GENDER-BASED VIOLENCE AND HIV/AIDS IN SOUTH AFRICA

A LITERATURE REVIEW

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A Literature Review

Developed by

Centre for AIDS Development, Research and Evaluation (CADRE)
for the Department of Health, South Africa

Written by

Ulrike Kistner

Additional research

This literature review was compiled with the assistance of Zinhle Nkosi, Warren Parker, Kevin Kelly, Tanya Jacobs and Susan Fox.

Note

This review is a companion document to a series of reviews of gender-based violence and HIV/AIDS in South Africa. Resources include a bibliography that is available as a searchable database on the Cadre website (www.cadre.org.za). Related project documents are also available on the site.

Contact information

Centre for AIDS Development, Research and Evaluation (CADRE), Braamfontien Centre, Braamfontein, Johannesburg. Tel: (011) 339-2611. Fax: (011) 339-2615.
e-mail: cadrejhb@cadre.org.za

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EXECUTIVE SUMMARY

A strong link has been observed between gender-based violence and HIV/AIDS. The World Health Organisation's division on Gender and Women's Health (2000) has identified four areas in which the women's vulnerability to violence and HIV/AIDS overlap:

❑ Forced sex may directly increase the risk of HIV transmission to women through physical trauma.

❑ Violence, and threats of violence, may limit the ability to negotiate safe sex.

❑ The experience of sexual abuse in childhood may lead to increased sexual risk-taking in adolescence and adulthood.

❑ Sharing HIV test results with partners may increase the risk of violence.

These conditions for the correlation between gender-based violence and HIV/AIDS can be specified and amended in considering the history and the structures of gendered power relations in South Africa. In describing and analysing violence, gender and HIV in post-apartheid South Africa, and in charting transformative interventions, two frameworks have emerged: gender-based violence and human rights. They provide the thread for this Literature Review.

HIV/AIDS has compounded the context in which social and economic marginalisation, and the erosion of 'masculinity' combine to render women subject to oppressive social structures and to gender-based violence.

For many South Africans, poverty brings social marginalisation, which effectively renders them 'citizens without rights'. Under these conditions, custom, kinship, and community are more tangible than the constitutional references to formal equality and abstract rights. Within custom and kinship structures, the role of women is tightly circumscribed.

For men, social dislocation, unemployment and poverty often mean the loss of a sense of what it means to be a man. Men who feel their position, status, and identities threatened in this way, tend to re-assert their idea of masculinity and control through violent action.

While gender-based violence is not limited to conditions of economic and social marginalisation and HIV/AIDS, we can observe a strong interrelation between all of these factors. Poverty and social marginalisation affect men and women in different ways. The phenomenon that has been described as 'the feminisation of poverty' is exacerbated by HIV/AIDS, rendering girls and women particularly vulnerable.

HIV/AIDS has compounded the context in which social and economic marginalisation, and the erosion of 'masculinity' combine to render women subject to oppressive social structures and to gender-based violence. HIV/AIDS has exacerbated the economic and social insecurity of women, and women's social and economic insecurity, in turn, makes them vulnerable to infection with HIV/AIDS. Fear of violence, stigmatisation, exclusion and destitution dominates the lives of many women in South Africa. Women's fear of a violent response from their partner may prevent them from:

❑ negotiating safe sex

❑ seeking voluntary testing and counselling

❑ seeking STI treatment

- reporting rape and receiving post-exposure prophylaxis

- disclosing their HIV status

- taking nevirapine to prevent vertical transmission

- formula-feeding their babies.

Thus, gender-based violence is a risk factor for HIV-infection and an HIV-positive diagnosis may be followed by gender-based violence. The latter includes the burden of care that is to a great extent shouldered by women and girls. However, gender-based violence is broader than violence against women. The framework of gender-based violence that has been broadly adopted for social interventions by non governmental organisations (NGOs) working in this field, acknowledges that some of the same mechanisms that are oppressive and abusive of girls and women keep men and boys welded to masculine identifications. Normative ideals of 'masculinity' and 'femininity' tend to reinforce each other, being cemented by reference to 'culture', in structures of interpersonal relationships that militate against communication, joint decision-making, and negotiation of safe sex practices between partners. Sexual coercion weighs particularly heavily on adolescent girls, who may be abused by their teachers, by older men with whom they enter into transactional sex relationships, and by boys who, in the latters' understanding, 'pay' for sex with money for subsistence needs and consumer items.

While constructions of 'masculinity' have recently come under the spotlight in research on youth culture, much work would have to be done to challenge understandings of gender roles through socialisation, education and social service provision.

To address the intersection between HIV and gender-based violence, some fundamental re-orientations in social policy would be required:

- Introducing a basic income grant and making disability grants more accessible would mitigate the stigma attached to people living with HIV/AIDS.

- The provision of post-exposure prophylaxis, and general access to antiretroviral (ARV) treatment to those who require it would, according to some researchers, prevent a rift between people diagnosed as HIV-positive and HIV-negative, and would counteract some of the fears and myths about HIV/AIDS.

- Social service provisions (including non-judgemental, accessible and friendly health care services, and HIV testing and counselling) are needed that would contextualise and support the medical treatment and health requirements.

- Appropriate and accessible social services and social security for women are essential to addressing gender-based violence and vulnerability to HIV infection. They should be guided by gender-transformative approaches to social policy.

Interventions are required that combine a set of specific rights:

- sexual rights – to promote respect for bodily integrity and autonomy; to facilitate access to information, informed choice, appropriate medical treatment, to friendly, non-judgemental, and affordable sexual and reproductive health services

❑ civil-political rights – to promote equality of opportunity and of access to social and political institutions and services by which people can exercise their rights as citizens

❑ socio-economic rights – to guarantee the life and the security of the person, the sustainability of livelihood, and social security.

The rights-approach has been vindicated by a number of considerations:

❑ A narrow model of individual health is of limited value for any programme addressing sexual behaviour (whether violent behaviour or high-risk behaviour – they are closely linked).

❑ A rights-approach supports socially negotiated decision-making and responsibility.

❑ With its emphasis on integrating sexual and reproductive rights and socio-economic rights, it would counteract a tendency that has become more marked since the adoption of the 1996 South African Constitution, and with the controversies around the provision of anti-retroviral treatment of people living with HIV/AIDS, of a separation between human (including socio-economic) and civil/political rights.

❑ A rights-approach would serve to counteract the tendency, in evidence throughout South Africa's history of apartheid, to accept violence as normative.

❑ A rights-approach is central in charting transformative interventions.

INTRODUCTION

Gender and HIV/AIDS in South Africa at a glance

In November 2002, a report commissioned by Cabinet to establish the causes of death among South Africans, was released by the Medical Research Council (MRC) and Statistics South Africa. The report, compiled on the basis of a 12% sample of death certificates for the period 1997-2001, confirmed what many research organisations and the national Department of Health had mooted a year earlier: that AIDS-related illnesses were a leading cause of death among young women in South Africa. Among young women aged 15-29 who died in 2001, AIDS-related illnesses claimed 22.5%, while the proportion of men who died of AIDS-related conditions stood at 7.6% in the same time period. The Nelson Mandela/HSRC HIV/AIDS Survey revealed that the age group 25-29 is most at risk of HIV infection (with an HIV/AIDS prevalence rate of 28%). In the age group above 15-29 years, the prevalence levels for African women are significantly higher than for African men (17.6% compared to 13.5%, respectively). The prevalence of HIV in women peaks within the 25-29 age group (SABSS 2002: 52-53).

According to the South African Demographic and Health Survey (SADHS) of 1998, it is among more or less the same age group (15-24), that the highest incidence of abuse by a partner in the last year is reported (7.3% for age group 15-19; 7.9% for age group 20-24).[1] It is highest among young women with below-matric education levels. On a provincial breakdown of rape and abuse, Western Cape, Gauteng and Mpumalanga ranked highest.[2] The majority of rape survivors are young women. Judging by the SADHS statistics, young rural African women (aged 15-19) are most at risk for abuse during pregnancy.

> *These findings are extremely significant because they indicate that young women, the demographic group which is already at highest risk of HIV infection in South Africa, simultaneously represent precisely the group which is at highest risk of rape. (Kim 2002)*

What comes to the fore in these statistics is the gendered nature of HIV/AIDS, throwing out new challenges to a society with one of the highest incidences of gender-based violence 'for a country not at war",[3] as the saying goes. Yet are we equipped to take up these challenges? A recent survey conducted among government health and education departments, AIDS counsellors, NGOs and community-based organisations (CBOs) working in the fields of HIV/AIDS awareness training, gender-based violence counselling and training and youth projects, revealed that there was virtually no understanding of gender issues beyond a vague notion of the relations between women and men, girls and boys.

Our understanding of violence has, until now, been largely derived from two

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1. This is in stark contrast to the extremely high percentages adduced by loveLife: 39% of 12-17 year olds are said to have reported having been forced to have sex, while 33% are said to have indicated that they were afraid of saying 'no' to sex .

2. Figures for the incidence of rape in Gauteng for 2001 are given as 16 000 by the South African Police Services. During the same year, 12 000 cases of rape were processed by health and police services in Gauteng.

3. Forms of gender-based violence typical of war and armed conflict have been listed as mass rape, military slavery, forced prostitution, forced 'marriages', multiple rapes, gang rape, rape of young women, violent sexual assault, resurgence of female genital mutilation, survival sex or sex in exchange for food, shelter, or protection (WHO: Women's Health: Violence Against Women Information Pack, p. 12).

sources. It has, firstly, been gleaned from the study and experience of the political violence of apartheid, and of political resistance shaped by the national liberation movement. In the legal-political arena, much work has been done, through the Constitution and through recently passed legislation, to provide women who have experienced violence, with means of redress. In the absence of a national strategy for dealing specifically with violence against women, much is being done by organisations – mainly NGOs and CBOs – in providing services to women who have been violated, beaten, and abused. In the face of the enormous psychological, personal, familial, social and economic toll exacted by the levels of gender-based violence in South Africa, many of the organisations working in this field under great pressure, have been effectively limited to a crisis response. However, these models of explanation and of redress through the Constitution, legislation and service provision, show some limitations in getting to grips with gender-based violence. Our understanding of HIV/AIDS, being largely derived from two bio-medical models on the one hand, and from references to conditions of poverty on the other, has also left us somewhat handicapped in dealing with the gender structures of HIV/AIDS. Comparatively few strides have been made on the interface between HIV/AIDS and gender-based violence. While national HIV/AIDS awareness campaigns have stressed the need for prevention strategies, the prevention of gender-based violence has not come into the ambit of preventive and promotive health campaigns. Most surveys and projections of the prevalence and incidence of HIV/AIDS in South Africa have defined and calculated risk and vulnerability related to the individual in monocausal[4] ways. And many intervention strategies have targeted the individual in isolation from his/her social conditions, relations, and pressures.

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Very generally speaking, men and women, under different conditions, form identifications with constructed masculinities and femininities, which are aligned with power relations. Gendered power relations are at work in the extent to which one can move around; in choosing an intimate partner; in going about one's livelihood under conditions of material deprivation; in the decision as to whether or not to disclose one's HIV status; whether or not one would decide to go for voluntary counselling and testing (VCT); how to communicate the test result to others; in the way one would react if one's intimate partner discloses that he/she is HIV positive; in the ability to negotiate or initiate safe sex and condom use; and in the decision about who is to care for a person living with HIV/AIDS in the household. Organisations dealing with gender-based violence have recently begun to make the linkage in their counselling and training work (Stop Women Abuse Helpline, Nisaa Institute for Women's Development, People Opposing Women Abuse (POWA), and Masisukumeni Women's Crisis Centre). There are as yet few intersectoral linkages and very few organisations have developed communications materials on this combination of factors. These gaps arise partly from the paucity of research into theoretical issues of this intersection that would have vast implications for policy formulation, for organisational work and for activism addressing gender inequity and gender inequalities. Gender-based violence and HIV/AIDS issues have, up to this point, been dealt with largely along parallel tracks, or by way of referring to parallel statistics. There is a notion, vague at best, that gender-based violence is in some way related to the prevalence of HIV/AIDS. Until recently, however, the specific social structures, relations, and processes contributing to HIV and gender-based violence have not been well understood.

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4   They overlook the fact that individual and social-psychological phenomena are inevitably brought about and shaped by multiple causal factors, if they can be called 'causal' in the strict sense at all.

LITERATURE REVIEW

This Literature Review identifies research, knowledge, resource and service gaps, so as to open up the terrain for further research, debate, and information-gathering with a view to feeding into the formation of explanatory models, into education, media, health communications, policy and service-delivery.

The Literature Review sets out an inital conceptual and methodological base, to which it returns at the end. The explanations for the incidence and the contexts of gender-based violence and HIV/AIDS are put forward by listing indicators and predictors, and by outlining psychosocial, behavioural and contextual factors. The research gaps emerging in the process are listed in summary form at the end of the Literature Review. Human rights considerations provide the framework for the suggested transformative interventions.

This Literature Review is the first in a series of reviews. Related reviews include a review of organisations working in the field of gender-based violence and HIV/AIDS; and reviews on particular aspects of gender-based violence and the ways in which it impacts on the prevalence of HIV/AIDS, as in Rape and Post-Exposure Prophylaxis and Child Sexual Abuse. This series of reviews will inform communications strategies for transformative interventions.

A companion document to this Literature Review is a comprehensive Bibliography. It includes issues of theory, policy, research gaps, and intervention strategies. In the course of our bibliographical searches, we traced some 700 key documents that have been published in various forms over the last four years, either in South Africa or with direct relevance to AIDS policies and activism in this country, by researchers and policy organisations working on gender-based violence and HIV/AIDS. The Bibliography includes pamphlets, information and policy documents, proposals, reports, evaluations, conference papers, articles published in journals and Internet websites, and is available at www.cadre.org.za.

The Women, Violence and HIV/AIDS Project

This project focuses on the intersections of the inequalities that divide South African society. It recognises that the patterns of HIV transmission, incidence and prevalence are structured by gender and social inequalities, within which violence against women and girls is embedded. The project aims to make an intervention through research, analysis, information, and through developing communication materials for action, education and policy. It provides organisations, stakeholders, and policymakers with resources, methodologies, guidelines and tools.

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One of the major challenges in dealing with gender-based violence at any level is that of providing explanatory models which can guide interventions. Given the extent, intensity, impact, and the consequences of the lived experience of gender-based violence in our society, the very attempt at a description might strike one as callous. Yet to be able to address it in such a way that we can understand, explain and change it, requires a systematic investigation. This is the path that this project, and more specifically, this set of reviews has embarked on. Its aim is not to add to sensationalism, nor do we intend to get stuck in the impotence generated by the overwhelming nature of sexualised violence. Rather, we intend to take stock of the work that addresses violence – in theory, social research, organisational work and policy formulation – in such a way as

to pose questions, mount challenges, and make proposals for action at various sites and levels of interpersonal relations, policy formulation, communications, education and training, institutional structures, social and political frameworks and processes.

