aspect of women's vulnerability.

Two of the primary indicators proposed to track the country's response to the epidemic are relevant to an integrated response to violence against women and HIV/AIDS. One indicator listed under 'Prevention', is the number of sexually active women using condoms (but it is not clear whether this refers to male or female condoms). This places the burden of prevention upon women (why is no parallel investigation of men's condom use proposed?) and neglects the social context in which condoms are used. As our previous discussion highlights, this is an area fraught with fear and even violence for women.

'Abuse of women' is included as another indicator. However, rape is the only gender-specific abuse listed under this section. The other suggested indicator is 'the number of cases of workplace abuse related to employees contracting HIV' (2000:12). Since this form of abuse is not unique to women, its inclusion within this category prompts the question of how the writers have conceptualised violence against women - particularly when no reference to domestic violence is included.

The Strategic Plan identifies four priority areas of action: prevention; treatment, care and support; research, monitoring and evaluation; and human and legal rights

- Goal 5 of 'Prevention' is the investigation of "options to reduce HIV/STD transmission and pregnancies resulting from sexual assault". Strategies for achieving this objective include reviewing research on the use of ART to

prevent HIV transmission following a sexual assault, and an assessment of sexual assault services for women and men (2000:16).

- Goal 15 of 'Human and Legal Rights' aims to develop policy and legislation relating to HIV/AIDS, commercial sex workers and sexual assault. Strategies include:
  - developing criminal law mechanisms which protect the rights of victims of sexual violence
  - investigating the provision of PEP to victims of sexual violence
  - investigating the decriminalisation of commercial sex work (2000: 21)

Domestic violence is not referred to at all in the document, nor is the development of microbicides. Condom usage is also promoted extensively by the Strategic Plan. Arguably, the Plan as it currently stands, has not been guided by the principle to ensure that women are able to take effective measures to prevent infection.

Despite its stated aims, the Department of Health also expresses contradictory attitudes towards ART for rape survivors. Thuthuzela Centre and Groote Schuur Hospital in the Western Cape both provide PEP to rape survivors (Groote Schuur having done so for the past two years). GRIP, however, was ordered out of state hospitals by the MEC for Health in Mpumalanga for providing a similar service. Notably, the decision to expel GRIP came very soon after President Mbeki's public questioning of the efficacy of AZT, while the Western Cape provincial government's announcement of a R2-million a year project to provide ART to rape survivors was announced shortly before local government elections in 2000. The Western Cape, unlike Mpumalanga, is one of two provinces not controlled by the African National Congress. It is not unreasonable to conclude that provision of ART is at least partly dependent upon political parties' stances on HIV/AIDS, as it is dependent upon their concern for rape survivors.

World AIDS Day 2000 (1 December) emphasised the theme "Men making a difference" (Gauteng AIDS Directorate, November 2000). In Gauteng, this was described as encouraging men "to take a lead in addressing their own sexual behaviour and the social role conditions that put our youth at extraordinary risk of HIV infection" (*ibid*). Men were to take on this challenge through their roles as parents, teachers, celebrities, religious leaders or workers. The campaign was to be closely monitored and a Campaign Review undertaken in January 2001.

Mann and Tarantola identify three dimensions to vulnerability to HIV infection: the personal, the programmatic and the societal (1996, in Tallis 1998:9). Factors contributing towards personal vulnerability may include lack of access to information, attitudes towards HIV, relationship dynamics (such as fidelity or violence within the relationship), biological vulnerability and personal skills. Programmatic vulnerability describes the contribution HIV/AIDS programmes make towards either increasing or decreasing vulnerability to infection, while societal vulnerability refers to how the broader socio-cultural context may impact upon women's risk of infection (1998: 9 - 10).

On the basis of the literature review, we have attempted to illustrate women's greater personal and societal vulnerability to infection. By neglecting to take these circumstances into account in designing programmes around HIV, institutions or organisations are further contributing towards women's vulnerability. As our overview finds, most government and NGO responses to HIV/AIDS and violence against women have been shaped and driven by concerns around rape. While what has been done to date around rape is by no means complete, the circumstances of women in abusive relationships have yet to feature on the policy, programme and legislation agenda.

In this section we identify a range of current gaps and put forward recommendations on how these could be addressed. In the absence of much-needed research to guide programme and policy development, most of these recommendations are inevitably short-term. They are also but one part of the long term goal to challenge and transform inequities between men and women.

