

## UNAIDS Technical Meeting on Young Women in HIV Hyper-endemic Countries of Southern Africa

# Gender-based violence, young women and girls, and HIV in southern Africa Policy and Programme Action Brief

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### 1. The challenge

Gender-based violence (GBV) goes beyond the physical trauma of rape, childhood sexual abuse and forced sex, to include sexual coercion of any kind, non-sexual physical violence and related forms of abuse based on gender.

GBV survivors are at increased risk of HIV infection, as traumatic abrasions and lack of lubrication increase the risk of transmission. GBV also increases HIV risk indirectly by increasing the likelihood of high risk behaviours. Revictimisation compounds the risk.

GBV perpetrators are at especially high risk of HIV infection. They are more likely to force unprotected sex with people who have been victimised before, and who are more likely to be infected. Combining GBV perpetrators and victims, around one third of people in southern African are currently in a self-perpetuating cycle of GBV and HIV.

The challenge is to break this cycle.

### 2. Evidence of the problem and interventions that work

There is evidence of higher HIV risks among people with a history of gender based violence and higher rates of GBV among those who are HIV positive. Mostly cross-sectional designs, these studies do not tell us what comes first, GBV or HIV. There is evidence, however, in favour of GBV as a potentially actionable cause – direct or indirect – of HIV infection.

- a) Prospective (follow-up) studies show GBV causing HIV infection directly: previously HIV-negative victims of rape become HIV positive.
- b) Many studies report coerced first sex and childhood sexual abuse associated with HIV risk in later life. In these cases, GBV clearly precedes HIV infection.
- c) In cohort studies of HIV discordant partners (one HIV-positive and other negative), there was a marked increased risk of infection among partners who reported GBV.
- d) At least one author reported a gradient between HIV risk and intimate partner violence (IPV), with HIV risk highest among women reporting more violence.

### *Indirect effect of GBV on HIV risk*

GBV can lead to HIV infection directly through trauma, or it can do so indirectly. Mechanisms include choice disability in relation to prevention or adoption of high risk attitudes and behaviours.

- a) *Attitudes*: People with a history of sexual assault are more likely to endorse hostile attitudes towards women and are more likely to accept violence against women.
- b) *Multiple partners*: GBV survivors are more likely to report having multiple partners.
- c) *Transactional sex*: childhood sexual abuse is strongly associated with “sex trading”. Power differentials in these settings increase the likelihood of unsafe sex.
- d) *Condom use*: GBV is related to inconsistent use of condoms. Fear of GBV is a well recognised reason for accepting unprotected sex.
- e) *Reduced testing or disclosure of status*: Fear of violence also reduces disclosure of HIV status and HIV testing.
- f) *Sexually transmitted infections* indicate high risk sex; the damaged mucosa also facilitates of HIV transmission. GBV victims have higher rate of STIs.
- g) *Reception of awareness programmes and education*: A history of GBV reduces likelihood of partner participation in programmes of PMTCT; and survivors of GBV may interpret awareness programmes differently to other people.
- h) *Intention to spread HIV*: Some young people say they would deliberately spread HIV if infected; this is more common among youth who have suffered forced sex.
- i) *Perpetrators of GBV*: Abusers have frequently been abused themselves. They tend to pick on people who have already been abused, putting themselves at special risk of HIV infection. Their disdain for the rights of other people rapidly converts their acquired infections into risks for future victims.

### *The context of vulnerability:*

Intergenerational sex and transactional sex are contexts of often unequal power relations. GBV-related choice disability regarding high risk practices may be compounded by food insecurity, minority or migrant status, substance abuse or a mixture of these factors. Other contexts that enable the GBV-HIV cycle include pervasive myths, for example, that sex with a virgin can cure HIV/AIDS, and legal systems that generate little disincentive for GBV or spreading HIV. Short-sighted AIDS prevention programmes fail to think through and test fully their effects on other aspects of prevention. For example, fear-based messages increase the stigma of HIV/AIDS, with negative consequences for voluntary HIV testing, disclosure and GBV.

### *Evidence of impact of interventions*

*Primary prevention* (stopping the risk of GBV before it occurs): Several studies show reduction of violence through school-based interventions. A South African trial shows reduction of GBV and HIV risk behaviours among women with income enhancement and gender training. This advantage for the women receiving the intervention did not result, in the two years of the study, in a measurable decrease in HIV across the whole community. Another trial of an intervention to reduce GBV reported a non-significant reduction in HIV incidence. At least three other primary prevention trials are in progress in southern Africa.

*Secondary prevention* (for those with the risk factors, to stop this leading to HIV): Successful interventions focus on recovery from GBV, negotiating skills to increase protective practices, and condom uptake with regular partners. Male circumcision could be considered long term secondary prevention, as this could protect perpetrators from infection by their victims, and thus reduce the cycle of infection.

*Tertiary prevention* (reducing the consequences for those infected with HIV) focuses on coping reinforcement for those who become HIV-positive and, for those who go on to AIDS, uptake and adherence of antiretroviral therapy (ART).

### 3. Future research

#### *Scope and types of research needed*

*Subgroup analysis:* Since there are already a number of well designed trials of HIV prevention interventions currently ongoing; it makes sense to do GBV subgroup analysis of these trials. This can provide useful information with very little investment.

*Complex interventions:* Most AIDS prevention research focuses on the impact of single interventions rather than a calculated mix of synergistic actions. Southern African countries implement complex interventions to combat AIDS and the question to answer is the added value of each intervention, or its impact in the face of all else that is going on.