Guided by this rapid appraisal, further phases of the project are likely to include

- rape and Post-Exposure Prophylaxis (PEP)

- gender-based violence related to disclosure of serostatus

- child sexual abuse

- cultural socialisation, gender-based violence, and HIV risk

- trafficking and migration.

Working concepts

There are a few concepts and definitions that need to be spelt out and clarified at the outset. This is not simply a matter of a pedantry about terminology, as the terms and concepts with which we are working carry methodological implications. The first one goes to the heart of the naming of this project.

'Gender-based violence' and 'violence against women'

'Gender-based violence' is a term that is not simply synonymous with 'violence against women'; nor has it simply replaced a feminist emphasis on 'women'. The analysis of 'gender-based violence' recognises that violence directed against a person on the basis of his or her gendered identity is not directed at women and girls only. (This stance, taken for instance by POWA, marks a shift from earlier, more narrowly feminist analytical frameworks in the organisation.) Some of the same mechanisms that entrap girls and women in subordinate roles, keep men and boys entrapped in masculinist identifications that are being played out in abusive ways. Nevertheless, these mechanisms produce gender-differential effects: '…the environments in which people become vulnerable to gender-based violence involve situations in which being gendered as 'a woman' or as 'a man' is extremely significant' (Bennett 1999: 2). Where this distinction is being rigidly upheld, gender-based violence tends to come close to being construed as an 'institutional fact' (or, in South Africa-speak, as 'culture of violence'). However, one should be careful not to homogenise the category of 'man' and 'woman', respectively. Women, specifically, experience violence at different stages in their lives. They also experience violence differently according to their social status, occupation, ethnicity, religion, ethnicity, relation, sexuality, etc (J Lewis 2000: 22).

The terms 'gender-based violence' and 'violence against women' do not feature synonymously and interchangeably in this Literature Review. They are used differentially, yet often in combination, pointing to an analysis of gendered power relations within which men and women are positioned differentially, and whose effects they experience differently.

A comparison with the evolving paradigms in thinking on gender and development might be useful here. Within the 'Women in Development' (WID) framework from the 1950s onwards, the focus was mainly on the way in which women specifically were disadvantaged by development policies. To address

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this, welfare-type development policies advocated women-focused projects, and separate structures and organisations for women (for example, 'women's desks' in NGOs). Much hope for reducing the inequality between men and women was pinned on reducing income inequality.

The 'Women and Development' approach was formulated in the 1970s as an alternative to the reformist WID framework. Here, the emphasis was on empowering women in particular contexts, taking account of the intersections between class, culture, and gender.

However, it was found that this approach does not adequately take cognisance of the social structuring role of gender relations. Gender roles, for instance, regulate economic activity, mobility, control of resources, participation in decision-making, and social interaction. Excluding men from discussion and decision-making about development project work at household and community levels was bound to lead to conflict. Some of these insights informed the 'Gender and Development' approach that came to the fore in the 1990s. One of the spin-offs of its institutionalisation was the integration of gender projects into mainstream development activities.

The gender-based violence framework allows us to conceptually distinguish between sex, sexuality, and gender and their interplay in specific situations, conditions, constructions, and roles. This distinction is crucial in accounting for specific forms, conditions, and impacts of gendered violence.

This approach, which has driven some of the sea changes that we have seen in South African government-structural and legislative transformations since the latter half of the 1990s, has not been without its pitfalls. Mainstreaming gender has generated new gender-neutral approaches that do not consider specific aspects of women's marginalisation and subordination. It has de-mobilised an active women's movement that played a crucial role in pioneering those very institutional, constitutional and legislative changes (see Makan et al. 1997: 17; see also Manicom 2001: 11; Hassim 2002).

Some parallels between development policy frameworks and frameworks for analysing gendered violence emerge from this outline. The 'Violence against Women' approach closely resembles the 'Women in Development' framework in its exclusive emphasis on the impact on women, without an underlying analysis of the socially-structuring role of gender. The 'Gender-based Violence' approach closely resembles the 'Gender and Development' framework in its inclusive analysis of gendered power relations.

Recognising that the forms of gendered violence that put people at risk for HIV infection, are not confined to man-on-woman blows and threats, it is the 'Gender-b ased Violence' framework that this Literature Review takes for its framework. This framework also allows us to conceptually distinguish between sex, sexuality, and gender and their interplay in specific situations, conditions, constructions, and roles. This distinction is crucial in accounting for specific forms, conditions, and impacts of gendered violence. By the same token, it is necessary for identifying, explaining and transformatively addressing specific risk situations, factors, and behaviours; and the obstacles to safe sex, sexual rights, and behaviour change, within an ethics of care and responsibility.

However, considering the new gender-neutrality or blindness entailed in the 'Gender and Development' and gender mainstreaming as it has panned out in South Africa, we should be cautious not to leave out of consideration the specific ways in which women are vulnerable to and affected by gender violence and HIV/AIDS. A national campaign of 16 days free of violence against women and children at the end of November/beginning of December 2002 has done much to highlight the plight of abused women and children in the media. The State

President, Cabinet ministers, members of parliament made appeals to that effect in their public appearances over 16 days. But already there are signs that this campaign unfolds in the arena of the symbolic actions of high politics and the charity of big business (see for example, *The Star* supplement Monday 25.11.02). A nationalist rhetoric is not far off, with gender mainstreaming efforts being presented as showcases of nation-building (see Manicom 2001: 18), in which 'our' women, 'natural' survivors and make-shift make-doers in the face of marginalisation, poverty and disease, become the symbols of national strength and endurance. Against such appropriations, we would need to mobilise in the social arena, for reclaiming public spaces, for living in safety free of fear, and for access to social security and comprehensive health services – not as a matter of specific qualities of women, but on the grounds of a struggle for rights and justice.

'Sex' and 'gender'

Geeta Rao Gupta provides some definitions and outlines of the relationship between 'sex' and 'gender' as follows:

> *Gender is not a synonym for sex. It refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. It is a social and cultural construct that differentiates women from men and defines the ways in which women and men interact with each other. Gender is a culture-specific construct – there are significant differences in what women and men cannot do in one culture as compared to another. But what is fairly consistent across cultures is that there is always a distinct difference between women's and men's roles, access to productive resources, and decision-making authority. (Plenary address to the 13th International AIDS Conference, Durban, 12 July 2000 in Jenkins 2002: 1)*

An analysis of the specific relationship between 'sex' and 'gender' is the key to understanding gender oppression.[5]

'Patriarchy'

The term 'patriarchy' is not particularly helpful in mapping patterns of gender-based violence. Gendered relations of power are not a simple matter of domination and submission. There is unevenness in the exercise of power, which is continuously contested, redefined and renegotiated. (For a more detailed exposition of gendered power, see the section on 'Methodological problems in research on gender-based violence and HIV/AIDS', especially the subsection on 'Power and empowerment' below.)

'Sexualised violence'

For a long time in the history of feminist theory, analyses of gender-based violence eschewed any reference to 'sexualised violence' or 'sexual coercion', claiming that gender-based violence is simply a matter of asserting power in ways that force a woman into submission and humiliation. We have decided to use the term 'sexualised violence'/ 'sexual coercion' in this Literature Review, as one specific

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5 For more detailed accounts and key contributions to this debate, which is a cornerstone of feminist and gender theory, see Rubin 1975; Fuss 1989; Flax 1990; Butler 2000.

form, among a whole host of others, of gender violence based on, enforcing, and perpetuating unequal power relations. It is often used as a weapon of war, and as a means of asserting domination, through the extreme degradation of the person or group upon whom it is enacted. Sexualised violence is one of the most humiliating forms of gender violence that is experienced as undermining not only personally and familially, but also communally. The pervasiveness of the trauma, and the personal, familial, communal and social upheaval that it entails, may be part of the design on the part of the perpetrator(s).

Naming violence as 'sexualised' allows us to point to its specific impacts on the physical and mental health of the survivor, and on his/her social context.

Sexualised violence includes rape, unwanted sexual advances or sexual harassment, sexual abuse of children and of disabled people, forced marriage, denial of sexual and reproductive rights (including forced abortion), violent acts against the sexual integrity of men and women, including female genital mutilation and obligatory virginity testing, forced prostitution and trafficking of people for purposes of sexual exploitation (Krug et al. 2002: 149-150).

'Victims' and 'survivors'

In this Literature Review, we refer to persons who have been raped, abused, or experienced any other form of gender-based violence, as 'survivors', in order not to cast them in the role of helpless victims. If categorised as 'victims', they may elicit paternalistic responses amongst those to whom they report the abuse (for example, police and medical officers). We have opted for 'survivors' also in order to acknowledge the strength that people have to muster in dealing with and coming to terms with any one or a combination of these experiences.

'Culture'

Unless we could specify the parameters of specific 'cultures' and 'subcultures' and their implications and consequences for gender-based violence and HIV/AIDS, we have tried to steer clear of generic references to 'culture'. Talk of 'culture' has often been used to justify institutions and practices that undermine women's autonomy. Women are not exempt from reproducing cultural practices that in some respects undermine women's dignity and autonomy, as, for example, the abahloli – the groups of older women who conduct virginity testing in KwaZulu-Natal and other parts of South Africa (see Scorgie 2002). With respect to other traditional practices, there is considerable debate among African women. Among a group of Xhosa-speaking women interviewed about lobola (bridewealth), for instance, there was considerable disagreement about what 'Xhosa culture' was. The researchers conclude, 'the fact that so many women indicate that they hold views which differ from their perceptions of the 'norm' in their culture is a sign that a process of questioning and re-examination is underway among women at a community level' (Jewkes et al. 1999a: 8). Many African women identify references to 'culture' as one of the causes of violence against women (see Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002).[6] As a Sudanese woman activist put it, 'Why is it only

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6   Despite the fact of the legal recognition of customary marriages which was aimed at instituting gender equality, African women point to customary marriage arrangements as major causes of gender-based violence. These arrangements include the levirate, the sororate, polygamy, child betrothal and forced marriages, inheritance, and lobola (bohali, bogadi) (Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002).

when women want to bring about change that culture and custom become sacred and unchangeable?' Culture is neither static nor monolithic. Culturally specific traditions, institutions, beliefs, values, and norms can be and are being mobilised as creative resources for interventions to challenge violent and abusive acts and practices.

EXPLAINING VIOLENCE AND GENDER-BASED VIOLENCE

Gender-based violence in South Africa

With South Africa regularly making headlines with a reputation for having one of the highest rates of violent crime in the world, the same questions inevitably crop up: why, why here, why now, why this escalation in numbers and degrees, what is it about the make-up of this society that makes for such high levels of violence? The enormity of the issues, the multifaceted nature of potentially contributing factors, the inadequately and erratically recorded statistics, the often inaccurate police detection and recording work, and the low rate of convictions make any explanations partial at best.

Attempting to explain gender-based violence in South Africa, and gender-based violence more generally, presents an uneven picture. Such attempts take little account of the structural co-ordinates of violence and the ways in which it plays itself out at the intersections between race and gender. Approaches to explaining gender-based violence more specifically, tend not to focus on any particular set of political, social, and economic conditions.

Violent crime in post-apartheid South Africa does not come out of the blue. Researchers at the Centre for the Study of Violence and Reconciliation point out that within resistance to apartheid under the motto of 'ungovernability' and 'people's war', violent means of resolving conflict and bringing about political change were positively sanctioned. The endorsement of violent means found its application in other social arenas, too. A peculiar form of political introversion took place. With the legalisation of previously banned political organisations, references to a clearly defined enemy were being turned inward, to the internal structures. Displaced aggression has been vented on the most physically, socially, economically, and politically vulnerable, victimising and scapegoating women, children, the elderly, and immigrants.

Displaced aggression is compounded by a crisis in masculinity, fuelled by high unemployment and poverty that is experienced as personal rather than social failure. The erosion of the criteria of masculinity is experienced as emasculation – a loss of power and control that defines a sense of masculinity – and may be followed by violent action through which masculinity is thought to be re-asserted (see Simpson 1993; Simpson 1998: 7-9).

Within this generalised account of violence in post-apartheid South Africa, the conditions of women – and especially of women in rural areas – have been described by reference to discriminatory practices; poverty; limited access to education, health, transport and other services; and limited access to justice in cases of gender-based violence. However, there are few accounts that identify the structural conditions of gender-based violence in South Africa.

African women in South Africa were positioned in a dualistic structure of apartheid's logic of governance, confined largely to the rural areas under the jurisdiction of traditional leaders. The few who 'made it' into the urban areas, were employed largely as servants, their position in the labour market most precarious. Within the provisions of customary law, African women would never get beyond their status as minors. The legal status of women has changed with

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the 1996 Constitution, and with a range of other acts passed since then (e.g. Domestic Violence Act, Maintenance Act, Promotion of Equality and Prevention of Unfair Discrimination Act, Recognition of Customary Marriages Act, Choice of Termination of Pregnancy Act), with universal civil citizenship, equality and human rights. However, the economic and social conditions under which most black South Africans still live, and the intractability of the social question within the framework of prevailing macro-economic policies, effectively render them citizens without rights. The remaining dualistic structures of governance, divided into civic and ethnic structures, have not effectively been dismantled, but have been revived at a number of levels, particularly in the rural areas. In the former Bantustan areas – remnants of apartheid's geography – traditional leaders play an important role in local governance. Local organs of popular justice that had arisen partly in resistance to and partly in conformity with apartheid's justice system, have been refunctionalised in some areas. They perpetuate a system of governance in which subjects are not treated as citizens with constitutionally guaranteed rights. Inasmuch as this form of governance remains intact, albeit partially, to assert the dictates of kinship, custom and community against an abstract state and universal citizenship (see Mamdani 1996: 18), the position of women, particularly women in the rural areas, remains tightly circumscribed. The bounds of 'custom' and 'tradition' are in some cases being upheld with the co-operation of local women's organisations.

Within the domain of custom, kinship and community, the relations of bond are the dominant ones. The bond governs hierarchical relations of domination and dependence within a primary localised community. Affects of love and honour are nurtured, and debt and punishment are violently exacted. Love, dependence, honour, obedience, and the right to violence characterise the bond. It is in the relations of bond that women experience the power of patriarchy at its harshest.

The dualism of the colonial state that has been retained in part in the post-apartheid dispensation, moreover, gains added force in the face of economic and social insecurity to which the majority of South African households are exposed. For those on the margins of the market, the non-market force of land, of kinship and custom holds more security than formal equality. Tribal authorities stand at the intersection between the market and its margins, guarding the limits of both. Control over the geographic and social mobility, the economic activity, the social relations and interactions, and the bodies of women is pivotal to the role of traditional authorities in structures of local governance.

HIV/AIDS has …exacerbated the economic and social insecurity of women, and women's social and economic insecurity, in turn, makes them vulnerable to HIV infection.

HIV/AIDS has compounded this picture: it has exacerbated the economic and social insecurity of women, and women's social and economic insecurity, in turn, makes them vulnerable to HIV infection. Caring for sick and dying and bereaved household and community members has increased the burden of care on women and girls. To the extent that the community and the state rely on women's and girls' role as caregivers, they are taken out of spheres of education and economic activity to return to those structures that bind them. The role and resources of family and household are stretched, often beyond their limits, when people's declining health makes them turn to 'home' for care and support. In any case, both the state and people living with HIV/AIDS have come to rely on family and household structures, ties, and resources. The bond is being re-asserted societally, beyond family and household, in the face of caring, illness, death, dying, and bereavement.