1. Developing a shared understanding of violence

Attempts to integrate work around violence against women and HIV/AIDS offer opportunities to rethink definitions and strategies in creative ways that may increase our understanding of both violence and HIV/AIDS. Such reassessment is particularly important given how the intersection of the two issues allows for the emergence of new forms of discrimination and violence, as well as the intensification and compounding of existing problems. Virginity testing, community violence following disclosure of one's HIV-status (as in the case of Gugu Dlamini), and a lack of access to treatment and healthcare for women living with HIV have been identified as forms of violence against women by the HIV/AIDS sector. These behaviours have not traditionally been addressed by the violence against women sector.

Arguments around what constitutes violence are not academic self-indulgences as they carry implications for policy, legislation and intervention. Definitions are also of strategic and political significance. A broad definition of violence will allow for the inclusion of a large number of different acts, creating the impression of a widespread, compelling problem. Conversely, the more

narrow the definition, the more unusual the problem seems. Problems affecting greater numbers of people may attract greater political attention and appear more of a priority than those affecting a minority of people - particularly in a country with limited resources

However, broad definitions may collapse important analytical distinctions between acts and behaviours and ultimately become so inclusive as to be meaningless. This is particularly relevant to research. Precise and specific definitions are more likely to enable clear identification of exactly which acts or behaviours may increase or decrease the risk of HIV transmission, as well as to permit comparisons between studies.

In trying to increase understandings of violence, it is helpful to distinguish between circumstances that facilitate or increase vulnerability to violence, from the violent acts themselves. Understanding what makes behaviour violent or abusive also always requires attention to the context and meaning of the act. In some instances virginity testing will increase vulnerability to sexual violence.When performed without consent, or used by the tester as an opportunity to fondle a child's genitals, then it certainly constitutes an abuse. Another example is abandonment. All things being equal, abandonment, by itself, would be morally reprehensible but not necessarily abusive behaviour. However, all things are not equal between men and women; women do not enjoy the same rates of employment as men nor the same income levels and, as a result, are very likely to be economically dependent upon their partners. Deserting somebody under these circumstances as well as leaving them solely responsible for the care of dependent children is arguably abusive. By broadening the current legal definition of domestic violence such circumstances may fall within the ambit of the Domestic Violence Act (which can also be used to enforce maintenance orders).

Recommendations:

- standardisation of definitions for research purposes
- testing the ability of the Domestic Violence Act to accommodate abandonment as a form of economic abuse
- testing the ability of the Domestic Violence Act to protect women who experience violence following their disclosure of their sero-status
- developing a rights framework through which to tackle violence, as well as access to care and treatment.

2. Integrating work around violence against women and HIV/AIDS

One interviewee from the violence against women sector observed that HIV/AIDS is seen as an issue requiring specialist knowledge - a factor which has inhibited their engagement with issues relating to HIV/AIDS. However, interviewees from the HIV/AIDS sector noted that gender has not been well-

integrated in HIV/AIDS work - and it was also clear from some interviews that a few organisations are uncomfortable with gender analyses of violence and HIV/AIDS. As a result, neither sector has really been able to take up issues and concerns arising from the overlap of violence with HIV/AIDS.

Recommendations:

- in-service training around HIV/AIDS for violence against women organisations
- in-service training around gender and violence against women for HIV/AIDS organisations
- joint advocacy around issues such as the provision of HIV PEP
- increasing opportunities for networking, advocacy and information-sharing through bodies such as the National Forum emerging from the Tshwaranang seminar, the AIDS Legal Network, the Treatment Action Campaign, and the National Network on Violence Against Women.

3. Making shelters for abused women accessible to HIV-positive women

In their research for the book *Reclaiming Women's Spaces*, Park, Peters and De Sa identified 25 shelters for abused women and their children in South Africa, with the majority being clustered in urban areas (2000: 252). According to Park *et al*, policies regarding women with HIV/AIDS vary from shelter to shelter, with some accepting HIV-positive women and others not. Most are not equipped to deal with women with full-blown AIDS (2000:269). Our impression is that shelters also feel ill-equipped to deal with HIV-positive women (on the basis of a lack of knowledge and resources), and, in a communal setting, also do not know how to protect other residents from possible infection.

At the time of the book's publication, research to develop a policy on women with HIV/AIDS and shelters was under way which will ensure the admission of HIV-positive women into shelters and guarantee that their status is kept confidential (*ibid*). At the time of writing this report, the policy was still not finalised.

