

# HIV/AIDS and violence against women

ALEXANDRA NEAME reflects upon why World AIDS Day is significant in the campaign to end violence against women

The annual *16 Days of Activism Against Violence Against Women Campaign* begins on 25 November, International Day for the Elimination of Violence Against Women, and concludes on 10 December, International Human Rights Day. The campaign spans these two dates as a way of identifying women's rights, including the right to live free from violence, as *human rights*. World AIDS Day, on 1 December, is often mentioned as significant in the "16 Days" period. However, there is little elaboration, in Australia at least, of the links between violence against women and HIV/AIDS.

This discussion of the links between HIV/AIDS and violence against women is framed in the context of South Africa, for two reasons. First, the sheer magnitude of the problems of gender violence and HIV/AIDS in South Africa means that much research on the intersection of violence against women and HIV/AIDS is being produced there. Second, these conditions are also gradually prompting a re-evaluation of both gender violence and HIV prevention strategies, and the emergence of new best practice responses that link violence against women and HIV/AIDS.

## Prevalence of gender violence and HIV/AIDS in South Africa

Globally, HIV/AIDS and violence are the greatest public health issues facing women today (Jacobs 2003). South Africa's rates of both violence against women and HIV/AIDS are among the highest in the world.

### HIV/AIDS

Sub-Saharan Africa remains the world's worst affected region, with 25–28.2 million adults and children living with HIV/AIDS; 3–3.4 million newly infected; and an adult prevalence rate of 7.5–7.8 per cent, according to the *AIDS Epidemic Update 2003* (UNAIDS and WHO 2003). It is also the only region in the world where women are significantly more likely (at least 1.2 times) to be infected than men. The ratio is highest among young people aged 15–24 years, with two and a half times more women than men infected.

Women's greater vulnerability to HIV is mediated by both biological and socio-cultural factors.

In South Africa, the rate of HIV infection among pregnant women attending antenatal clinics has reached 25 per cent<sup>1</sup>; however, these statistics do not highlight the gendered distribution of HIV/AIDS. The Nelson Mandela/HSRC HIV/AIDS Survey indicated that the age group 25–29 is most at risk of infection, with prevalence at 28 per cent. In the 15–29 age group, prevalence is 17.6 per cent for African women, compared with 13.5 per cent for African men. A Medical Research Council study of death certificates from 1997–2001 found that AIDS related illnesses killed 22.5 per cent of the young women aged 15–29 who died in 2001, while the proportion of men who died from AIDS in the same period was 7.6 per cent (South African Department of Health 2002).

### Violence against women in South Africa

The 1995 Human Rights Watch report *Violence Against Women in South Africa: State Responses to Domestic Violence and Rape*, noted that the levels of reported rapes had risen each year, attributing the increase both to greater reporting and increasing violence generally. The number of reported rapes increased by 20 per cent from 1994 to 1999, with 51,249 rapes reported in that year. Estimates of the levels of under-reporting vary. However, South African Police themselves suggest that only 1 in 35 rapes are reported to them. Based on police statistics and estimates of underreporting, a study by the University of South Africa estimated that one million women and children are raped annually (cited in Leclerc-Madlala 2002).

Physical and sexual violence against women in intimate partnerships is believed to be endemic in South Africa. The most conservative prevalence estimates, from the 1998 South African Demographic and Health Survey (SADHS), found the incidence of abuse by a partner in the last year was highest at 7.9 per cent for those aged 20-24, and 7.3 per cent for 15-19 year olds (Department of Health 1998). Smaller, more targeted studies revealed especially alarming rates of sexual violence and/or coercion experienced by young women in relationships:

- The LoveLife survey found 39 per cent of 12-17 year olds reported having been forced to have sex, and 33 per cent indicated that they were afraid of saying no to sex (cited in Kistner 2003a: 9).
- Maforah et al. (cited in CHANGE 1999: 10) surveyed 191 teenage mothers at an antenatal clinic outside Cape Town. Of these mothers, 32 per cent reported that their first intercourse had been forced; 72 per cent reported having sex against their will at some point; and 11 per cent said they had been raped. In addition to this, 78 per cent claimed they would be beaten if they refused sex; and 58 per cent said they had been beaten by their sexual partner ten or more times.