Social conditions that give priority to the relations of the bond beyond the household and family, while expecting citizens to structure their relations and interactions in the mode of contract, i.e. on the grounds of equality, are likely to fail in producing mechanisms that hold violence at bay (van Zyl 1990; 2002).

While this may partly explain why gender relations are so violent, and why gendered violence assumes such proportions in South Africa, the reverse question would also have to be dealt with, namely, why violence is so gendered, so sexualised? (Moore 1994: 154) According to Henrietta Moore, '[g]ender idioms are frequently used to order differences in power and/or prestige, with the result that power itself is represented in many contexts as sexualised' (148). Sexualised power can be observed particularly in conditions where 'gender' (the social role expectations, the social status conferred, the social structures modelled on this primary social structure, etc.) is reduced to sex (the biological fact of the anatomical difference between the sexes); it is prevalent where gendered power relations are assumed and legitimised to be 'natural', 'given', non-negotiable, not up for debate, and unchangeable. Instances of sexualised representation of violence, will be discussed in the sections on 'Vulnerable groups': 'Prisoners, miners, youth'; and on 'Masculinity'.

… why is violence so gendered, so sexualised?

Predictors and indicators for gender-based violence

Closely related to attempts at explaining the incidence of violence, and of gender-based violence in particular, is the identification of predictors and indicators for gender-based violence. The measurement and prediction of social and psychological processes by deductive models and causal logic is problematic. Nevertheless, it is useful to identify some of the factors that play a role in gender-based violence in order to plan targeted intervention strategies.

Indicators for predicting violent outcomes within heterosexual relationships have been indentified as:

❑ HIV status

❑ age

❑ age gap between partners of six or more years

❑ educational level

❑ marital status and/or living arrangement

❑ either partner's concurrent intimate relationship(s)

❑ financial dependence of one partner on the other.

Violence against women and children around the world has been reported to be most common where:

❑ the concept of masculinity is linked to toughness, male honour, or dominance

❑ physical punishment of women and children is culturally tolerated

❑ violence is accepted as a means of interpersonal conflict resolution (Heise et al. 1999: 8)

❑ women are economically dependent and have limited access to employment, education, training, cash, and credit

- conditions of poverty where children of working parents do not receive adequate care during the times when their parents are absent; or where children themselves are working under conditions that make them vulnerable to sexual exploitation; or where girls and women are at risk of rape in the course of their daily subsistence tasks

- there is a low conviction rate for crimes of violence; cases of gender-based violence are inadequately researched, documented, followed up and prosecuted

- there are few or no organisations dealing with gender-based violence in research, law, education, social and political activism and advocacy, and service provision.

By contrast, violence against women and children has been reported to be at low levels where:

- women have power and authority outside of the family

- family members intervene to prevent and reduce the likelihood of domestic violence

- there are all-women collectives (Heise et al. 1999: 9)

- there are community sanctions against gender-based violence

- women are economically independent from men.

In men, predictors and indicators for the use of violence against an intimate partner have been identified as follows:

- family background: family poverty in childhood and adolescence; having witnessed or experienced violence as a child

- educational status: low academic achievement

- emotional factors: low self-esteem; emotional dependence; insecurity; exhibition of anger and hostility; depression; personality disorders

- relationship factors: economic stress; poor family functioning; sense of inadequacy of not living up to the ideal of a family provider

- community factors: weak community sanctions against domestic violence; low social capital

- social factors: traditional gender norms; social norms supportive of violence; no easy access to divorce for women; adults routinely resorting to violence to solve conflicts; notions of manhood linked to dominance, male honour, and aggression

- political factors: weak laws against gender-based violence; high levels of violent crime and other forms of violence.

Intimate partner violence is reported to be highest where societies are in transition, and/or where the status of women is changing, for example, where women assume non-traditional roles, or enter the work force. Moreover, '[d]uring times of economic and social disruption, women are often more independent and take on greater economic responsibility, whereas men may be less able to fulfil their culturally expected roles as protectors and providers' (Krug et al. 2002: 99-100).

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Groups vulnerable to gender-based violence and HIV/AIDS

Based on some of these predictors and risk factors for gender-based violence and HIV/AIDS, we can identify groups that are particularly vulnerable. This does not mean that they are singled out for bearing primary responsibility for the transmission of HIV, nor does it mean that intervention strategies should be focused only on them. Rather, intervention strategies should be planned in such a way as to transform the forms and imbalances of power that have contributed to particular social and economic burdens in these groups.

> *It is usually serial human rights omissions, that often originate in social conditions but impact directly on the civil and political autonomy of individuals, that creates a unique vulnerability of whole populations (rather than population groups whose sexual behaviour creates vulnerability) to HIV and AIDS. This means that prevention strategies have to address the full spectrum of human rights implicated, both social and economic, as well as political or civil.*
> *(Heywood & Albertyn 2001: 8)*

… intervention strategies should be planned in such a way as to transform the forms and imbalances of power that have contributed to particular social and economic burdens.

Children

It is widely known, and has been confirmed independently for South Africa, that most perpetrators of child sexual abuse are known to the children concerned (see for example, Malala & Junius in Hall & Samuwiro 2002: 11-12). This suggests that child sexual abuse mostly takes place at home and school and in the related social surroundings. Perpetrators can be family members, teachers, and boyfriends.

Child sexual abuse includes:

❑ sexual coercion with physical force or threats

❑ incest, stranger rape, date rapes, etc

❑ sexual harassment and sexual contact with children

❑ child prostitution and forced marriage

❑ virginity testing

❑ forced pregnancy, contraception, abortion

❑ genital viewing and filming

❑ exposure to pornography and adult genital exposure

❑ statutory rape (Malala in Hall & Samuwiro 2002: 12).

Child abuse and child rape are particularly traumatic experiences for children and their primary caregivers. The experience of being sexually abused as a child can have long-term consequences, including Post-Traumatic Stress Disorder (PTSD) with heightened fears, self-blaming, social withdrawal, sleep disturbance, mood swings, eating disturbances, regressive behaviours, increasing dependence on the mother, anxiety, fear of recurrence of the trauma, depression, guilt, self-destructive behaviours, negative self-perception, sexual problems, difficulty in social interactions, depression, cognitive and concentration difficulties. It can lead to high-risk coping strategies later in life, involving early sexual debut, drug and alcohol abuse, transactional sex, multiple partners. The experience of sexual abuse in childhood can create models of partnerships that women are likely to

re-create through their life-choices (S Lewis 1997: 5).

In the light of these findings, research and interventions would have to be designed to identify and target girls and young women early enough to effect behaviour change. It would be important to find out what kind of recovery strategies can prevent high-risk behaviours (WHO 2000: 14).

Often children who have an overwhelming sense of fear of the rapist, are not willing to disclose what has happened, even within a supportive environment. In such situations, the child needs to get a sense of being protected and supported unconditionally. The primary caregiver, where possible the mother, should also receive counselling and support, as her responses are pivotal for the way in which the child deals with the trauma. The frequently expressed notion that the child will be 'ruined' for life, would need to be addressed, as this response can lead to blaming and stigmatisation (S Lewis 1997: 18, 8, 6, 10).

In many cases, child rape occurs in the child's everyday environment; in most cases, the rapist is known to the child and the parents. Perpetrators, in many cases, are school teachers and relatives. This is what possibly accounts for the large-scale under-reporting, and the relatively low conviction rates.

In many cases, child rape occurs in the child's everyday environment; in most cases, the rapist is known to the child and the parents. Perpetrators, in many cases, are school teachers and relatives. This is what possibly accounts for the large-scale under-reporting, and the relatively low conviction rates. The importance of rights-advocacy and good police-work in providing efficient and sensitive services to rape survivors is highlighted by the likelihood that, in the absence of prosecution, the psychological trauma to the rape survivor and his/her family will be exacerbated (S Lewis 1997: 1, 22).

Children affected by HIV/AIDS

HIV/AIDS affects children in many ways. Children affected by HIV/AIDS fall into one or more of the following categories:

❑   children living with HIV/AIDS

❑   children whose parents are sick or have died of AIDS

❑   children whose siblings, relatives or friends have the disease or have died

❑   children whose households are stressed by children from another family who have been orphaned by AIDS

❑   children, such as those on the street, who are at high risk of infection with HIV (WHO/UNICEF 1994: 5).

Orphans are particularly vulnerable – bereft of the care of their parents, they often have to fight for survival for themselves, their households, within extended families, whilst at the same time dealing with stigma and discrimination. Children affected by HIV/AIDS who have been taken in by neighbours and relatives, are at risk of exploitation (including withholding of resources, or abuse of their entitlement to a child care grant). Under these conditions, children are at risk of HIV infection through substance use, risk-taking, early marriage, sex work, and emotional instablity (see Gray 2001: 13; WHO 2001: 19).

The psychosocial needs of children who are caring for or have lost one or both parents to HIV/AIDS, are often overlooked, or treated as secondary to their immediate survival needs. The illness and loss of a parent is very traumatic for a child, especially in the context of fear and stigma of the disease, and the high probability that a child will lose both mother and father. If left unaddressed, this trauma could have serious developmental effects (see WHO/UNICEF 1994: 9, 7).

'If children are to develop the resilience to deal with the challenges in their lives, their psychosocial needs must receive proper and prompt attention' (UNAIDS 2001: 14). Children need to be able to mourn, express their grief, and learn to use the memory of their loved ones as a resource.

Living with ill and dying family members affects children in particular ways. They are often catapulted into assuming adult roles, such as those of caring and providing, while restricting their access to social networks, schooling, and peers. It is particularly girls who face these responsibilities and sacrifices.

Adolescents

It is widely considered characteristic of young people to experiment and take risks as they assert their independence from parents and other adults, and to look for approval from and conformity with their peers (Morrell et al. 2002: 13). Adolescent girls are particularly at risk in the context of social and family destabilisation. In trying to escape from social and family upheaval, they tend to seek the fulfillment of their needs for acceptance, intimacy and autonomy through deference to the desires of their sexual partners (Varga 1997: 49). Safe behaviour modelling, peer education, life-skills training are crucial interventions at this stage. Adolescent girls are particularly at risk for both sexual coercion and HIV/AIDS.

In the media reports in the wake of the 16 days free of violence against women and children campaign, the incidence and the forms of sexual harassment and abuse of schoolgirls by their teachers, was highlighted (see also the Department of Education's 1997 Report on Gender Equity in Education in Joint Monitoring Committee on the Improvement of Life and Status of Women 2002). In addition to the trauma resulting from harassment and abuse at school, girls' education and level of educational achievement might be adversely affected.

More generally, girls' vulnerability is determined in large measure by their limited experience with gender relations in adult society, their insecurity and lack of status in relation to older boys and men. 'Sugar-daddy' relationships between adolescent girls and older men, formed often with the approval of the girls' families – have become proverbial and contribute to the high rate of HIV infection among girls in their late teens and early twenties.[7] The age differentials in both the relationships and the rates of HIV infection, are often related to spousal relationships characterised as 'adult-child' relationships, with the male partner playing the role of the authoritative father, diminishing the woman's status and decision-making powers in the relationship (Pivnick 1993: 441).

Age differences of between one and five years between partners in first sexual experience seem to be the norm. Given that this age difference characterises relations at first sexual experience, which for a significant percentage of young women was given as age 16 or younger, it can be assumed that young women's powers of sexual negotiation and decision-making are severely compromised (DOH, AIDS Helpline 2000: 29).

Recognising that age differentials between adolescent sexual partners challenge the very notion of consent, the Law Commission made proposals to the effect that it is not simply the age of consent that should be a criterion in determining statutory

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7.   Morell et al. document the differentials in HIV prevalence among teenage youth aged 15-19, in KwaZulu-Natal, estimated at 15.64% for African schoolgirls, compared to 2.58% for African schoolboys (2001).

rape, but also the age differentials. 'Rather than create a blanket prohibition of sexual acts with children below 16 years of age, the provision [proposed by the Law Commission] specifically provides for a two year age difference as a defining age gap for non-consensuality, when one of the respondents is younger than 16 years.' (Kelly et al. 2002: 62-63).

In the literature on youth sexuality, there are some reports of a 35.1% teenage pregnancy rate among 15-19 year old women. This is inaccurate. The rate is 35.1% for 19 year-old women; however, it is 16.4% across the age group 15-19 (South African Demographic and Health Survey, Department of Health, 1998).

Rachel Jewkes spells out the impact of teenage pregnancy:

> *Teenage pregnancy reduces the likelihood of the mother completing schooling, reduces prospects for subsequent employment and earnings, compromises the financial position of her family's household (maintenance from the father is rarely forthcoming), and negatively impacts on the child, who is born into relatively greater poverty. (1999a: 27)*

Women in relationships with men

Researchers on gender-based violence within the CSVR point to a consistent correlation between a prior history of gender-based violence and HIV infection (Vetten & Bhana 2001). They refer to a study conducted by Maman et al. in 2001 in Tanzania, which concludes that:

> *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. (in Vetten and Bhana 2001: 7)*

The impact of gender-based violence on the health of the survivor can be dramatic. Gynaecological disorders associated with sexual violence include vaginal bleeding, painful menstruation, pelvic inflammatory disease, sexual dysfunction, premenstrual distress (Heise et al. 1999: 18). There appears to be a correlation between the severity of the abuse, and the number of gynaecological symptoms:

> *The number of gynaecological symptoms appears to be related to the severity of abuse suffered, whether there was both physical and sexual assault, whether the victim knew the offender, and whether there were multiple offenders. (Heise et al. 1999: 18)*

Pregnant women

Around the world, there are high levels of physical and sexual abuse of pregnant women, especially pregnant teenage women, usually by a male partner.

Violence against pregnant women can have serious health consequences for both women and their babies. Pregnant women who have experienced violence are more likely to have a history of STIs; to have vaginal, kidney and cervical

Researchers on gender-based violence… point to a consistent correlation between a prior history of gender-based violence and HIV infection.

infections; to have unwanted or mis-timed pregnancies; to have bleeding during pregnancy; to gain insufficient weight; to delay seeking prenatal care; to have an increased risk of miscarriages and abortions, premature labour, pre-term delivery, fetal distress and low birth weight of the baby; to engage in harmful behaviours, such as smoking, alcohol and drug use; to experience extreme stress and anxiety, leading to pre-term delivery or fetal growth retardation by increasing stress hormone levels or immunological changes; to die or commit suicide (Heise et al. 1999).

Migrant and refugee women

Refugee women often attain asylum and access to accommodation and services on the basis of being married to male partners who are granted asylum. They are practically not recognised or given status in their own right. This makes them extremely vulnerable to abuse not only from their surrounding social environment, but also from their partners. With their right of access to basic services at local government level not being clarified (see Palmary 2002),[8] any help and advice they might seek in cases of rape, abuse, and domestic violence would jeopardise their already precarious status. Rates of rape are proportionally very high, as are reported experiences of genital mutilation. Although there is a general awareness of HIV/AIDS, a high percentage of refugee women do not see themselves at risk. They also show low levels of knowledge about the modes of transmission of sexually transmitted infections (STIs) (Abrahams and Hajiyiannis 2001: 17).