In light of Maman *et al's* (2001) findings of a relationship between HIV and violence, drawing in the shelters forming part of the battered women's movement in South Africa is particularly important. HIV infection may increase women's risk of violence, and abandonment may become an actual consequence of disclosure to an abusive partner - both circumstances potentially increasing women's need and use of shelters. HIV-positive women staying in shelters may be stigmatised by other shelter residents, making it important to openly address residents' fears of infection, as well as their treatment of HIV-positive women. The presence of an HIV-positive woman may also awaken other residents' fears about their own status and shelter workers may very well need to support women through the process of being tested.

Recommendations:

- finalisation and adoption of policy/practice around admissions and treatment of HIV-positive women
- in-service training for shelter workers to increase their knowledge of the linkages between HIV/AIDS and domestic violence
- developing information and education programmes around HIV/AIDS as a standard component of shelter programmes. This may include encouraging women to participate in VCT
- assisting women to comply with treatment regimens.

4. Deciding the controversies surrounding HIV PEP

There is no conclusive data on the effectiveness of AZT after sexual exposure (Sowadsky, 1998). The supposition that it could prevent HIV infection is extrapolated from other situations. The provision of AZT to healthcare workers after occupational exposure to HIV (such as needlestick injuries) has proven safe and effective. In addition, certain animal studies have suggested that a window of opportunity may exist in which ART could suppress HIV infections after exposure to HIV. The prevention of mother-to-child transmission through the provision of ART has further added scientific evidence on the effectiveness of ART in preventing HIV transmissions.

In the absence of clinical trials investigating the efficacy of ART, medical centres providing HIV PEP to rape survivors are attempting to monitor sero-conversion. However, monitoring and follow-up of rape survivors' compliance with treatment and their experience of side effects presents a key challenge. Based on the lack of routine follow-up, it is difficult to quantify the number of rape survivors who do sero-convert (Kim, 2000). Nonetheless, of the approximately 500 rape survivors who have presented for treatment at Sunninghill Clinic since 1998, 68% qualified for PEP. Seventy percent of this group completed the full PEP regimen. None of the clients followed up have sero-converted with the exception of one survivor who received PEP more than four days after the rape (*ibid*). Groote Schuur Hospital has provided PEP to approximately 40 of the 100 rape survivors, who have presented for treatment. Routine follow-up and monitoring of sero-conversion is scheduled at intervals of one week, six weeks and three months but data is not available yet as formal monitoring mechanisms are still being put in place (*ibid*).

Several issues are relevant to PEP and violence against women:

- Within a situation of domestic violence, where sexual violence may be prevalent, there is an increased risk of repeated exposure to the virus, especially if the partner is known to be HIV-positive. PEP is not, however, recommended in cases of repeated exposure (Sowadsky, 1998).

- In most cases, PEP involves an initial 3-day emergency dose of ART within 72 hours of the rape. This is accompanied by baseline HIV tests to determine the sero-status of a person before the usual four week regimen is prescribed. Given the stigma attached to being HIV-positive, as well as the possibility of partner violence in the face of disclosure, women may not want to learn their HIV status.
- The treatment regimen of PEP is complex and must be taken as prescribed if it is to be effective. If not taken, drug resistance to the virus can occur. The drugs also have a host of side effects, some of which can be serious (Sowadsky, 1998). There may be many situations in which women will not disclose being raped (out of fear of being blamed, or through not wanting to upset other family members). Trying to keep the rape a secret may give rise to a host of practical issues in complying with treatment where a woman has not disclosed to her support system or has a non-existent support system. In this context, the likelihood of complying with taking medication as prescribed, or taking medication at all, is reduced.
- PEP needs to begin no later than 72 hours after an incident of rape (Sowadsky, 1998). In rural areas where there is generally very poor infrastructure, women's accessibility to these kinds of services within 72 hours is seriously compromised, placing them at risk of HIV infection.

Given that a number of women do not define their experiences of force and coercion as rape, it may be necessary to make ART available to all those who have been exposed to high risk sexual encounters (this would include situations where a condom bursts and it is known that the one partner is positive), rather than only to those women and men who report rape. This approach would have to be balanced against the caution of not using ART in cases of repeated exposure, or of creating the impression that ART is a substitute for safer sex practices. Alternatively, provision of ART should perhaps not be linked to reporting of rape to the police.