*Economic analysis:* Economic analysis should accompany these studies. This is relevant not only in relation to implementation costs, but because economic empowerment is a major aspect of prevention.

*Research focus:* Few current HIV prevention programmes address the needs of the choice-disabled, those who by reason of GBV are unable to make or to implement their prevention choices. This could be tagged onto other research – asking, for example, how to increase the relevance of condom promotion or male circumcision for the choice disabled. Another promising focus would be with *HIV discordant couples*, where these cohorts are available. *The interaction between prevention initiatives* is also important as is *research on perpetrators*. It is possible that perpetrators understanding better their own HIV risks could help to motivate a reduction in sexual violence.

#### *Building African skills in GBV-HIV prevention*

There is an urgent need for African skill development in high level research. Existing initiatives need full government, regional and international commitment.

- i) Policy and political: appreciation of the value of and the way to use local high quality evidence related to GBV and its role in the epidemic can be transferred in brief *executive retreats*, which could be regional or national.
- ii) *Short courses* can transfer the skills needed for detailed interaction on AIDS prevention research, with a special focus on GBV. A national or regional *consensus team* could standardise instruments and define and refine structured outcomes; this will build local skills and optimise research to national needs.
- iii) *Hands-on training* in GBV prevention implementation research: a combination of *in-service internships*, *degree courses* and fully funded *research posts* could help to bring this to pass. A permanent university *research chair in GBV-HIV* in each one of the eight priority countries should be a priority.
- iv) Community capacity is crucial for AIDS prevention. Current HIV prevention research focuses on individuals and largely ignores the powerful influence of communities and networks. As communities engage in collective and cluster interventions, they can acquire the confidence and skills to lead their own HIV prevention initiatives.
- v) Media sensitisation and training: Much has been done across the region to use mass media for edutainment and awareness programmes. There is also room for general awareness among journalists of the GBV dimensions of HIV and AIDS.

#### **4. Policy and action recommendations**

##### *Policy and policy discourse*

Policies must recognise that GBV increases HIV risk both directly and indirectly through increasing high risk practices. Both GBV survivors and perpetrators are at high risk. GBV is actionable – the policy paradigm must address primary prevention (stopping the risk by reducing GBV), secondary prevention (stopping GBV leading to HIV) and tertiary prevention (reducing the consequences of HIV).

1. Legal review: Policies should ensure that laws in the high risk countries cover GBV, rape, CSA and failure to disclose HIV status.
2. Policy review: the HIV and AIDS prevention policies of each country should be reviewed to clarify their position on GBV-HIV. Key questions include: does the policy recognise the role of GBV on the HIV risk of victims; does it recognise the special HIV risk and subsequent role of GBV perpetrators; does it deal adequately with issues of primary prevention of GBV and HIV. Prevention of GBV should be promoted as a national and regional HIV prevention issue.
3. GBV and HIV prevention bodies in the UN and in national governments are usually quite separate at present. These “silos” are unhelpful and partly to blame for the low position of GBV-HIV on policy agendas. Concerting of these forces could have a positive effect on prevention of both GBV and HIV.
4. At present, much AIDS prevention in southern Africa is driven by international donors. GBV reduction and the amelioration of its indirect effects on the epidemic are not manageable as a vertical programme, although vertical programmes are attractive to some local and donor decision makers. It is necessary to engage with these external drivers of prevention to increase their understanding of GBV and its role in the epidemic. Asking policy questions about the relevance of campaigns or prevention programmes for the choice disabled can reduce the current trend of donors to invest mainly in prevention exclusively for the choice-enabled, those who can implement their prevention decisions.

##### *Programmes*

Each country should commit resources to socialising (communicating) the available information on GBV and HIV among prevention stakeholders. The exact cultural underpinning of the GBV-HIV dynamic may be different in different parts of the region, and there is an urgent need for country specific information on what it takes to tackle GBV or to reduce its effects on HIV. Effective GBV prevention is likely to include a structural component like access to credit or earnings, and a GBV awareness component covering GBV survivors, potential GBV victims and GBV perpetrators.

Legal reform: Countries where the legal framework is out of step with what is needed for GBV prevention and dealing with cases of GBV will need to promulgate new laws, to provide training for service providers (including police and health workers), and to implement knowledge translation programmes to involve the public in the legal reform.

Primary prevention programmes are needed, to focus on reducing risk factors for GBV. Programmes should be implemented in collaboration with bodies already working on GBV prevention. They should include structural and awareness/education elements, programmes in schools, a focus on men (as perpetrators and as victims of CSA), emphasis on resilience; and positive role models.

Secondary prevention programmes hinge on recovery from GBV – interventions can increase resilience of people who suffered GBV but who are not yet HIV positive. Psycho-educational interventions can also improve negotiating skills of those at risk of GBV. Longer term prevention

strategies for reduction of HIV infection independent of any reduction of GBV, like male circumcision, could play a role.

Tertiary prevention of GBV includes making it easier to report abuse, to get support once abused and to increase deterrents for perpetrators. Given the sad reality that only one in five cases might be reported, one in four of those go to court, and of those only a minority of perpetrators are convicted, judicial processes are unlikely to play a role in decreasing overall GBV. Some advocate zero tolerance for CSA in schools, with suspension of teachers accused of CSA and sacking of those convicted; but the potential for false accusations needs fuller consideration.

Programmes focused on perpetrators could increase their awareness of their own safety and, perhaps in time, reduce the distain for the safety of others that is often part of GBV and transactional sex.