POWA, the Black Sash, the South African Migration Project (see especially the latter's study on HIV/AIDS), and the Human Rights Committee are taking up the issues facing refugees and migrants from other countries, particularly those related to violence against women and children.

Same-sex relationships

Coercion in same-sex relationships in South Africa is a subject largely shrouded in silence. It has only recently been included in the definition of rape, and it has not been recognised by police and law-enforcement agencies where it occurs in the form of domestic violence.

The occurrence of gender-based violence in same-sex relations has been described by social historians and gender analysts for institutions, such as prisons and mine hostels (Moodie et al. 1991; Moodie and Ndatshe 1994; Dirsuweit 1999; Gear and Ngubeni 2002). It is only recently that scholars and activists are studying its forms and implications in the broader social arena in South Africa (for example, National Coalition for Gay and Lesbian Equality; Reddy and Louw 2002) and in youth culture (Reddy and Louw 2002).

However, it is not same-sex relationships per se that pose a risk for gender-based violence and HIV/AIDS, but the conflation of 'sex' and 'gender' within rigidly defined gender roles. In heterosexual relationships, gender-based violence is partly conditioned by processes of masculinisation: patterns and modes of male violence – institutional, public, and private – along with notions of female inferiority.

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8   In terms of the Refugee Act of 1998, refugees are allowed to seek employment and access to education within six months of applying for asylum. However, there is no clarity about access to services delivered at local government level, such as housing, primary health care, water, sanitation and safety (Palmary 2002: 1).

Women under attack from men are 'feminised' according to templates of female inferiority (Bennett 1999). This does not, however, only apply to heterosexual relations, but also to same-sex relations where gender-roles are often violently enacted and enforced.

Prison 'marriages' provide a clear example of violent enforcement of gender roles, where 'men' and 'wives' are defined by their sexual roles of penetrating/active and penetrated/passive, respectively (Gear and Ngubeni 2002).[9] One of the upshots of the study on gender-based violence in prisons is the continuity between gender-based violence inside and outside of prison. Gender-based violence outside of prison is mimicked in prison 'marriages'. But it also works the other way round: young prisoners get socialised into violent models of gender relations in which they ground their future partnerships. The continuities and discontinuities between gendered life inside and outside of prison would require more research.

Close parallels, albeit with a different degree of coercion, can be observed in what Moodie et al. and Epprecht have described as 'mine marriages', enforced by a code or gang law, between older and experienced mine workers and young novices the mining industry, in which the younger partner would be enjoined to play a passive role (Moodie et al. 1991; Moodie & Ndatshe 1994; Epprecht 2001: 1).

In a recent study on African youth culture, Reddy and Louw found that roles of same-sex partners are often modelled on heterosexually normed gender relations.

> *Youth who identify as gay are usually those who are passive and typically perform 'feminine' roles in their relationships. They may even refer to themselves as 'girls' or 'women' and to their partners as their 'men' or 'husbands'. Most commonly the active participants will not identify themselves as gay, as the term is seen to connote a feminine gender. They may in fact continue to have sexual relations with women to assert their masculinity.[10] (2002: 89)*

While there clearly are continuities to be observed between gendered identities inside and outside of total institutions, between institutionalised direct coercion and the wider social arena, such continuities appear to be vigorously denied by those enmeshed within them.

Gear and Ngubeni's study shows that prison experiences fuel and socialise inmates into homophobia, as crime and sexual coercion experienced in prison become associated with homosexuality (2002: 59, 80).

Possibly related to this is the denial of HIV/AIDS and of what constitutes risks. Condoms are not always accessible. Nor are prison conditions conducive to the internalisation of risk.

Similarly, the study on perceptions and interventions around HIV among black men including same-sex relationships, points out that there is a widespread notion

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9.   see footnote 10

10. This is not unique to South Africa: In Mexico, where homosexuality is equated with femaleness, penetrating other men 'is not considered homosexual. Indeed, having sex in this way with other men may in fact reaffirm his masculinity as the penetrator of others. The opposite is true for for the man who allows himself to be penetrated. He is the only one likely to be seen as homosexual' (Liguori et al. 1996: 76 in Foreman 2000: 2-3). A similar fluidity in gender categorisation and construction of masculinity can be observed in gender constructions in some sub-cultures in South Asia and Brazil, where the roles of penetrating and penetrated, active and passive, define virility and femininity or 'effeminateness', respectively. This applies to both heterosexual and male same-sex relations (Foreman 2000: 2).

that penetrative sex in same-sex relations does not pose an HIV transmission risk. Risk is perceived to be present only when gay men have had sex with bisexuals, who are considered to be vulnerable to HIV through their relations with women (Reddy & Louw 2002: 89).

The implications of these studies for further analysis, policy, service provision, extension of the human rights framework, and for education and awareness-raising, are of a tall order. We would need to come to understand more clearly the complex relationship between sex and gender as it is being played out in both heterosexual and same-sex relationships, within sexual and social relations. The high incidence and prevalence of HIV in prisons[11] under conditions of violent gender stereotyping and sexual coercion, and in the absence of effective health and counselling services, calls for an urgent revision of correctional services policies and protocols along the lines of what the organisation Friends Against Abuse advocates. And the reduction of 'gender' to 'sex' that often provides a structuring role in violent and coercive sexual-social relations, would have to be addressed and debated in transformative interventions at every level (see section on 'Transformative interventions', and specifically the subsection on 'Gender and HIV training').

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Sex workers

Members of the Sex Workers Education and Training Project (SWEAT) point out that the stigmatisation of sex workers increases their vulnerability to both gender-based violence and HIV/AIDS. They therefore advocate the decriminalisation of sex work, the introduction of a code of conduct, access to non-judgemental health services, and unionisation, with the aim of protecting sex workers from economic and social marginalisation, and violence (Gardner & Sloan 2000). These demands are included in the new South African Sex Worker Charter, adopted in October 2002. More specific problem areas raised in the Charter concern clients refusing to wear condoms, verbal and physical abuse from the community, and poor services from health service providers and police.

Forms of gender-based violence

In analysing specifically what is happening at the interface between gender-based violence and HIV/AIDS, it is important to note the varied forms of violence which might structure and determine responses to HIV/AIDS in individual cases. Physical violence seldom comes alone, and it has long-term consequences. Its purpose is control, intimidation, and subjugation. The fear that it elicits, is instrumental in exercising power and control well beyond an individual incident of physical violence. In intimate relationships, physical violence is often accompanied by economic, psychological/emotional and sexual abuse (see Krug et al. 2002: 89). Many women report that they suffer more from the impact of continuous emotional abuse that forms the backdrop of (threats of) physical abuse, than from that of physical abuse per se.

In 1993, the UN General Assembly adopted a declaration on violence against women. This includes '[a]ny act of gender-based violence that results in or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether

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11.   See footnote 12

occurring in public or private life'. The definition encompasses, but is not limited to, physical, sexual and psychological violence occurring in the family and in the community, including:

- rape and gang-rape

- battering

- sexual abuse of female children

- female genital mutilation and other traditional practices harmful to women

- dowry-related violence

- domestic violence, marital rape

- intimate femicide

- non-spousal violence

- violence related to exploitation

- sexual harassment, and intimidation at work, in educational institutions, and elsewhere

- trafficking in women and children, forced prostitution

- violence perpetrated or condoned by the state

- secondary victimisation of persons who have been raped, abused, and harassed at the hands of police and district surgeons to whom they are reporting the incident of violence (through for example, not acting adequately on the case, subjecting the survivor to renewed humiliation, through long waiting periods and lack of privacy, etc)

- economic violence, including withholding of money for essential living purposes for the partner and child(ren).

Economic violence includes the withholding of work contracts, salaries, passports, work and residence permits for migrant women. Migrant women, and women whose jobs are insecure, are particularly vulnerable to such infringements. They might face the added forms of economic violence in the form of arbitrary dismissal, deduction from or withholding of wages, eviction from accommodation in the case of women domestic workers (see Motsei 1990; Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002) and farm workers.

Some of the less visible forms of gender-based violence include the preference of sons, and comparative neglect of girls in the same family. It manifests itself, among other things, in a disproportionate amount of housework and care work for girls from a young age onwards, and in the inequality that does not give girls the same opportunities for and access to education that boys within the same family enjoy.

Gender-based violence also occurs in same-sex relationships where gender roles are heterosexually normed.

Interviews conducted by Cadre with organisations working in the field of violence against women in South Africa, indicate that women seeking help to deal with violence and abuse, are distinguishing between different forms of

violence, and recognise the withholding of economic resources, verbal threats, and emotional blackmail as forms of abuse. They are beginning to speak out on forms of emotional and economic violence and violence in the form of the denial of sexual and reproductive rights (interviews with Stop Women Abuse Helpline, Nisaa, Masisukumeni, Tshwaranang Legal Advocacy Centre).

Discussion

The reasons for the persistence of violence and of gender-based violence in post-apartheid South Africa, with a new Constitution that provides the framework for legislation taking account of the position of women, are unclear. In trying to explain this, researchers have pointed to the endorsement of violent means to achieve desired ends, and to displaced aggression vented on women and children. In the face of continuing poverty, social dislocation and marginalisation, and the persisting urban-rural divide, traditional authorities have in some respects retained their role in local governance, tightly circumscribing the status, mobility, and opportunities and activities of women.

The rigidity with which stereotypical gender roles are being asserted owes its force partly to the conflation of sex and gender: gender roles are often violently enforced and enacted on the basis of what biological sex is taken to stand for. This applies to both heterosexual and same-sex relations. Violence and coercion in same-sex relationships often results from enforcing heterosexual norms and role expectations. Where such violence occurs under generally coercive conditions, the denial of HIV risks is common.

HIV/AIDS has added to the burden and vulnerability of women: it has exacerbated the economic and social insecurity of women; and women's social and economic insecurity, in turn, makes them vulnerable to infection with HIV/AIDS. There are groups of people who are particularly vulnerable. Children, and children affected by HIV/AIDS, who have experienced loss, mourning, family disintegration and economic hardship, or rape and sexual abuse, may adopt high risk coping skills later in life. Adolescent girls are particularly at risk in the context of social and family destabilisation. Relationships in which the women are considerably younger than men and experience abuse at the hands of older men, are frequent. Additional risks for women in age-differentiated relationships are infection with HIV, teenage pregnancy, and violence at the hands of the male partner during pregnancy.

The links between low status, lack of social support, poverty, gender-based violence, and the risk of contracting HIV that this case illustrates, have been demonstrated more generally.

Intervention strategies to address these problems would have to combine political, social, and psychological approaches, and establish intersectoral collaboration:

❑ The urban-rural divide that structures differential access to citizenship, to economic and educational opportunities, and to social services, would have to be addressed.

❑ Aims of and programmes for gender equality have largely been confined to the urban areas, and to the sphere of civic citizenship. Local government structures should be included in this programmatic vision and implementation.

❑ Social service provisions, and social security for women are essential to address gender-based violence and vulnerability to HIV infection. They should be

The reasons for the persistence of violence and of gender-based violence in post-apartheid South Africa, with a new Constitution that provides the framework for legislation taking account of the position of women, are unclear.

guided by gender-transformative approaches to social policy.

❑ Legal provisions regarding gender-based violence would have to be implemented, in tandem with training of police, court and medical officers; with improved access to police stations and health facilities; and with appropriate and friendly health service delivery. Prevention of secondary victimisation is imperative.

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❑ To improve the social status of women, improved access to social security, employment and education are required.

❑ The psychosocial needs of children, particularly children affected by illness and loss of family members due to AIDS, and children who have experienced sexual abuse, need to be addressed along with their survival needs. Further attention should be devoted to recovery strategies in cases of child abuse, so as to prevent high-risk behaviours later in life.

❑ Through education, life-skills training, and guided activities within youth programmes, adolescents should be taught communication, social and conflict resolution skills. Social services should strengthen and support family networks of adolescents. Such programmes should provide structured opportunities for debating and contesting stereotyped gender roles, and for modelling alternatives.

❑ Health services would need to become more proactive in screening for gender-based violence, and counselling and referral in cases of sexual abuse, rape, and other forms of violence. More generally, health services should encourage male partners to become informed and participate in decision-making on sexual and reproductive health issues arising within a relationship.

❑ In the light of the staggering incidence of rape and HIV in prisons, health and social services in prisons would need to be improved with the aim to prevent violence, to provide life-skills training focusing on sexual rights, communication and conflict resolution skills, to protect juvenile and first-time offenders and awaiting-trial prisoners, to improve rehabilitation prospects, and to provide voluntary counselling and testing, PEP, and condoms.

GENDER-BASED VIOLENCE, HIV/AIDS AND HUMAN RIGHTS

International human rights instruments

The fact that women are asserting their rights against gender-based violence of various forms, confirms the important role of a rights-based approach to gender-based violence and HIV/AIDS. As Albertyn points out, 'as the epicenter of the epidemic has moved from the first to the third world and from (gay white) men to (poor black) women, so the rights emphasis has begun to shift from a focus on individual rights of privacy and non-discrimination to embrace more global social and economic concerns of poverty and inequality' (2000: 1). In the last few years, numerous international human rights declarations were ratified to take account of, and to give guidelines to, organisations working in legal advocacy, health care delivery, social policy, teaching and awareness-raising, and service provision internationally. These include

❏ The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1993) provides a comprehensive definition of gender-based violence, and recommends that signatories provide effective legal measures to protect women against violence, take preventive measures to change attitudes, and provide services and assistance to women (Soul City: 2-3).

❏ The International Community of Women Living with HIV/AIDS (ICW) has issued twelve statements asserting the needs of women living with HIV/AIDS globally.

❏ The International Conference on Population and Development in Cairo (1994) and the Fourth World Conference on Women in Beijing's Platform for Action (1995) agreed that human rights include the right of women to control over their sexuality.

❏ The Barcelona Bill of Rights (Women and HIV/AIDS) includes the right to sexual and reproductive health services in conjunction with gender equity in education and economic independence.

❏ The Southern African Development Community (SADC) Declaration on Gender and Development (especially the Addendum on Violence) require interventions at the legislative, social service, and educational levels to remove discrimination against women, to empower them, to promote and protect their human rights, to provide support to those who have been abused, and to take action against perpetrators of gender-based violence.

❏ The SADC AIDS and STD Programme recognises the linkages between the status of women and violence as factors contributing to the spread of HIV (Klugman 2000).

Determining the objectives for sexual rights campaigns has given rise to some controversy that created much debate at the Fourth World Conference on Women in Beijing in 1995 (see Klugman 2000). In the countries of the global North and West, it was argued, sexual rights are often associated with the search for and assertion of the freedom of sexual expression, particularly with regard to sexual orientation. In the countries of Asia, Africa and South America, in contrast, sexual

…the rights emphasis has begun to shift from a focus on individual rights of privacy and non-discrimination to embrace more global social and economic concerns of poverty and inequality.

rights were taken to refer, among other things, to the right to say no, and how to say no, to unwanted sexual advances and sexual coercion. In the latter context, sexual rights also referred to the need for accessible, affordable, comprehensive, informed, non-judgemental, friendly and efficient health services that can provide for sexual and reproductive health needs at every level – prevention, treatment and care.