Recommendations:[21]

- prioritising research into the efficacy of ART to prevent HIV infection following rape
- developing a comprehensive policy on rape and HIV/AIDS. Such a policy should also consider the feasibility of not linking access to ART to reporting rape
- investigating measures to provide ART to rape survivors at state expense (based perhaps on the criteria developed by Groote Schuur)
- ensuring that all rape survivors receive information and counselling on the risks of HIV infection following rape, the efficacy of ART in reducing the risk of transmission, safer sex practices, and pre- and post-test counselling

21. We have adapted a number of these from the AIDS Legal Network's Lobbying Update on rape and HIV/AIDS (No 2, August 2000).

- training rape crisis counsellors or HIV/AIDS service providers to assist women with complying with ART
- providing public education around the health rights of rape survivors.

5. Development of microbicides[22]

Microbicides are attractive because their use does not depend upon male co-operation - a very significant consideration in the face of domestic violence and/or men refusing to use condoms. A microbicide is a substance inserted into either the vagina or rectum to reduce the transmission of STIs (including HIV). They can be manufactured in different formulations including gels, sponges, vaginal rings, creams, suppositories or foams. Microbicides work in three ways:

- killing the virus, or acting as a barrier to it
- inhibiting the virus from infecting particular cells
- making the vagina (or rectum) into a hostile environment to prevent the virus from taking hold.

No viable microbicide currently exists, although there is growing consensus that it is theoretically possible to develop a product that can prevent the transmission of HIV and other STIs.

Recommendations:

- research by pharmaceutical companies to develop viable microbicides
- the prioritisation of microbicide development in policy documents such as the National AIDS Strategic Plan (microbicides are not mentioned at all in the current Strategic Plan)
- advocacy to promote the development of microbicides

6. The criminal justice system and HIV-positive women

A further gap to consider is the treatment by the criminal justice system of HIV-positive women. The 1997 gang rape in Mamelodi, Pretoria of a twelve-year-old girl is a case in point. She died some two years later in 1999 before the case was tried. The matter was then withdrawn and the suspects freed (*Saturday Star*, 4 December 1999).

Much public indignation around the case seems to have focussed on whether or not the girl had been infected with HIV by the alleged rapists. While such concerns are potentially relevant to the nature of charges laid against the suspects, they are irrelevant at another level. All sexual offence cases involving HIV-positive complainants need to be prioritised by the police and courts, regardless of whether or not the women were already infected at the time of the attack, or infected as a result of the attack. Stress is thought to exacerbate the progression of HIV/AIDS. In addition to the rape itself, other factors

22. *Information supplied by Vicci Tallis from research in progress for the Treatment Action Campaign*

compound such women's stress, including police investigations that go nowhere, and court cases that limp along. Police officials and court prosecutors need to be made aware of how their behaviour may (unintentionally) play a role in worsening someone's health.

Recommendations:

- developing and implementing standing orders for members of the South African Police Service (SAPS) around the treatment and handling of rape survivors who are HIV-positive or at risk of HIV infection. In light of the provisions contained in the Bill allowing for the compulsory HIV testing of rape suspects, this process must be accompanied by training on HIV for members of the SAPS - particularly as the Bill proposes that a SAPS investigating officer be the one to deliver the results of the HIV test to the rape survivor concerned
- developing and implementing a protocol for prosecutors around the treatment of HIV-positive rape survivors. Again this should also be accompanied by training around the protocol
- monitoring and engagement with the SALC's fifth interim report, "The Need for a Statutory Offence Aimed at Harmful HIV-related Behaviour"
- advocating for a comprehensive, multi-dimensional strategy around the implementation of the proposed compulsory HIV testing legislation.

7. VCT and violence

Partner notification is usually promoted in VCT programmes and programmes on MTCT. The objective of such disclosure is to promote safer sex practices and encourage partner testing.

The likelihood of disclosure benefiting both the woman and her partner is intricately linked to the level of expertise which counsellors bring to VCT, including confidentiality, non-judgmental attitudes, gender sensitivity and knowledge of violent relationships. Suggesting couple counselling for instance, when a woman is in an abusive relationship may place her at increased risk of abuse. The World Health Organisation (1999) recommends as minimum requirements for VCT in ante-natal settings adequate numbers of qualified, trained staff, the maintenance of confidentiality through the provision of adequate space, as well as staff debriefing. However ante-natal clinics are often short-staffed, over-crowded, and not always able to offer privacy. Some nurses may be judgmental (Mthembu, 1998; and Sewpaul and Mahlalela, 1998) as well having limited or no knowledge of domestic violence. Nurses also experience a high degree of stress and burnout.