While both gender-violence and HIV/AIDS have been regarded as at epidemic proportions for some time, the idea that these two threats to women's health may be causally linked is more recent. The next section considers some of the explanatory frameworks now being used to describe the relationship between sexual violence and HIV/AIDS.

### HIV/AIDS and violence against women

Rather than understanding violence against women and HIV/AIDS as distinct social and medical problems, there is a consensus that "patterns of HIV transmission, incidence and prevalence are structured by gender and social inequalities, within which violence against women and girls is embedded" (Kistner 2003a: 11). The World Health Organisation's *Violence Against Women and HIV/AIDS: Setting the Research Agenda* (WHO 2000: 12), identified four linkages between violence and HIV:

- forced sex may directly increase women's risk for HIV, both as a result of physical trauma, and because condom use is unlikely in such contexts;
- violence within intimate partnerships limits women's ability to negotiate safe sexual practices within the relationship, and thus compromises HIV prevention efforts;
- childhood sexual abuse may lead to increased sexual risk taking as an adult; and
- HIV testing and disclosure of serostatus<sup>2</sup> may increase women's risk of experiencing violence.

### Rape and HIV/AIDS

Women's greater vulnerability to HIV infection is mediated by both biological and socio-cultural factors in South Africa. It is known that during heterosexual intercourse women are at greater risk of HIV transmission than men for physiological reasons (the vagina's greater mucosal surface can sustain more abrasions and this increases the likelihood of infection)<sup>3</sup>. Women are also more likely to have asymptomatic and untreated sexually transmitted infections, which dramatically increase the risk of HIV transmission (Weiss and Gupta 1998). Since sexual assault can involve more genital trauma than consensual sex, forced sex is seen as further increasing women's risk of contracting HIV<sup>4</sup>. In the South African context, high levels of HIV infection in the general population make it likely that many sexual assaults are committed by perpetrators who are HIV-positive.

There have been moves in South Africa to provide rape victims with free post-exposure prophylaxis (PEP), a course of antiretroviral drugs to prevent seroconversion and HIV infection (Kistner 2003b). However, there are a number of salient arguments about whether this is cost-effective or even ethical. The World Health Organisation demonstrates that, from a public health perspective, PEP following rape would prevent only a very small number of infections for a massive investment of resources (WHO 2000: 34-36). Poor compliance has been noted for PEP in many studies, further decreasing the value of such an investment.

In terms of the ethics of administering PEP to rape victims, there is a small window of opportunity for PEP to be started after potential exposure (72 hours, at the outside). This means that only ►

Research into gender and HIV suggests that violence against women cannot be understood as an isolated issue, or as contained solely within the boundaries of sex and gender relations.

victim/survivors reporting and seeking medical treatment immediately after the rape will receive treatment. It has been suggested that the trauma of HIV testing and the side effects of the drugs would compound the trauma already suffered by victims. Another problem with PEP from a victim/survivor perspective is that it reinforces the invidious distinction between women who are the victims of stranger rape, and those who experience ongoing sexual violence at the hands of an intimate partner.

Finally, state provision of antiretroviral drugs to a particular “class” of people (victims of sexual assault), when drugs are not usually obtainable, raises the question of equity. Is it ethical to imply that rape victims “deserve” antiretroviral drugs more than people who have been infected through consensual sex, or vertical transmission? Given the stigma and prejudice attached to HIV/AIDS, any intervention that symbolically identifies certain people as deserving or undeserving of treatment, and therefore attaches ideas of innocence or guilt to different modes of transmission, is highly problematic.