South African legislation pertaining to violence against women

The post-apartheid constitutional and legislative changes, as well as the establishment of various parliamentary and constitutional commissions, have brought about major changes in favour of women's access to legal redress and gender equity.

In South Africa, a human rights framework that integrates gender equity with sexual and reproductive rights, and with access to treatment and care, would be imperative. The post-apartheid constitutional and legislative changes, as well as the establishment of various parliamentary (the Office for the Status of Women; the Parliamentary Women's Group: the Committee on the Improvement of the Quality of Life and Status of Women; Gender Desks in various government departments) and constitutional commissions (the Commission for Gender Equality), have brought about major changes in favour of women's access to legal redress and gender equity. The following rights and laws are relevant to forms of gender inequality, gender-based violence and sexual coercion:

❑ The Constitution and the Bill of Rights (1996): Equality (also through the Promotion of Equality and Prevention of Unfair Discrimination Act (2000)), Freedom and Security of the Person, Privacy, Access to Health Care (meaning that the Government must do everything in its power to realise this right; free Health Care for Women and children under 6)

❑ The Choice of Termination of Pregnancy Act (1997)

❑ The Maintenance Act (1998)

❑ Domestic Violence Act (revised 1999)

❑ The Recognition of Customary Marriages Act (1998), giving women in customary marriages equal status and equal control over property

❑ The Criminal Law Amendment Act (1997), imposing a mandatory life sentence on anyone convicted of rape who knew that he was HIV positive at the time of the rape. A woman who has been raped can request that the accused be tested for HIV.

Legislative revisions and campaigns in process

Rape

In December 2002, the Law Commmision approved a draft bill revising the provisions of the Sexual Offences Act by introducing a range of far-reaching proposals. The draft bill has been handed to the Minister of Justice and Constitutional Development, to be tabled before Parliament.

The Law Commission has reviewed the laws pertaining to the definition of rape – unlawful sexual penetration under coercive circumstances – with a view to including sexual coercion among same-sex partners, and forms of penetration not covered by the Act. This has become particularly urgent in relation to the staggering incidence of prison rape, and the high risk for HIV infection through rape in prisons.[12] It is an issue that is taken up by Friends Against Abuse, a group

advocating prisoners' rights – including sexual rights, access to health care and treatment for HIV/AIDS – and rehabilitation.

The Law Commission has been challenged to educate district surgeons, police officers, and magistrates about the trauma of rape, about the needs of survivors, about expeditious procedures and proper reporting. The proposals take up this challenge by providing for medical and psychological treatment of survivors immediately after the rape incident. If the survivor is at risk of HIV/AIDS or any other sexually transmitted disease, he/she is to be given all necessary treatments, at state cost.

The proposals also give expression to the recognition of the severity of rape trauma. Recognising that trauma, stigmatisation, and fear might prevent rape survivors from reporting the incident immediately, the proposals stipulate that courts should not draw any inference from the length of time taken to report the incident. No rape survivor should have to go through secondary victimisation at the hands of police, medical or court officials. This is a consideration that should be given high priority in view of the high rate of unreported rape. (NICRO estimates that only 1 in 20 rape cases are reported; the South African Police Services puts the rate at 1 in 35.)

The South African Law Commission's proposed alterations of the definition of rape will mean that the state will not be required to prove absence of consent on the part of the person who has been raped. In the proposed legislation, marriage is not regarded as an impediment to rape, which means that a husband can be convicted for raping his wife. An application to this effect can be brought even retrospectively. The definition of 'penetration' has been broadened considerably. The new definition of 'penetration' allows for the possibility of both men and women to be rape victims and perpetrators. It has also allowed other forms of sexual abuse (for example, oral sex rape) and gang rape to be included in the definition of rape (Smith 2002).

Two of the Law Commission's innovative proposals relate directly to the context of HIV/AIDS. The first one concerns the willful infection of others. The definition of rape has been broadened to include failure to disclose to a sexual partner diagnosed with a life-threatening sexually transmissible infection. The second one concerns the notion of consent. The Law Commission recognises that it is not the absolute age of 16 that should be the decreed age of consent, but that age differentials between adolescent partners are more important in considering the very possibility of consent. The Law Commission proposes to make a two year age gap between sexual partners below the age of 16 a criterion for non-consensuality, and hence for statutory rape. The proposed new clauses determine statutory rape in this context in the case of:

❑ any person who intentionally commits a sexual act with a child at least two years younger than him/her

❑ any person who commits any act with the intent to invite or persuade a child, at least two years younger than him/her, or who allows any person to commit a sexual act with that child

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12   The mortality rates in South African prisons were highlighted in an article in the Mail & Guardian (8.11.2002), which quoted a South Africa country profile on drugs and crime, compiled by the United Nations Office for Drug Control and Crime Prevention: 'Between 1995 and 2000 the number of natural deaths [in South African prisons] increased by 484%. According to post-mortems conducted, most of those deaths are believed to have been the result of HIV/AIDS.'

❏ consent by a child to any sexual act, which shall not be a defence to a charge under this section {Section 14 of the Sexual Offences Act] (Kelly et al. 2002: 63).

Implementation of legal provisions regarding rape, sentencing and conviction of the rapist, and appropriate assistance for rape survivors remain uneven and in many cases inadequate.

As with domestic violence cases (outlined below), submissions to the Joint Monitoring Committee on the Improvement of the Quality of Life and Status of Women heard in November 1999, indicate that the police services 'remain[s] inaccessible, insensitive and ineffective in preventing violence against women and assisting victims of violence'. 'Submissions described police as accusatory ('Why did you go with him'; 'You should not walk in that area alone'; 'You know what happens at the shebeens, you shouldn't have been there'), hostile ('you're wasting my time – come back when you get your story straight'; 'what do you want us to do about it?'; 'why did you wash yourself?') and uncooperative ('find him and then come back to us'; 'sit here until a female officer arrives to help you') (Recorded by UCT's Institute of Criminology's Gender, Law and Development from women in the rural areas of the Southern Cape). In some cases, police were reported to have attempted to dissuade women from laying charges against perpetrators of violence, by stressing the negative outcomes for women if they insisted on the arrest of the perpetrator.

Masimanyane Women's Support Centre in East London described 'a lack of communication, lack of training and lack of transport to hospitals and police stations'; 'a reluctance on the part of medical examiners to appear in court for fear of witnesses being treated with disrespect'; women having to wait for their court appearance in the same hallway as her assailants; survivors not being given any information about process and procedures; and inadequate preparation for trial. Concern has been raised about gender-stereotypical views on women taken by the judiciary, suggesting that women collaborate in crimes against them.

In an attempt to address one aspect that could give rise to such stereotypical views that contribute to secondary victimisation, a request was tabled at the Violence Against Women hearings in November 1999, to remove question 11 (e) from the J88 form, which asks for 'date of last intercourse with consent' (Joint Monitoring Committee on the Improvement of Life and Status of Women 2002).

Post-Exposure Prophylaxis (PEP)

Cabinet recently approved a draft bill that will allow rape victims to apply for a court order compelling the rapist to be tested for HIV (Vetten & Gerntholtz 2002: 8), to enable women to make informed decisions on PEP and safe sex practices. Vetten and Gerntholtz investigate the effective actionability of the provisions of this bill once it becomes law. Given that only 40%-58% of reported perpetrators are arrested (in North West, Mpumalanga, Gauteng, Northern and Western Cape), only about half of the women who report rape, will be assisted through the provisions of the bill. With the added complication that the anti-retroviral drugs given in post-exposure prophylaxis will have to be taken within 72 hours after the rape incident[13] and taken for 28 days, the percentage of women who will have this option will be even smaller. If the legislation is to have any tangible effect in assisting women who have been raped, the suspect must be arrested and tested for HIV within three days of the rape incident. To be safe, the woman

would have to take a 28 day course of anti-retrovirals, even if the rape suspect tests negative, as he may still be in the window period before HIV would register positively in his test results.

The Violence Against Women hearings in November 1999 heard reports of inadequate counselling and preventive treatment of rape survivors for pregnancy, STDs and HIV/AIDS. PEP was often not available in the health facilities to which rape survivors reported, and forms (the J88 form) were inadequately filled in by district surgeons (Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002).

However, the Department of Health has recently announced the implementation of a programme to provide counselling and testing, and antiretroviral drugs for post-exposure prophylaxis in all public health facilities. To qualify for this, women who have been raped must report the case to the police, obtain a case number, present themselves to a public health facility within 72 hours of the rape incident, and undergo testing. There is a question mark over the provision of PEP to those women who decide not to report the rape and/or those who decide not to undergo testing.

Although the Department of Health announced the general roll-out of PEP by end-December 2002, there seem to be many issues of protocol that require clarification. The time period after the rape incident, within which PEP would be effective, is a matter of controversy.[14] Also controversial is the type of test administered, which is linked to the strategies of improving adherence to drug regimens through repeated visits to the health facility, and follow-up counselling, information and monitoring.

Basing the provision of PEP on the rape survivor's serostatus is likely to deepen the divisions between persons who are HIV-positive and those who are HIV-negative. Adequate referral systems, ongoing counselling and information, and the general accessibility to antiretroviral treatment would go some way to address this otherwise widening rift.

Researchers and activists are calling for a national policy guiding the care and treatment of rape survivors within the health care system (Vetten & Gerntholtz 2002: 8).

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The Domestic Violence Act

The Domestic Violence Act, which came into operation on 15 December 1999, has been welcomed by gender activists because it broadens the definition of domestic violence to include physical, economic, sexual, verbal, emotional and psychological abuse, harassment, stalking, intimidation, damage to property, and entry into a woman's residence without her consent. The provisions of the Act are not restricted to married couples, but apply to a range of other living-together arrangements. The Act places more obligations on the police services. It allows for more powers to arrest the abuser and it obligates the police to help the abused woman. This includes explaining her rights to her, helping her to find a safe place to stay and providing assistance with medical attention. It limits the

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13   This period within which treatment would have to commence, is controversial. Other organisations and researchers call for commencement of treatment immediately after the rape incident. Some organisations argue that treatment will be effective optimally if started four hours after the rape incident, others advocate commencement of treatment within the first seven hours after the rape incident.

14   See footnote 13

granting of bail for persons accused of having committed rape, and provides for minimum sentences for murder and rape with aggravating circumstances. For the first time, the Act provides for disciplinary action against police officers who fail to do their duties in this respect. The Act obliges the abuser to continue to support his partner and children financially, and to comply with the Protection Order. The Protection Order is innovative in comparison with the provision of a Court Order in the previous Prevention of Family Violence Act, as it is does not immediately render the abuser subject to criminal law procedures.

Women have generally reported negative experiences with police and courts. Some reports indicate poor police service, where women in need of protection were not taken seriously and appropriate action was not taken.

The problems with the revised Domestic Violence Act do not lie in the detail, but in its implementation. Inadequate resources are being allocated to the implementation of the Act. Women have generally reported negative experiences with police and courts. Some reports indicate poor police service, where women in need of protection were not taken seriously and appropriate action was not taken. Ridicule, failure totake appropriate action on complaints, and failure to protect the person reporting violence from an intimate partner, were common experiences reported by organisations who are researching and delivering services to people in same-sex relationships (POWA, National Coalition for Gay and Lesbian Equality). Reports on the experience of courts complained of 'inexperienced, unprofessional and ill-prepared prosecutors, insensitive treatment of traumatised witnesses, lack of facilities at courts and lack of transport to courts, magistrates' lack of understanding of issues of gender violence, clogged-up court rolls, and unnecessary postponement of matters, a shortage of regional magistrates and more qualified prosecutors, intermediaries and interpreters' (Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002 [based on hearings on Violence Against Women, 8-17 November 1999]). The Commission on Gender Equality raised some related concerns: the failure of sheriffs to serve interdicts in informal settlements and in rural areas; and a lack of follow-up in domestic violence cases.

Research on the scope and duration of abuse in domestic violence is hampered by the fact that 'domestic violence' in the police statistics falls under common assault or assault with the intent to do grievous bodily harm. This is a serious impediment in preventing intimate femicide, which is usually preceded by a long history of abuse. A new form is being developed which will allow for recording separate statistics for domestic violence.

Individuals' and organisations' experiences with invoking the Domestic Violence Act have thus been mixed. A more even geographical distribution of police stations and health facilities, and accessible, safe and affordable transport to police, health and welfare services would have to be ensured. And a great deal of training still has to be offered to the police service, to clerks of the court, and to prosecutors, to familiarise officers with the provisions of the Act and with the situation, the special needs, and the trauma of rape victims. There are indications, from the Department of Justice as well as from NGOs (for example, Tshwaranang Legal Advocacy Centre), that training of police officers will be stepped up. NGOs rendering services to abused women have indicated positive responses where they have undertaken to collaborate with and provide training to local police services (for example, Masisukumeni, GRIP, POWA, NISAA). Organisations working in the field of legal advocacy and gender-based violence (Tshwaranang Legal Advocacy Centre, Centre for the Study of Violence and Reconciliation, AIDS Law Project), have distributed information booklets and pamphlets widely in the public service, in health care facilities and police stations, and in educational institutions.

Organisations providing services for women who have experienced gender-based violence, are lobbying for government funding to ensure the sustainability of shelters, counselling services, and other programmes for women and children.

Intimate femicide

There are indications that the provision of a Protection Order in the Domestic Violence Act does not provide women with sufficient protection against further abuse, partly because of the delays and complications of proceeding from a Protection Order to a criminal trial. The international literature suggests that the attempt to leave or end a violent relationship does not necessarily guarantee a woman's safety. A woman's risk of being murdered is greatest immediately after separation (Heise et al. 1999: 7). It is difficult to assess the extent of this problem, and the kinds of responses of a violent partner, due to under-reporting and due to the fact that femicide is not a category in South African law. It is thus not possible to analyse and assess any possible link between domestic violence and intimate femicide. This is what a campaign launched by Tshawaranang Legal Advocacy Centre is designed to address.

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The Sexual Rights Campaign

International conferences on women, on population and development, and HIV/AIDS have called for the inclusion of sexual rights within human rights.[15] In South Africa, the Sexual Rights Campaign was launched as a response to the high rates of HIV infection, particularly among young women, in the context of violence against women. It is a joint effort of the Women's Health Project, the Joint Enrichment Project, the National Association of People Living with AIDS, the National AIDS Convention of South Africa, the National Network on Violence Against Women, the Planned Parenthood Association of South Africa, the YMCA, and community-based organisations. It recognises that in South Africa, women often compromise their rights and health through their economic dependence on men, and through their own cultural, positively sanctioned efforts to provide sexual pleasure to their partners. The advocacy of sexual rights, promoted in information and training workshops, is coupled with the demand for economic and social security.