These factors pose serious challenges to traditional VCT models.

Recommendations:

- developing a screening protocol on domestic violence for HIV counsellors which will lead to routine screening of all women testing for HIV
- training on domestic violence for HIV counsellors. Such training should address myths and stereotypes about domestic violence, provide information about women's options and legal remedies, as well as how to assess the risk of violence women might face in disclosing to their partners. If women cannot disclose their status for fear of the consequences, they should be supported in that decision
- referring women to other specialist services dealing with violence against women
- investigating the use of third parties to assist women with disclosure of their HIV status. Maman *et al* (2001) cite the case of a woman whose priest assisted her to inform both her partner and family of her status
- revising the National AIDS Strategic Plan to take into account the relationship between domestic violence and HIV/AIDS.

8. The ABC of HIV prevention: creating messages for men and women

The message to abstain, be faithful, and to use a condom is still proposed as the main approach to the prevention of HIV transmission. At the risk of repetition, this is not a viable response to the HIV epidemic for the many women subjected to rape and other forms of sexual coercion, or whose partners are neither faithful nor willing to use condoms. The ABC is far too blunt an instrument to deal with these lived realities and, as long as it remains the primary approach to dealing with HIV, contributes significantly to women's programmatic vulnerability to HIV.

Alternatives to this approach must take into account the subtle process by which women come to define and understand their experiences of sexual coercion, as well as the negative meanings attached to condom use. Further, for behaviour change to take place, individuals must not only be willing to change, but also be located in the kind of environment that supports such change (Webb, 1997). It is most important then that health workers, educators and researchers engage far more actively with communities of women and men. Such community-based options may also create the kinds of supportive contexts needed to encourage and sustain behaviour change (Campbell *et al*, 1998).

Recommendations:

- evaluating existing projects and initiatives to understand what, if anything, is the extent and nature of their impact and effectiveness. This would also include assessing whether or not particular projects can be duplicated elsewhere

- engaging in public information and education campaigns to challenge coercive sexual practices and marital rape. These campaigns should be developed in conjunction with women. A group of women like those interviewed by Kottler provide invaluable insights into understanding how women deal with sexual violence, the process they engage in to redefine their experiences, as well as how such changes are brought about and sustained
- developing public education and information campaigns with men
- developing public information and education campaigns that outline how to access government grants (such as disability grants, or child support grants) in the event of abandonment by a partner, or how to use the Domestic Violence Act to deal with abandonment
- developing public information and education campaigns around treatment and care options.

9. Research

Here we broadly sketch out some of the many research questions needing answers.

Recommendations

- investigating the links between childhood sexual abuse and rape and women's subsequent involvement in high risk sexual behaviour (as either adolescents or adults)
- investigating the impact of violence upon the care and treatment of HIV-positive women
- investigating the causal pathways between HIV and violence to disentangle risk factors
- investigating the risk of HIV infection following rape
- investigating whether experiences defined as `forced' sex or `pressurised' sex carry a greater or lesser risk of HIV infection than experiences defined as rape
- investigating the meanings men and women attach to testing and disclosure
- investigating the consequences of disclosure for both women and men
- investigating the gendered dimensions of community perceptions and responses to women and men living with HIV or AIDS.

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Condemned to death by AIDS rapists (*Sunday Times*, 10 November 1996).

No lifeline for rape survivors facing AIDS (*The Star*, 4 March 1997).

Rape victim waits for AIDS test results (*The Star*, 4 June 1997).

UN sees link between AIDS and Gender Violence (*Inter Press Service*, 3 March 1999).

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Free AZT for rape victims (*Weekly Mail and Guardian*, 16 April 1999).

Zuma resists rape/HIV studies (*Weekly Mail and Guardian,* 21 May 1999).

Dlamini case dropped for lack of proof (*The Sunday Independent*, 14 August 1999).

AIDS worker killing fiasco under review (*The Mercury*, 31 August 1999).

'I was raped, I have HIV, but I will not give up' (*Weekly Mail and Guardian*, 15 October 1999).

'World first' rape insurance draws fire (*Cape Argus*, 12 October 1999).

Insurer says rape policy 'compassionate' (*The Star*, 12 October 1999).

'Rape survivor policy' slammed (*The Star*, 12 October, 1999).

Big response to rape insurance pioneer (*The Star*, 3 November 1999).