### Violence and gender inequality in intimate partnerships

Sexual violence and coercion within intimate partnerships exacerbate women’s biological vulnerability to HIV infection for the reasons outlined above. In addition, however, intimate partner violence and sexual abuse exist within broader patterns of gender inequality that undermine women’s ability to

protect themselves from HIV. Two problems emphasised in the literature are sharply differentiated norms of masculinity and femininity, and an ensuing sexual double standard. Both these factors are evident to a greater or lesser degree in virtually any culture; however, they are having particularly disastrous consequences in the context of South Africa’s HIV pandemic.

Kistner (2003a: 45) is one of many authors who emphasise the problematic nature of gender identity in South Africa. According to these authors, “masculinity” is constructed by many South Africans in terms of positively valued attributes such as commanding sex within a relationship, having uncontrollable sexual “needs”, and controlling decisions about sex, sexual experimentation, and having multiple

partners. “Femininity”, in contrast, is frequently described in terms of not having multiple partners, providing sexual pleasure to men, and taking responsibility for reproductive and sexual health issues.

Such a gender dichotomy leads to a sexual double standard that enshrines men’s sexual access to women and sanctions male sexual experimentation and multiple partners, while closely regulating women’s sexuality. Where men explicitly disassociate having multiple partners from promiscuity (a trait only associated with women), they may refuse to take responsibility for safe sex, and women may not be able to challenge this refusal. When these gendered power dynamics are taken into account, the insensitivity of HIV prevention strategies to women’s experience of sexual relations becomes apparent. The classic HIV prevention strategy relies on implementing the “ABC” of sexual practices: *Abstain; Be monogamous; Condomise* (use condoms).

Advising abstinence as a means of HIV prevention assumes that women are always in control of when they have sex. Varga’s (1997) study of sexual decision-making and negotiation among youth in KwaZulu-Natal challenged such an assumption. She found that although 55 per cent of the women reported having refused sexual advances from their current boyfriend, 71 per cent had “not been successful”. Varga (1997: 56) states: “Refusal nearly always resulted in physical coercion, abuse or threats of rejection. Many female subjects chose not to refuse sex in order to avoid physical abuse and maintain the stability of the relationship.”

Within an established sexual relationship, women’s monogamy is of little value in terms of HIV prevention if they are unable to secure *men’s* fidelity. In the study referred to above, Varga also describes the importance men place on being *isoka* (a man with many sexual partners), rather than *isishimane* (a man having only one or none). The young men in her study emphasised that *isoka* and promiscuity are completely unrelated: “Being *isoka* was considered a natural, laudable and traditional part of African manhood. In contrast, being promiscuous was seen as being distasteful and dirty... associated with women thought to have many sexual partners – such women being known as *izifebe*, whores” (Varga 1997: 56).

A study from Rwanda (Allen et al. 1991) of 1458 women aged 18-35, illustrates the danger women are exposed to when they assume that *their* fidelity protects them from HIV. Ninety per cent reported being monogamous, although only 34 per cent felt certain of their partner’s fidelity. Twenty-four per cent of women who thought they were in mutually monogamous relationships were HIV positive. Two-thirds

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of the women had had only one lifetime partner (their husband), yet 21 per cent of these were infected. As Heise and Elias (1995: 934) point out: “Many women feel incapable of challenging their husband’s infidelity – to do so places their relationship, their economic security and their physical safety at risk.”

Finally, women report significant difficulty in persuading their partner to accept condom use, as it is seen as a sign of distrust or infidelity (Selikow, et al. 2002; Fox 2003). AIDS workers report that men are more likely to use condoms with girlfriends or prostitutes than with wives or primary partners. Men’s refusal to use condoms, and both men and women’s association of condoms with distrust and infidelity and a subsequent unwillingness to suggest condom use, are significant barriers to HIV prevention in virtually every society (Weiss and Gupta 1998).