The mediation of and equality through rights and rights-inspired legal provisions, while limited in the absence of a politics of human rights, is a goal worth fighting for and defending. This becomes clear considering the fate of gendered citizenship in countries like Canada, where the norm of equality was expelled from politics and policy under a rhetoric of dismantling the welfare functions of state, and under a new form of governance – viz. that of competition for a place in the labour, housing, education and health markets.

With the state abrogating its role in relation to society, marginalisation and reversion to relations of bond would adversely affect the content and the very notion of citizenship, especially for women.

15　The Fourth World Conference on Women in Beijing in 1995 presented the following definition of sexual rights within the framework of human rights pertaining to women: The human rights of women include their right 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. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences (Platform for Action of the Fourth World Conference on Women, September 1995, para 96, UN Doc. A/CONF.177/20 (October 17, 1995).

A rights framework

A rights-based approach is increasingly being adopted by organisations and research aiming to prevent gender-based violence and HIV/AIDS is being undertaken. Such an approach has been advocated on the basis of a number of considerations. As rights activists of the AIDS Law Project point out:

> … *not only do human rights omissions and violations create greater vulnerability, but they also compound a vicious circle whereby people who are infected with HIV and AIDS because they lack the autonomy needed for behaviour-change – become prey to a further series of human rights violations that further undermine their dignity and equality… the denial of social and economic rights (food, shelter, livelihood) precipitates the denial of civil rights (autonomy, privacy, security of the person) and thereby exacerbates vulnerability to infection. (Heywood & Albertyn 2001: 9-10)*

It has become clear that a narrow model of individual health is of limited value for any intervention directed at sexual behaviour. In such health promotion, the responsibility for health is placed on the individual with the assumptions 'that fear or anxiety automatically triggers rational reactions that can be refined and channeled into particular behaviour (safer sex), and that once awareness and concern is established, a logical, predictable train of reactions can be set in motion.'

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Messages aiming to address individuals carry further limitations: the individual is usually seen in connection with 'the condom solution', which displaces the need to debate attitudes on gender, identity and power. These would need to be brought into safer sex and HIV prevention education (see J Lewis 2000: 25).

A rights-based approach, in contrast, recognises that contexts, frameworks, and agendas are pivotal in creating conditions for changes in individual action-orientations, cultural traditions and customs, norms, values, prohibitions, and policies (see Parker & Kelly 2001: 2). It gives credence to the fact that it is not primarily individual choice, based on factual knowledge of health risks, that determines sexual behaviour. Instead, it places emphasis on socially negotiated sexual identifications, on the social conditions for decision-making and taking charge, as determining factors in sexual behaviours (Campbell et al. 1998).

However, a rights-based approach would not altogether bypass the trap of 'victimhood'. Researchers should guard against describing women in terms of 'the gender problem', as disempowered and weak, as the victims, 'whose position needs to be rectified through commitment to human rights and projects focused on empowering women' (J Lewis 2000: 24). Lewis elaborates on these pitfalls:

The problem here is that the discourses that name the terms of women's victimisation, invoke women's situation as the problem to be solved, and chart women as the objects of exploitative or abusive male behaviors needing protection and special support. This kind of 'gender strategy' provides crucially needed local responses to the real situations of women affected by discrimination, male violence, and control. But the ensuing emphasis has often been to deal with the damage in the victims' lives, emphasizing the importance of legal protection or survival support for women, at the detriment of engaging with the conditions that facilitate and reproduce the causes of damage. (2000: 24)

Judith Butler similarly outlines the pitfalls of women's issues' mobilisations within representational politics. Such mobilisations are listed as fighting for positions of power, lobbying for legal and constitutional change, and lobbying to have women represented at all levels of governance and in public institutions. In these mobilisations, the criterion of rights is universalised, and counts for the condition and the measure of the position of women, with frequent references to the inequalities by which women are excluded. The resulting problem for a feminist representational politics is that '…the feminist subject turns out to be discursively constituted by the very political system that is supposed to facilitate its emancipation' (1990: 2). It implies the risk that identity articulated through rights is produced and regulated through law and bureaucracy; and that in the process, political recognition becomes an instrument of subordination (Brown 1995: 98). Butler outlines the consequences of this double bind for feminist critique:

It is not enough to inquire into how women might become more fully represented in language and politics. Feminist critique ought also to understand how the category of 'women', the subject of feminism, is produced and restrained by the very structures of power through which emancipation is sought. (1990: 2)

Some of these pitfalls could be addressed through a gender-strategy that is directed at gender-based violence more generally, considering that some of the same mechanisms that are oppressive to women (for example, the reduction of 'gender' to 'sex') are locking men into oppressive sexual and social relations (for example, in the same-sex relations that are modelled on heterosexist norms).[16] Organisations working in the field of gender-based violence in South Africa are not limited to service or legal provision. Inevitably – and they would hardly be effective if they did not engage in this multi-pronged way – organisations combine legal advocacy, engaging with government structures at various levels, collaboration with other organisations, education and awareness raising, research, communications, campaigning for gender equality, community outreach, and counselling.

…some of the same mechanisms that are oppressive to women are locking men into oppressive sexual and social relations.

Lewis' reservations about 'special' legal and service provisions for women

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16   While this observation cannot be generalised and while the data might not have been validated in every case, it is nevertheless noteworthy that a comparison of some studies on gender norms held by men and women, yields a symmetrical picture. A survey of views held by 2 000 men in South Africa, conducted by the Reproductive Health Research Unit's Male Involvement Project in 1998, noted that: 58% believed that the concept of rape did not apply to a husband forcing his wife to have sex; 48% thought the way a woman dressed caused her to be raped; 22% approved of a man hitting his partner – compared with 5% who approved of a woman hitting her partner (in Heise et al. 1999). Kottler's 1998 investigation of 20 wives' (in her study defined as women living with male partners, irrespective of marital status) subjective definitions of rape, showed how women, while naming various forms of abuse, defined their experiences in terms other than directly and explicitly 'rape' (in Vetten and Bhana 2001: 4).

notwithstanding, there are good reasons to opt for a rights-based approach in the South African context. The South African Constitution of 1996 grants human rights to everyone, and civil, political and some social rights to citizens of the Republic. Human rights pertaining to human life, however, are separated from the regulation of political and social life. This tendency of an absolute separation between human and civil/political rights has received additional weight in the contestations over the provision of life-prolonging and life-saving drugs for people living with HIV/AIDS, and the health systems necessary for their provision. While the Constitution serves as a reference point in matters of civil litigation, and increasingly so in the adjudication of reported cases of racism, it has often failed those advocating human rights in the strict sense, in matters of sexual and reproductive rights and treatment access, and in matters of security of livelihood. Considered in this context, the Sexual Rights Campaign, with its insistence on sexual rights as human rights, and the linking of sexual rights with socio-economic rights, is making an important political point.

Closely related to the dualism in human rights between the physical body and civil/political rights, is the tendency of post-colonial African states to thwart democratisation by de-racialising the 'public sphere' of society, while keeping socially and economically marginalised rural groups within the structures of ethnicity and community (Mamdani 1996). Separating human bodily existence from civil and political rights would effectively relegate matters of the body – sex, sexuality, health and illness, birth and death, definitions and infringements of bodily integrity, biological and social reproduction – to relations of the bond. In South Africa, this is probably one of the reasons for the vast under-reporting of cases of gender-based violence. For a long time, and in the absence of any social interventions, violence was widely accepted as normative, both by those who lived in violent conditions, and by the authorities. It was compounded by a lack of confidence in the police, by the sense of shame in which women shrouded their experiences of violation, by secondary victimisation that the survivors experienced at the hands of police and medical officials, and by the difficulty of obtaining convictions for crimes of gender-based violence (see Vogelman and Eagle 1991: 2).[17] Where agencies of the state – the police, the juridico-medical professions, the courts – have failed to take up these cases under criminal law, the injured parties might resort to mechanisms of informal justice. These have been taken up on numerous occasions, to spectacular effect, by women who grouped together to protest against violence and abuse. Informal, communal mechanisms might include public shaming, picketing at an abuser's home or workplace, imposing community service as penalty for abusive behaviour (see Krug et al. 2002: 105). The advantage of these methods is to make it known publically that an injury to a woman or a child is not a private matter. Yet there are serious draw-backs. Retributive justice, while forming part of a spectrum of legitimate moral responses to a violation, is also home to the logic of the bond from which values and practices of honour, shame, revenge, and the right to violence and punishment emanate (see Krug et al. 2002: 160). In the name of

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[17]   A study by the Masimanyane Women's Centre in East London found that the Mdantsane Magistrate's Court files reported 624 cases of rape between 1997 and April 1999, and that there was a discrepancy between the police and court records. Of the cases concerning violent acts against women at court, 368 had been postponed, 100 struck of the roll, 30 warrants of arrest were issued; 60 were withdrawn by either the state or complainant, 20 entered in error, 40 went to trial and 6 were finalised. The six sentences ranged from between two to nine years imprisonment. In the East London courts [over the same time period] we found 793 cases of violence against women of which 647 were postponed, 40 acquitted, 49 withdrawn, 25 moved to another court and 32 were sentenced. Sentences ranged from a R200 fine to 20 years imprisonment (in Foster 1999: 3; see also Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women: Report on Violence Against Women, 2002).

family, household, clan or community 'honour', members of the group who are seen to have been 'disgraced', can be stigmatised and ostracised. In the name of 'honour', men and women band together to blame women without penalising men (as they would, for instance, reject wives, sisters and daughters who have been raped). In the name of exacting punishment and 'revenge', women and children might get raped.

However, there are cultural resources derived from a framework of retributive justice within a 'community' context that could be creatively mobilised. Some of these measures, as they are practiced in parts of India (for example, in West Bengal) and Bangladesh, involve women acting as community counsellors, who take up cases of domestic violence and consult with individuals and families involved. In conjunction with representatives of community structures, they arrive at a restorative solution, which is formalised in writing and monitored by a local committee (Heise et al. 1999: 10).

Discussion

South Africa's long history of systemic violence generally, and gender-based violence particularly, is presently perpetuated by conditions of economic and social marginalisation. This calls for a response framed by human rights, integrating civil and political rights with gender equity, with sexual and reproductive rights, with access to treatment and care, and with socio-economic rights.

At present, legislative provisions are being revised to take account of all forms of rape.

The implementation of the Domestic Violence Act continues to present problems. More training needs to be provided to police, court and medical officials. Access to police stations and health facilities needs to be improved, particularly for women in rural areas. The extreme vulnerability of women and children in situations of domestic violence requires follow-up and the provision of adequate protection.

Organisations providing services to women and children experiencing gender-based violence, are calling for a national strategy on violence against women, for a national research database on gender-based violence, and for government funding for services rendered to survivors of gender-based violence.

South Africa's long history of systemic violence generally, and gender-based violence particularly, is presently perpetuated by conditions of economic and social marginalisation.

GENDERED IDENTITIES, NORMS, AND POWER

'The lesson we can learn from looking at violence through a gender lens is that it stems not only from political and economic inequality but is an expression of identity and the way in which identity is constructed and reconstructed by members of a society' (Simpson 1998: 9). In social settings where dominant discourses on gender construct the categories of man and woman as mutually exclusive and hierarchically related, sex and sexuality tend to be beset with violence, and violence is highly sexualised (Moore 1994: 154). Constructions of 'masculinity' and 'femininity' substantially contribute to such discourses.

Unequal power in sexual relations is implicated in the sexual transmission of HIV in three important respects:

❑ Unequal partners are unable to negotiate when and how they have sex, and how to protect themselves and each other from STIs and HIV.

❑ Unequal relationships are often mediated through sex as currency of exchange: as 'payment' for food, shelter, and goods.

❑ In unequal relationships, multiple partnerships for men are condoned (while they are negatively sanctioned for women), thereby increasing women's vulnerability (Tallis 2002: 17).

'Masculinity'

The last five years have seen a proliferation of studies on masculinity by anthropologists, gender activists, and scholars researching youth culture. Ever since epidemiological and impact studies of HIV/AIDS have been complemented by household and behavioural surveys, and quantitative by qualitative methods, 'masculinity' has emerged as one of the key factors in the normative and behaviour change models at the interface between gender-based violence and HIV/AIDS.

Constructions of gender categories are closely tied up with fantasies of power and fantasies of identity.

Constructions of gender categories are closely tied up with fantasies of power and fantasies of identity. A study by Christine Varga found that sex is a man's means of establishing power in a relationship. 'Having multiple sex partners [is] a status symbol, the yardstick by which masculinity, intelligence and success [are] measured among one's male friends' (1997: 55).

In Varga's survey, male participants voiced their expectation that sex must take place within the first few weeks (generally the first two weeks) of a relationship, if that relationship is to be viewed as 'serious' (1997: 55). Another study on teenage masculinity and behaviour change demonstrated how boys see themselves as powerful, and in control of the respective relationships and sexual encounters. They feel entitled to seek satisfaction for their 'needs', which are often differentiated and divided between various women (Thorpe 2001: 1, 5, 11). Men are seen to 'need' sex in ways in which women do not.

The corollary of the idea of the uncontrollability of sexual 'needs' in men is to shift the onus of safe sex onto women: because of their role as caregivers, women tend to be seen to be more responsible for safe sex, for containing supposedly 'uncontrollable' male sexuality, without being equipped with the power to negotiate or initiate safe sex (see Hoosen and Collins 2001: 9).

Most men whose responses have been surveyed in numerous studies on masculinity, do not grant women the right to decline men's advances. Closely related to this finding is the denial that forced sex amounts to rape (see for example, Thorpe 2001: 5, 8; Varga 1997: 56).[18]

Some of the understandings of the norms of masculinity are underlined by some Zulu terms denoting various categories of masculinity:

❑ Isoka is a complimentary term designating a man with multiple women partners. Being an isoka is not seen in the same light as promiscuity; it is also not considered a risk factor for any condition associated with HIV/AIDS. Being an isoka is considered a natural and traditional part of African manhood, a cultural birthright, earning him approval, praise and social status (Varga 1997: 55).

❑ Nostalgia is sometimes expressed by men and women alike, about the lost era of committed relationships and long-lasting love. This motivates a distinction between 'good' and 'bad' ubusoka. 'Good' ubusoka of times gone by is understood to have entailed the payment of lobola, and the practice of non-penetrative sex when multiple partners were involved. This nostalgia is rekindled partly through melodramatic love scenes in TV soap operas, magazines, and music (Hunter 2001: 16). Isishimane, in contrast, is a derogatory term designating a man with one woman partner, or none (Varga 1997: 55-56).

The distinction between different 'types' of men was also found to operate in township youth culture. A recent study found that having multiple partners, and engaging in crime and conspicuous consumption, was thought to confer prestige, status, and control on a young man. Conversely, the man who does not entertain multiple partnerships, does not wear the latest fashions, is not involved in crime, and strives for educational achievements, is thought to be undesirable (Selikow et al. 2002: 24-25).

Thus, economic marginalisation closely corresponds to sexual marginalisation. Men seen to be poor would find it difficult to develop partnerships with women. Unemployed men have not only no status in the market economy, but they also have no status in the sexual economy (Hunter 2001: 8). Some of these constructions of masculinity have direct implications for HIV-risk perception. Being an isoka is not seen to have anything to do with promiscuity, and is not considered a risk factor for any condition associated with HIV/AIDS; instead, HIV is often associated with 'dirty women', as women's bodies are believed to be naturally prone to harbouring 'dirt' (see Leclerc-Madlala 2002: 88-90).