SA unveils second rape insurance policy (*South African Press Association*, 3 November 1999).

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Sex Abuse is normal, say women (*The Weekly Mail and Guardian*, 23 June 2000).

DA fires broadside on AIDS and rape (*Cape Argus*, 10 August 2000).

Man kills wife, her mom, self. (*Sowetan*, 23 August 2000).

Rape crisis as Mpumalanga shuts down NGO care (*Cape Times*, 16 October 2000).

Rob saga takes turn (*Lowvelder*, 6 March 2001).

Doubt on accuracy of Aids stats (*The Weekly Mail and Guardian*, 23 March 2001).

LIST OF INTERVIEWEES

Organisational representative	*Organisation*
Abdool Karim, Quarrisha	Medical Research Council (KZN)
Browers, Jeannette	Northern Cape Family Violence Fund
Christian, Brandon	Campus Law Clinic
Doans, E; Dudu, Z; and Modisane, D	Masimanyane Women's Support Centre
Fichardt, Valerie	AIDS Consortium
Dr. Floyd, Liz; and Molefe, Pauline	Gauteng Department of Health
Dr. Gazi, Costa	AIDS Babies Battling AIDS (ABBA) Trust
Hatane, Luanne	National AIDS Council of SA (NACOSA)
Heyward, Mark	AIDS Law Project
Hollamby, Gordon	South African Law Commission
Jarvis, Di	Mutual And Federal
Jewkes, Rachel	Medical Research Council (Gauteng)
Kedama, Pumzile	Planned Parenthood Association of South Africa (PPASA)
Kenyon, Barbara	Greater Nelspruit Rape Intervention Project (GRIP)
Kim, Julia	Health Systems Development Unit (HSDU), Department of Community Health, University of the Witwatersrand
Kissy, Freddy	Phagameng HIV/AIDS Information and Counselling Centre
Kubayi, Winnie	Centre for Criminal Justice
Mabatha, Nompumelelo	Gender Aids Forum
MacPhail, Catherine	Council for Scientific and Industrial Research (CSIR)
Madazhe, Mashudu	Centre for Positive Care
Makhaye, Gethwana	Shoshaloza Project
Dr. Martin, Lorna	University of Cape Town (Dept. of Forensic Medicine)
Maseko, Phepsile	Traditional Healers Association.
Masindi, Ndivhuo	Women's Health Project
Memela, Lungiswa	Western Cape Network on Violence Against Women
Merckel, Judy	Reproductive Rights Alliance
Meyersfeld, Sarranne	AIDS Training Education and Counselling (AIDSTEC)
Miller, Rolene	Mosiac
Mngomezah, Siphiwe	People Opposing Women Abuse (POWA)

Organisational representative	*Organisation*
Moema, Solly	Mothusimpilo
Mohapi, Charlotte	AIDS Counselling Care and Training (ACCT)
Moodley, Vanita	Vukuzithathe Network
Msezane, Bafana	Regional Head: Oxfam Australia
Mthembu, Promise	Treatment Action Campaign (TAC)
Musaba, Elizabeth	Empilisweni
Mwale, Thembeka	Siyophila
Nairne, Dorothy	AFRICARE
Ngubeni, Florence	Peri-Natal Research Unit (RHRU)
Nkosi, Rachel and Sideris, Tina	Masisikumene
Nyathi, Nomsa	National Association for People living with HIV/AIDS (NAPWA)
Potter, Audrey	Life Sense Group
Rose, Leslie	Coronation Women's Hospital
Singh, Dinesh	Open Door
Singh, Sewera	Nelson Mandela School of Medicine
Sister Bhagasa	Thuthuzela Project
Smith, Charlene	Consultant / Journalist
Snyders, Eugenie	National Education, Health and Allied Workers Union (NEHAWU) / Congress of South African Trade Unions (COSATU)
Strode, Ann	Aids Legal Network
Tallis, Vicci	Consultant
Thekiso, Mpho	National Network on Violence Against Women
Towell, Liz	Sinosizo Home Based Care
Tshabalala, Felicity	Township Aids Project
Dr. Usdin, Shireen	Soul City
Van der Merwe, Bernice	AIDS Action Group
Webster, Naomi	Tshwaranang Legal Advocacy Centre
Woodin, Niccola and Tinto, Ntombomzi	Rape Crisis (Cape Town and Khayalitsha)
Dr. Wulfsohn, Adrienne	Sunninghill Clinic