For this reason there has been a strong push to develop a topical microbicide – a substance that can be used in the vagina to reduce the transmission of HIV and other sexually transmitted infections (Gottemoeller 2000). This technology, unlike condoms, is within women’s control, and would give women the ability to protect themselves from HIV without the consent, or even knowledge, of their partner. Heise and Elias (1995: 940) make a strong argument for the development of a microbicide to be seen as a question of gender equality: “Only women who confront centuries of social conditioning that grants sexual licence to men, are expected to protect themselves with a technology that is outside of their personal control.”

### Childhood sexual abuse and high risk behaviour

The Research Agenda outlined by the World Health Organisation refers to studies indicating that women with a history of childhood sexual abuse initiate sexual behaviour earlier and engage in more risk taking behaviour. The World Health Organisation suggests that research should be undertaken to ascertain whether there is a direct association between childhood sexual assault and HIV, perhaps because “childhood sexual assault lower[s] self esteem, which then affects self-perceived ability to negotiate safe sex” (WHO 2000: 14).

Locating the source of high-risk sexual behaviour in childhood sexual abuse risks pathologising women and sexual assault victims; indeed, the World Health Organisation poses as a topic for future research: “Does childhood sexual abuse create expectations about partnerships that women fulfil in their choice of partners?” (WHO, 2000: 14).

While supporting victims of child sexual abuse is an end in itself, psychologising and internalising women’s “choice” of high-risk sexual behaviour neglects the numerous (and arguably more important) reasons that underlie high-risk sexual activity. The link between child sexual abuse and adult high-risk behaviour is occasionally mentioned in the South African literature<sup>5</sup>. However, there is frequent reference to the risks involved in a broad range of sexual practices that can be grouped under the rubric of *transaction or survival sex*, and there are compelling reasons for treating this group of practices as distinct from the long-term effects of child sexual abuse.

### Transaction or survival sex

There has been a rather naive tendency in HIV prevention theory to assume that people engage in sex, especially high-risk sex, in pursuit of pleasure. The childhood sexual abuse thesis positions high risk sex as a response to childhood trauma. Yet the implication for prevention strategies remains: high risk sex is an individual “choice”, resulting from some form of *internal* prompt, be it desire or trauma. From this perspective, avoiding high-risk sex is simply a matter of exercising self-control on the basis of a rational calculation. For many of the world’s women, however, engaging in high-risk sexual practices (like having more than one partner, exchanging sex for resources, or agreeing to particular types of sex to avoid abandonment) is more appropriately described as an economic survival strategy (Jacobs 2003).

Sexual relationships underwritten by economic necessity range from “sexual networking”<sup>6</sup> through to outright exploitation and abuse. At the more exploitative and abusive end of the spectrum, survival sex poses a range of HIV risks, in addition to that of multiple partners. Such relationships are characterised by a large age gap – a well-established HIV risk factor for young women (Kistner 2003a). They are also necessarily premised on an asymmetry of power, which constrains or nullifies the extent to which women can negotiate safe sex. ➤

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A typical example of transactional/survival sex is the large number of secondary school girls in Africa who are exploited by older men to afford school fees and expenses (Human Rights Watch 2001). Recognising the external (economic and social) forces implicated in transactional/survival sex (in contrast to the individualist perspective of the childhood trauma/high risk behaviour model) has important implications for HIV prevention. As Heise and Elias (1995: 939) point out: "Subsidising the uniform and school fees of adolescent girls in Africa might actually do more to reduce HIV transmission – by eliminating the need for Sugar Daddies – than the most sophisticated 'peer education' campaign."

As South Africa moves from an HIV epidemic into an epidemic of AIDS-related morbidity and death, younger children (especially girls) are increasingly left to care for dying relatives, or heading households after the death of parents<sup>7</sup>. A lack of economic and social support will dramatically increase the pressures on such young women to engage in transaction or survival sex.