While some of these criteria of masculinity are oppressive and abusive of women, women to some extent participate in shoring up constructions and practices in fulfillment of the ideals of masculinity. Thorpe's survey of teenage girls' and boys' responses to gender-stereotypical roles outlines girls' construction of masculinity, which was confirmed by boys: Girls saw ideals of masculinity mainly in terms of the provision of material goods, which was confirmed by boys of the same age. Boys attributed to girls the propensity to strike up relationships with boys as a way of accessing 'car, cash and cell', while boys, by their own admission, expected sex in return (2001: 7).

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18   This, among many other factors, might explain the low conviction rate for rape. There are studies, whose figures have not been validated due to small sample sizes, that have mooted a high incidence of domestic violence perpetrated by policemen (see *The Star,* Tuesday 11.12.02: 2).

'Femininity'

While sexuality studies in the context of HIV/AIDS research have mainly focused on masculinity (answering a call to male-focused sexuality research specific to HIV/AIDS – see Varga 1997: 51), there are relatively fewer studies on constructions of 'femininity', possibly because these are relegated to a picture of the structures, norms, subject positions, institutions and practices that produce and perpetuate women's oppression – a picture whose contours are assumed to be familiar.

While multiple partnerships are a matter of status and prestige for men, the same standard does not apply to women. Women have to remain discrete about relationships with men other than the primary one, for fear of violence and 'punishment' upon being 'discovered' to have been with another man.

In accordance with the ideals of masculinity outlined above, adolescents of both sexes view sexual experimentation positively for men, but negatively for women. While multiple partnerships are a matter of status and prestige for men, the same standard does not apply to women. Women have to remain discrete about relationships with men other than the primary one, for fear of violence and 'punishment' upon being 'discovered' to have been with another man. Such 'punishment' can take the form of rape or gang rape; the partner who feels cheated would summon the very men that 'his' woman has been with, to 'discipline' her (Hunter 2001: 7). In women, sexual experimentation is associated with promiscuity, dirt, STIs and HIV (Varga 1997: 49).

Some ideals of partnership and gendered roles are held in common by men and women and work against the adoption of safe sex practices. The notion that unprotected sex is a sign of trust and fidelity is often shared by both partners (Varga 1997: 49; Thorpe 2001: 6). Moreover, they frequently share the idea that pregnancy, childbearing and childrearing is the fulfillment of family and gender roles (Varga 1997: 47).

Some of the traditional ideals of 'femininity' militate against communication between partners, and negotiation and initiation of safe sex practices. If the 'good woman' is expected to be passive and ignorant, this would inhibit information seeking, negotion of safer sex, and access to STI treatment (Jackson 2000: 5). Women pledging 'virginity' tend not to negotiate protection at sexual debut (Jenkins 2002).

The ideal of virginity restricts women's ability to seek information on sexual health. In some parts of South Africa, notably in KwaZulu-Natal, virginity testing has been re-introduced. Some of the most marginalised people – particularly women living in the rural areas – have come to practice virginity testing as a way of re-instituting the cultural value placed on preserving virginity until marriage. The practice involves older women publicly performing physical checks on young consenting women in their teens and early twenties. They assert the value of virginity in a situation of a high rate of teenage pregnancy, STIs and HIV/AIDS, where elderly women often have to care for sick and dying adults and their children. The re-institution of virginity testing by rural women is supported by men upholding 'tradition', as well as by middle class male advocates of the 'African Renaissance'.

However, from the perspective of HIV/AIDS public awareness and human rights, this practice has detrimental effects, even as its adherents defend it by reference to culture within the discourse of rights (see Scorgie 2002: 62). It heaps blame and responsibility for the disease on women and women's sexuality. It places the responsibility for averting sexual intercourse before marriage on girls alone, and constructs sexual initiative as male preserve (Scorgie 2002: 66). It does not challenge men's claim to access to women's bodies, and indirectly promotes other sexual practices such as anal intercourse, which, depending on the context, might

place young women at increased risk for HIV (Morrell 2002: 15; Jackson 2000: 5). Virginity testing contributes to stigmatisation, which is exacerbated in cases where young women 'fail' the test. As Suzanne Leclerc-Madlala reports, the test result is given in grades of A, B and C, denoting 'degrees' of virginity.

> *A 'C-grade' is a mark of shame and disgrace. The girl's family may pay a fine. In the words of one tester, the girl is now like a 'rotten potato' who must be kept away from virgin girls in order not to 'spoil the bunch'. (2001: 3)*

The traditional leader can demand a fine from the girl's family to pay for the 'tainting' of the community. In many cases, groups of older women and even female family members endorse these sanctions. As Scorgie outlines, 'the performance of the test is not only to determine the sexual status of the girls and, in the long-term, to induce adherence to a new set of sexual norms, but also to display and confirm the expertise of the abahloli' (2002: 60).

Discussion

Gender-based violence is not only a matter of colonial and apartheid legacy, and it is not exhaustively explained by political and economic inequality – it is also a matter of gender identification in terms of 'masculinity' and 'femininity'. 'Masculinity' is constructed by many South Africans in terms of positively valued capacities: commanding sex within a relationship, men's uncontrollable sexual 'needs', decision-making 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 contraception.

… gender-stereotypical notions of 'masculinity' and 'femininity' are interwoven in complex ways with other social structures, norms, and values; they do not simply correspond to each other inversely.

However, gender-stereotypical notions of 'masculinity' and 'femininity' are interwoven in complex ways with other social structures, norms, and values; they do not simply correspond to each other inversely. Thorpe notes that the dominant discourse on masculinity counteracts simultaneously held equality-based understandings of relationships. However, as he concedes, these were found not to be sufficient to effectively challenge the dominant discourse of masculinity, due to:

❑ gender conflict, without learning how to handle conflict positively, pertains to conflict related to transactional sex, and conflict emanating from peer disapproval (for example, the choice by girls of different male partners for sex and money, resulting in competition among boys)

❑ notions of 'culture' shoring up beliefs about male dominance, multiple partners, sexual 'need', pregnancy as a sign of male potency, refusal to wear condoms

❑ lack of internalisation of risk (2001: 11).

Educators, peers, parents, and social service providers face the challenge of providing opportunities for debating and contesting gender constructions and gendered role expectations, and modelling alternatives that are supported and probed in practical situations.

SOCIAL/SEXUAL CONTRACTS AND EXCHANGES

The gender norms and gendered subject positions described above are directly implicated in the social/sexual economy, which links cultural, social and symbolic exchanges with economic exchanges. The link is all the stronger, as entire households and settlements or townships are left economically destitute, bereft of formal employment and social services. Inasmuch as women have less access to education, housing, and the labour market, as they enjoy no or inadequate social security, and face increasing economic marginalisation, their choices are severely constrained. At the margins of the market and of civic citizenship, social networks are structured by gendered relations of debt and credit, gift and theft, theft and retribution, honour and punishment, undercutting any notion of equality that would be required for the negotiation of safe sex practices between partners. The contradiction between formal equality (usually associated with generalised commodity exchange) and inequality (associated with social exchanges that are not mediated through a general equivalent) becomes exacerbated, and becomes a site of intense conflict. Social-symbolic exchanges tend to take on violent forms where they are closely yet contradictorily tied to economic exchanges. This manifests itself particularly in the various modes and forms and degrees of transactional sex, which, along with constructions of masculinity, have become a focus for sexuality studies scholars in and on South Africa over the last two years.

Women whose testimony was heard at the hearings on Violence Against Women in November 1999 identified 'tradition' as one of the sources of gender-based violence. They were referring in particular to lobola (bohadi) payments insofar as they were made in cash, rendering marriage a 'transaction' of 'buying a wife' (Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002).

Women in turn enter relationships often to escape physical abuse from male relatives and partners, to secure the means for their subsistence (rent, food, school fees and clothes), and to obtain other consumer items.

Not infrequently, conspicuous consumption enters the equation, to such an extent that sex in return for 'the three c's' (car, cell phone and cash) has become proverbial. Different kinds of male partnerships are entertained in return for different types of material support. Where the family cannot or does not offer this support, older men may strike up sexual and power-unequal relations with young women (the 'sugar daddy' phenomenon), often with the encouragement of the woman's family.

However, the exchange of sex for money is usually tacit rather than overt: there are no verbal agreements, only implicit understandings. One of the informal rules is the following: 'if a man has spent money on a woman, he feels she is no longer independent and therefore does not have a choice over whether or not she has sex, or whether a condom is used' (Selikow et al. 2002: 29). Such exchanges trap women and men in different ways. Some women who liaise with men who have multiple partners, may be eager to be elevated to the status of a primary partner (the 'regte' in township lingo), and may disregard precautions for safe sex. On the other hand, a man is said to be more likely to use a condom with casual women partners than with his long-standing partner, and the woman who is his long-standing partner might have limited power to negotiate the use

of condoms. She might also fear that the man on whom she is dependent, will leave her for another woman (see Campbell et al. 1998: 4). Alternatively, she might be accused of infidelity and of not trusting her partner if she attempts to negotiate the use of condoms (Selikow et al. 2002: 28).

These arrangements are perceived as oppressive by men as well. There is the continuous threat that their female partners will leave them for wealthier men, and resentment that women are benefiting at material cost to men (Pattman 2002: 38).

However, in analysing these exchanges in terms of money and sex exclusively, caution is advised. Interviewees in various studies of social/sexual contracts and exchanges insisted that their relationships are not mediated primarily by power or money (Pattman 2002: 39). To reduce these practices and understandings to sex in return for money is simplistic. They are just as much about emotional bonds arising from the need for protection, affection, security, care, and subsistence. They are also linked with a host of other factors of status and identity formation – for example, being 'Zulu', becoming an adult, or becoming a person of status (Hunter 2001: 17). Fantasies of identity tend to go hand in hand with fantasies of power – as Moore explains:

> The volatile relationship between fantasies of identity and fantasies of power frequently gives rise to violence both between women and men, and between men. In this sense, violence, when it occurs, is the result of a crisis of representation, as well as the result of conflict between social strategies connected to those modes of representation. (Moore 1994: 153-154)

GENDER-BASED VIOLENCE AND HIV/AIDS IN THE CONTEXT OF GENDERED INEQUALITY IN SOUTH AFRICA

Gender-based violence and HIV in South Africa

The World Health Organisation's division on Gender and Women's Health has identified four areas in which gender-based violence and HIV/AIDS overlap:

❑ forced sex may directly increase women's risk for HIV through physical trauma

❑ violence, and threats of violence, may limit women's ability to negotiate safe sexual behaviour

❑ sexual abuse as a child may lead to increased sexual risk taking as an adolescent/adult

❑ women who test for HIV and share test results with partners may be at increased risk for violence (WHO 2000: 12; see also Vetten & Bhana: 2).

Vetten and Bhana have noted other linkages between gender-based violence and HIV/AIDS. They name the willful infection of others in relation to the 'virgin myth', motives of revenge, not wanting to die alone, and the 'normalisation' of risk-taking behaviour.

The notion that a man infected with HIV may be cured by having sexual intercourse with a virgin has been given extensive coverage in the media. However, the prevalence of this myth has been disputed. While some assume that the myth is a widely held belief, and that it is supported by traditional leaders and healers, others remain skeptical. The latter maintain that information on HIV/AIDS and its modes of transmission has been widely communicated and has become common knowledge, certainly in the urban areas of South Africa. The Nelson Mandela/HSRC HIV/AIDS Survey found that a very small proportion (1.6% of respondents over 15 years of age) believed that 'AIDS can be cured by sex with a virgin'. However, 'relatively high percentages [10.1% of respondents over 15 years of age] responded 'don't know' meaning relatively high proportions of uncertainty about this dangerous myth' (SABSS 2002: 82). Anthropologists and activists remain divided on the issue. While some hold the 'virgin myth' responsible for the escalating incidence of reported child rape (among them Charlene Smith) and several organisations working with rape survivors agree (among them GRIP, Masisukumeni, Ekupholeni), others dispute it as a motivation for child rape (among them Rachel Jewkes).

On closer inspection, the 'virgin myth' is consistent with popular explanations of illness as they have been described in South African ethnographic monographs since the 1940s, and by contemporary researchers investigating current metaphors that inform the understanding of HIV/AIDS (Leclerc-Madlala 2002). The mark of a virgin, and one of the ideals of female sexual health and femininity, is said to be the 'dry and tight' state of the vagina, as opposed to the 'wet' state which is associated with dirt and disease, and the 'wide' state which is associated with 'loose women'. It is the latter who are blamed for the transmission of HIV (Leclerc-Madlala 2002: 91-93). While these ethnomedical models for explaining HIV/AIDS

seem to enjoy wide currency, it cannot be clearly established to what extent men act on them. The means for finding out might lie in a hypothesis that can be validated only retrospectively. As Suzanne Leclerc-Madlala explains:

> *Virgin cleansing as a therapeutic option against AIDS… may have acquired popular currency due to the fact that modern biomedical treatments have not been readily available to the mass of people infected and affected by HIV/AIDS. It remains to be seen whether the perceived scourge of child rape and rape more generally, along with the belief in virgin cleansing, recedes with the introduction of affordable and accessible anti-retroviral treatment. (2002: 94)*

Another explanation for the currency of this myth could lie in an undifferentiated understanding or communication about 'prevention' and 'cure'. Virgins, due to their lack of sexual exposure, may be considered desirable sexual partners because of the impossibility of HIV transmission from the young woman or man to the older man.

'Revenge' as a motive for rape has been documented in international literature on violence against women, particularly in situations of armed conflict (Brownmiller 1976; see also Human Rights Watch 1996) and, by extension, also in civil and ethnic strife. In both conflict arenas, rape is a way of humiliating the other group, defined as a clan, ethnic group, or nation. One of the motives of child rape have been identified as revenge against the mother, typically in situations where the mother refuses to have sex with a man who then abuses her child (WHO: Violence Against Women Information Pack). This is echoed in some of the discussions with organisations working in the field of gender-based violence (Tshwaranang Legal Advocacy Centre). Related to this are observations that an HIV-positive diagnosis might lead a man to become (more) abusive towards his woman partner, blaming her for transmitting the virus to him, and to engaging in sexual relations with multiple partners. The phrase 'I don't want to die alone' has become proverbial; black South Africans recognise it as a typical response of a man who has tested HIV-positive. (It was identified as such by educators and counselors in Tshwaranang Legal Advocacy Centre, Stop Women Abuse Helpline, AIDS Helpline).

… an HIV-positive diagnosis might lead a man to become (more) abusive towards his woman partner, blaming her for transmitting the virus to him.

At this stage, such responses to HIV/AIDS have not been systematically documented and investigated. Clearly more research is required. Among other issues, we would need to obtain a clearer picture on the question as to how men respond on finding out that they are HIV-positive.