### Voluntary counselling and testing and disclosure of serostatus

As well as increasing women's risk of contracting HIV, violence against women has been identified as a consequence of HIV/AIDS. Women may avoid voluntary counselling and testing for fear of their partner's reaction, and those who do disclose their serostatus may be at increased risk of violence. A study of the links between HIV infection, disclosure and partner violence found that 82 per cent of women who tested negative said that their partners showed support and understanding, while only 49 per cent of those who tested positive received a similar response (Population Briefs Special Edition 2000). Fear of stigma, violence or abandonment may also prevent women from taking AZT<sup>8</sup> during pregnancy to avoid vertical transmission, and from formula feeding their babies.

There is debate about whether men's experience of a positive HIV test result leads to violence against women. A number of authors mention anecdotal reports of men "vowing to infect women, so as not to die alone" after testing positive (Kistner 2003a: 71; Leclerc-Madlala 1997; Vetten and Bhana 2001). There is also substantial (and emotionally charged) debate over whether the "virgin cleansing" myth (that sex with a virgin can cure HIV) is leading to an increase in the rape of young girls and even infants by HIV positive men.

### The "virgin cleansing" myth

There has been a great deal of media attention, both in South Africa and internationally, on a perceived increase in child rapes because of the belief that sex with a virgin can "cure" HIV/AIDS. Both the extent of belief in the myth, and whether child rape is increasing because of it, are strongly contested.

Rachael Jewkes, Director of Gender and Health Research at the Medical Research Council, has argued that child rapes had existed in South Africa long before the AIDS epidemic, and that the attribution of child rapes to the virgin cleansing myth protects men's interests because it "enable[s] public outrage to be channelled without challenge to male sexuality and the hallowed institution of the family within which much of the rape occurred" (cited in Muthien, 2003: 24). Jewkes dissociates child rapes from the

HIV epidemic, claiming, "The root of the child rape problem substantially lies at more mundane doors. It should be regarded as part of the spectrum of sexual violence against women and girls" (cited in Leclerc-Madlala 2002: 87).

While it is certainly impossible to dissociate child rapes from broader issues of sexual violence, some commentators have offered a gendered analysis of the "virgin cleansing myth" that links local ethnomedical knowledge about disease and treatment, women's oppression, and the impact of interventions following the HIV epidemic. Leclerc-Madlala (1996, 2002) highlights the stigmatisation of adult women's sexuality as dirty, and of sexually active women as the bearers and transmitters of disease (in the literal form of "dirt") to men. The "virgin cleansing myth" is arguably consistent with popular explanations of illness (as caused by "dirt" in the blood), and cure (a process for cleansing "dirt").<sup>9</sup>

The belief that *women's* sexuality in particular is "dirty" is compounded by the primary targeting of women for HIV testing and education (broad-based HIV screening began in antenatal clinics) and by sexual health campaigns' focus on women's responsibility for sexual health and contraception. In education campaigns, HIV transmission was often represented as occurring unilaterally from women to men, while depicting women as complicit in their own infection (Muthien 2003).

As South Africa moves from an HIV epidemic into an epidemic of AIDS-related morbidity and death, younger children (especially girls) are increasingly left to care for dying relatives, or heading households after the death of parents.

Where sexually active women are seen as the bearers and transmitters of HIV, there is structural support for both the virgin cleansing myth, and also, as Kistner (2003a: 48) points out, a blurring between western public health categories of prevention and cure: younger girls are implicitly positioned, in the language of public health, as "low risk" sexual partners. Finally, Leclerc-Madlala (2002) questions whether the myth's durability would have been lessened had antiretroviral treatment, or even appropriate information and counselling, been available for those infected.

## Conclusion

Apart from the magnitude of the problems that violence against women and HIV/AIDS poses for women in Africa and many other parts of the world, one of the clearest implications of this area of study is that violence against women cannot be understood as an isolated issue, or as contained solely within the boundaries of sex and gender relations. Violence against women has an impact on, and is in turn affected by, economic relations, social and cultural schemas, and mechanisms of governance (medical practices, education programs and health intervention strategies).

This is a vital lesson to learn if violence against women is to be properly understood, and public health interventions designed and implemented in ways that attend to the impact that violence has on women's lives.

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## Endnotes

1. Obviously, HIV infection is not spread evenly across the country. KwaZulu-Natal is worst affected, with a rate of nearly 40 per cent, while the Western Cape has an adult prevalence one third of this.
2. Serostatus denotes the condition of having or not having detectable antibodies to a microbe in the blood as a result of infection. One may have either a positive (infected) or negative (not infected) serostatus.
3. It has been estimated that per-exposure transmission from man to woman is about 2.5 times more efficient than from woman to man (European Study Group on Heterosexual Transmission of HIV 1991).
4. While sexual assault is often described, from a forensic medical perspective, as resulting in little or no genital trauma, the level of trauma necessary to increase risk of HIV transmission is of a different scale.
5. For example, Fox (2003:16): "The experience of having been physically abused as a child, or having witnessed violence perpetrated by the father against the mother, may predispose the survivor to early sexual debut, multiple partnerships and other high risk activities . . . In order to address this, research and interventions would have to be designed to identify and target girls at an early age"; and Kistner (2003a: 70): "Children's responses to trauma . . . and to therapy would have to be documented, with a view to identifying recovery strategies that can prevent risk taking behaviour later in life."
6. "Sexual networking" is a phrase used by anthropologists and public health experts to describe patterns of multi-partnered sexual relationships.
7. While these relationships are not necessarily exploitative (and can and often do involve affection) they are primarily underwritten by women's economic need: "Women often have relationships with more than one man to gain access to resources – resources they do not command themselves because of entrenched gender discrimination in access to education, to credit and to the formal wage economy" (Heise and Elias 1995: 935). These researchers point out that women engaged in sexual networking strongly resist being identified as prostitutes, and further emphasise "the difficulty of applying western categories – 'prostitution', 'multiple partners', 'monogamous relationship' – to the reality of third-world women's lives. Such labels do not begin to capture the subtlety or fluidity of sexual networks under conditions of economic scarcity, nor do they acknowledge the degree to which economic vulnerability shapes the sexual decision-making of third world women" (1995: 936).
8. A phenomenon widely described in the "burden of care" literature (Machipisa 2001).
9. AZT (azidothymidine, marketed under the names Zidovudine or Retrovir) is a nucleoside reverse transcriptase inhibitor that has been routinely given to pregnant HIV-positive women following a 1994 study (ACTG 076) that claimed efficacy in reducing the transmission from mother to child.
10. The demonisation of women's sexuality has been a frequently recurring theme across many times and places, and has been linked with "virgin cures" for venereal disease in Europe in the 19th century. Smith (1979:303) describes a 1884 court case in which a man accused of raping a young girl defended himself on the basis that he did not mean to harm her, only to cure his "bad syphilis ulcers". ➤

## References

- Allen, S., Lindan, C., Serufilira, A., Van de Perre, P., Rundle, A., Nsengumuremyi, F., Carael, M., Schwalbe, J. & Hulley, S. (1991), "Human immunodeficiency virus infection in urban Rwanda: Demographic and behavioural correlates in a representative sample of childbearing women", *Journal of the American Medical Association*, vol. 266, pp. 1657- 1663.
- Department of Health (1998), *South Africa Demographic and Health Survey*, Department of Health, Pretoria.
- European Study Group on Heterosexual Transmission of HIV (1991), "Comparison of female to male and male to female transmission of HIV in 563 stable couples", *British Medical Journal*, vol. 304, no. 809.
- Fox, S. (2003), *Gender-Based Violence and HIV/AIDS in South Africa: Organisational Responses*, Centre for AIDS Development, Research and Evaluation (CADRE), Johannesburg, South Africa, available at: <http://www.cadre.org.za/publications.html>
- Gottemoeller, M. (2000), "Empowering women to prevent HIV: The microbicide advocacy agenda", *Agenda 44: AIDS: Global Concerns for Women*, available at: <http://www.agenda.org.za>
- Heise, L. & Elias, C. (1995), "Transforming AIDS prevention to meet women's needs: A focus on developing countries", *Social Science and Medicine*, vol. 40, no. 7, p. 931.
- Human Rights Watch (2001), *Scared at School: Sexual Violence Against Girls in South African Schools*, available at: <http://www.hrw.org/reports/2001/safrica/>
- Jacobs, T. (2003), *Domestic Violence and HIV/AIDS: An Area for Urgent Intervention*, Institute of Criminology, University of Cape Town, South Africa.
- Kistner, U. (2003a), *Gender-Based Violence and HIV/AIDS in South Africa: A Literature Review*, Centre for AIDS Development, Research and Evaluation (CADRE), Johannesburg, South Africa, available at: <http://www.cadre.org.za/publications.html>
- Kistner, U. (2003b), *Rape and Post-Exposure Prophylaxis in South Africa: A Review*, Centre for AIDS Development, Research and Evaluation, Johannesburg, South Africa, available at: <http://www.cadre.org.za/publications.html>
- Leclerc-Madlala, S. (1996), "Crime in an epidemic: The case of rape and AIDS", *Acta Criminologica*, vol. 9, no. 2, pp. 31-38.
- Leclerc-Madlala, S. (1997), "Infect one, infect all: Zulu youth responses to the AIDS epidemic in South Africa", *Medical Anthropology*, vol. 17, pp. 363-380.
- Leclerc-Madlala, S. (2002), "On the virgin cleansing myth: Gendered bodies, AIDS and ethnomedicine", *African Journal of AIDS Research*, vol. 1, pp. 87-95.
- Machipisa, L. (2001), "Women and girls bear the burden in Zimbabwe", *Choices*, United Nations Development Program, available at: <http://www.undp.org/dpa/choices/2001/december/index.html>
- Muthien, B. (2003), "Strategic interventions: Intersections between gender-based violence and HIV/AIDS", Gender Project, Community Law Centre, University of the Western Cape, report supplied by the author.
- Population Briefs Special Edition (2000), *Women's Health: Investigating Links between HIV and Partner Violence*, available at: [http://www.popcouncil.org/publications/popbriefs/pbse\\_3.html](http://www.popcouncil.org/publications/popbriefs/pbse_3.html)
- Selikow, T., Zulu, B., Cedras, E. (2002), "The Ingagara, the regte and the cherry: HIV/AIDS and youth culture in contemporary urban townships", *Agenda*, vol. 53, pp. 22-32.
- Smith, B. (1979), *The People's Health 1830-1910*, Holmes & Meier Publishers, New York.
- South African Department of Health (2002), *Annual Survey of HIV/AIDS Among Antenatal Clinic Attendees for the Year 2001*.
- UNAIDS & WHO (2003), *AIDS epidemic update December 2003*, available at: <http://www.unaids.org/>
- Vetter, L. & Bhana, K. (2001), "Violence, vengeance and gender", CSV/POWA, available at: <http://www.powa.co.za/Display.asp?ID=21>
- Varga, C. (1997), "Sexual decision-making and negotiation in the midst of AIDS: Youth in KwaZulu-Natal, South Africa", *Health Transition Review* (supplement 3 to vol. 7), pp.45-67.
- Weiss, E. & Gupta, G. R. (1998), *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention*, International Centre for Research on Women, Washington.
- WHO (2000), *Violence Against Women and HIV/AIDS: Setting the Research Agenda*, Meeting Report, 23-25 October 2000, Gender and Women's World Health Organisation, Geneva. ■