There is, however, some research to amplify, validate and give a South African inflection to the four areas of intersection between gender-based violence and HIV/AIDS identified by the WHO's Gender and Women's Health division. They will be dealt with one by one below, though not in the order in which the WHO's Gender and Women's Health report lists them.

Correlation between forced sex and HIV

The first area of intersection that stipulates a correlation between forced sex and HIV through physical trauma, is based on the consideration that women are anatomically and physiologically more susceptible to HIV infection. The vagina and the labia present larger exposed surface areas, and more susceptible mucosal surfaces in comparison with the penis. The presence of STIs might go undiagnosed and untreated in women, as they are not directly visible and might

be asymptomatic. Women are particularly vulnerable to damage to genital tissues during intercourse, and young women more so, as they have less developed genital tracts.

In Southern Africa where dry sex is practiced,[19] women's vulnerability to HIV infection is compounded by their attempts to enhance male sexual pleasure by inserting drying agents into the vagina. It makes sexual intercourse painful for women, and can easily cause vaginal lacerations. It also suppresses the vagina's natural flora (Schoofs 1999).

Correlation between child sexual abuse and risk-taking behaviour

…having been abused as a child, or having witnessed violence perpetrated by the father against the mother, would predispose the survivor to early sexual debut, multiple partnerships, to abuse of his partners later in life, and to high-risk behaviour.

It is recognised that the experience of having been abused as a child, or having witnessed violence perpetrated by the father against the mother, would predispose the survivor to early sexual debut, multiple partnerships, to abuse of his partners later in life, and to high-risk behaviour. In South Africa, this pattern has been discussed in relation to children growing up in poverty amidst high levels of unemployment, deprivation, and violence against women and children. In particular, it is pertinent to AIDS orphans and households headed by children, whose destitution would render them vulnerable to abuse, which they are likely to perpetuate once they make choices in their adult lives. Research is required to determine what kind of recovery strategies can prevent HIV-risk-related and other destructive behaviours.

Gender-based violence limiting VCT, STI treatment, MTCT prevention, and formula-feeding of babies

The areas of intersection that directly link violence against women to higher risk for HIV infection, are corroborated and amplified in the studies on the social impact of HIV/AIDS in South Africa. Women's fear of a violent response from their partner prevents them from negotiating and initiating condom use and other safe sex practices; it is likely to prevent them from going for voluntary counselling and testing, and for treatment for STIs; it prevents them from disclosing their HIV status to their intimate partners; and it might prevent them from taking AZT to avert vertical transmission and from formula-feeding their babies.

Stigmatisation of women living with HIV/AIDS

Organisations working in the field of gender-based violence and HIV/AIDS consistently point to the problem of stigmatisation of HIV-positive women (Tshwaranang Legal Advocacy Centre, Golden Triangle Women's Group, Masisukumeni, Stop Women Abuse Helpline, AIDS Helpline). This is consistent with studies on the social history of the control of sexually transmitted diseases, which show that STIs have historically, in various social contexts, been blamed on women (see Brandt 1985). In Zimbabwe, STIs are commonly referred to as 'women's disease' (Maduna-Butshe 1997: 8). One researcher notes that:

> *In descriptions of HIV transmission patterns, informants consistently represented transmission as 'unidirectional' from woman to man. Infected*

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19   The extent of this practice is disputed. Earlier reports of widespread use of drying agents have not been validated in recent surveys; what has been confirmed, however, in recently conducted interviews, is the value placed by black South African men and women, on 'dry and tight' vaginas (Leclerc-Madlala 2002).

men are represented as passive victims of 'dirty' women while infected women are seen as active participants in the acquisition of the infection. (Leclerc-Madlala 2001: 6)

The stigmatisation of people living with HIV/AIDS may proceed along well-trodden paths. As researchers of the Panos Institute note, '[h]ostility towards people with the infection in some cases may be no more than a mask of already existing prejudices' (in Heald 2001: 9; see also WHO: Fighting HIV-Related Intolerance: Exposing the Links Between Racism, Stigma and Discrimination, nd: 4). The talk of 'innocently' infected people (usually, this refers to babies, children, and sometimes men[20]), contributes to the stigmatisation of women living with HIV/AIDS.

Disclosure of HIV status and gender-based violence

Women typically disclose their HIV status at a crisis moment: when in contact with AIDS patients at the clinic or support group, or when facing the illness and death of a partner or child or other relative. The fact that mothers, through having to look after their own health and that of their children, are often the first ones to be diagnosed, exposes them to blame from their family, household, neighbours, and community. Heaping blame on women for the transmission of the virus might have been fuelled by the fact that it was initially pregnant women who were tested in the antenatal clinics.

In the time lapse between the diagnosis and the decision to disclose the diagnosis – for many women, this time lapse is between two and three years – women living with HIV experience great anxiety. They fear a violent response from their partners and in-laws, and/or stigmatisation, abandonment and destitution, and ostracisation. This fear is consistent with women's responses to abuse, as they have been described in the international literature on violence against women. Any thought or plan of leaving a violent partner is typically beset with fear of retribution, concern for the children, fear for survival in the absence of other means of economic support, fear of social stigma, and fear of ostracisation by family and friends (Heise et al. 1999: 7). In the case of an HIV-positive diagnosis, it seems these anxieties are compounded. This overwhelming anxiety was described by all organisations working with gender-based violence and HIV/AIDS who were interviewed for this survey. Moreover, women are anxious in the uncertainty over how long it will take for them to fall ill with HIV/AIDS related symptoms. They face anxiety over the impact of HIV on their relationship and over the question as to what will happen to their children (Shabalala 2001: 3, 4, 9, 8).

While the fear of serostatus disclosure has been clearly linked with fear of violence in the reported experience of individuals and of organisations dealing with gender-based violence and HIV/AIDS, the specificities of disclosure would have to be unpacked. Studies on the conditions and processes of disclosure are needed. The range of types of responses to an HIV-positive diagnosis resulting in disclosure – immediate or delayed – would have to be documented. And they would have to be explored in relation to different ways of living with HIV/AIDS, and to different styles of activism.

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20 Leclerc-Madlala notes that men may consider themselves as 'innocently' infected if they hold the common view that adult women's sexuality is 'dirty', harbouring diseases capable of weakening men's immune systems, and making them prone to illness (2001: 6).

To understand the link between gender-based violence and HIV/AIDS in relation to disclosure, the relationship between anticipated violence on disclosure, and the actual experience of disclosure, would have to be researched and documented. At the moment, it is not clearly established, and no generalisable findings have been presented. There are some indications that there are discrepancies in the general picture. It is not clear whether the fear of the partner's anticipated reaction is driven by a history of violence, or whether this fear can be retrospectively validated by a partner's actual violent response to an HIV-positive test result. This question emerges from the general observation that a large proportion of women who do disclose their HIV status meet with supportive reactions from their partners. The Report on Violence Against Women and HIV/AIDS by the WHO's Gender and Women's Health division, estimates the negative responses of partners to be 10-25%) (2000: 14). A study by the Horizons Programme involving Muhimbili University College of Health Sciences and the Population Council in Dar es Salaam probed the link between HIV infection, disclosure, and partner violence among women attending the Muhimbili Health Information Centre (a VCT clinic in Dar es Salaam). A report on the findings states that:

> [m]ost women said that partners showed support and understanding when told of the test result. However, the proportion of women who reported this positive reaction was significantly greater among HIV-negative women than among HIV-positive women – 82% vs. 49% (Population Briefs Special Edition, Spring 2002: 2).

The sampling and design of this study shows serious limitations. Similar limitations are evident in a South African study by Sixgashe (2000) featuring interviews with 28 women who had been diagnosed HIV-positive at least three months prior to the interview:

> 15 of these women had not disclosed their HIV-positive status, mainly out of fear of being rejected by their 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. (In Vetten & Bhana 2001: 7)

A generalised fear of rape curtails a woman's mobility, her, and the exercise of her rights, and drives her into relationships with a man from whom she hopes to get protection.

The limitations of these studies notwithstanding, they raise important questions for further research. More, and more differentiated, studies on experiences with and attitudes towards disclosure would be required for transformative interventions. If a discrepancy can be validated between the anticipated violence upon disclosure and the actual experience of disclosure, activists, counsellors and educators would have to factor in the psychological and social impact of general levels of violence against women. A generalised fear of rape curtails a woman's mobility, her, and the exercise of her rights, and drives her into relationships with a man from whom she hopes to get protection. However, the intimate relationship with a partner is often the space of the most threatening experience of violence (see Vogelman & Eagle 1991: 5, 6). As Hanmer comments:

> The pervasive fear of violence and violence itself has the effect of driving women to seek protection from men, the very people who commit violence against them. Husbands and boyfriends are seen as protectors of women from the potential violence of unknown men. Women often feel safer in the company of a man in public and the home is portrayed as, and often feels, the safest place of all, even though statistically speaking, women are more likely to be violently assaulted in marriage and by men known to them. (Hanmer 1981: 190)

It is the study of these contextual factors, only sketchily outlined here, that could provide a key to understanding any potentially emerging discrepancies between anxiety and fear of violence, an anticipated violent response to disclosure on the one hand, and the actual experience of disclosure on the other.

Such a study could provide impetus for educational, counselling, and service delivery programmes. Beyond that, the ways in which VCT, and counselling on sexual and reproductive health are implemented, would have to be reconsidered. Attitudes of health workers towards their clients would need to be addressed, so that women, young women in particular, do not feel judged, criticised, and rejected when they come to the clinics for information, testing, counselling, treatment, or termination of pregnancy. VCT programmes would have to be designed and implemented with a view to helping couples come to terms with HIV infection and to maintain the relationship – especially in the case of sero-discordant couples. If sexual and reproductive health services target only women, men are unlikely to get involved in taking responsibility for contraception, childcare, and STI treatment. Men have come to see contraception as women's business. Men would have to become involved in information and decisions on family planning, sexual and reproductive health, and treatment options.

VCT programmes would have to be designed and implemented with a view to helping couples come to terms with HIV infection and to maintain the relationship – especially in the case of sero-discordant couples.

While women who have been tested should make the decision as to whether or not to disclose their test results, this is often not a clear-cut decision. Some organisations in the field of gender-based violence and HIV/AIDS in South Africa encourage disclosure; however, counsellors should consider the risk of violence, and counsel for safe disclosure plans.

Health consequences of gender-based violence

Gender-based violence is thus not only a risk-factor for HIV infection, most notably in cases of child sexual abuse, of transactional sex, in the inability to negotiate and initiate safe sex practices, in the fear of violence upon accessing VCT and treatment programmes, and in the fear of violence upon disclosure. The converse is true as well: gender-based violence can occur as a result of an HIV-positive diagnosis. The latter case includes many instances which are not readily seen as 'violence': girls are being taken out of school to care for sick and dying household members; mothers and grandmothers shoulder the burden of care for people living with AIDS.

Gender-based violence is a risk-factor not for HIV alone. It gives rise to a host of other health problems, which in turn could be risk factors for HIV. Some of the physical and mental health problems associated with gender-based violence have been listed in the social and community medicine literature as follows: injury, unwanted pregnancy, gynaecological problems, miscarriage, STIs, permanent disability, self-injurious behaviour (including unprotected sex), alcohol and drug abuse, depression, fear, anxiety, low self-esteem (Senanayake nd: 3-5; Heise et al. 1999: 19).

Role of health workers in addressing gender-based violence

A number of comprehensive guidelines and information packs have been developed to assist health workers in helping survivors of gender-based violence (for example, the Women's Health division of the WHO published a Violence Against Women Information Pack; see also Heise et al. 1999). They generally

advise health workers on paying attention to possible symptoms and signs of abuse, and on how to ask about abuse. In addition to the medical, documentation, referral and follow-up procedures, they encourage health workers to develop empowering strategies, and to map out safety plans with their women clients.

In South Africa, with high HIV-prevalence among young women, and high levels of gender-based violence, the development and implementation of such protocols are imperative. Such protocols would have to be integrated into other campaigns and policy frameworks which confront dominant stereotypical attitudes towards gender-based violence. Women living with HIV have reported 'judgemental and hostile reports from service providers, including testing without consent and refusal for services' (Tallis 2002: 9). Female nurses, while generally recognising that gender-based violence is a serious problem, tend to think that the women concerned may have acted in ways that provoke violence. Male nurses constructed a long list of reasons that would justify a man beating his wife, including disobedience, disrespect, and neglect of household and childcare duties. They did not think that a man had commited rape if he forced his wife to have sex, and they thought that wife-beating was both a means of discipline and a way of expressing love or forgiveness (Kim & Motsei 1999 in Heise et al. 1999: 27).

Health services for women in South Africa leave much room for improvement. The provision of PEP, which was to be implemented in all public health facilities by the end of 2002, would have to be closely monitored, to ensure that it reaches survivors who request it, to ensure that health workers are trained to administer it, and to provide the required information, counselling, and follow-up.

Discussion

A major factor that is generally recognised as linking gender-based violence to HIV/AIDS, is a woman's fear of a violent response from her partner, which compromises her ability to negotiate safe sex, to disclose her HIV status, and to seek treatment for STIs and other infections. In South Africa, women's fear of violence leads them to compromise their health, and to risk HIV transmission, is compounded by social and economic marginalisation which render them doubly vulnerable.

For the case of South Africa, a number of other more specific factors have been identified. The myth that a man can be cured of HIV through having sex with a virgin has been named as a factor in the increase in reported child rape. Related to this is the value placed on a dry vagina by men and women, and the practice of dry sex, which has been named as another factor contributing to the vulnerability of women to HIV infection.

The high incidence of child rape has raised concerns over the trauma to the child and recovery strategies. Not meeting the psychosocial needs of children might lead them to practice high-risk behaviour later in life.

Revenge and anxiety over an HIV-positive diagnosis has been named as another motive for abuse of women.

These factors that describe the close link between HIV/AIDS and gender-based violence, highlight the need for:

❑ Universal access to ARV treatment. This could go some way in obviating the virgin myth, and the stigmatisation of women as harbingers of

A major factor that is generally recognised as linking gender-based violence to HIV/AIDS, is a woman's fear of a violent response from her partner, which compromises her ability to negotiate safe sex, to disclose her HIV status, and to seek treatment for STIs and other infections.

HIV/AIDS. It would certainly reduce the gap between HIV-positive and HIV-negative people, between HIV-positive mothers and their babies treated with nevirapine, between rape survivors who receive PEP and those who do not.

❑ Sexual and reproductive health services that address themselves to both women and their male partners, to encourage information – and health-seeking, and joint decision-making.

METHODOLOGICAL PROBLEMS IN RESEARCH ON GENDER-BASED VIOLENCE AND HIV/AIDS

Under-reporting

Gender-based violence is subject to vast under-reporting due to shame, trauma, fear of violence, stigmatisation, and secondary victimisation. Assumptions about the degree of under-reporting also vary enormously, thus affecting projections, and evaluations of the impact of interventions (e.g. Statistics South Africa assumes that 50% of all women who admit to having been raped reported the matter to the police (Hirschowitz et al. in Vetten & Bhana, 2001: 4); the South African Police Services assume that one in 35 cases are reported; Jewkes et al. assume that one quarter of women raped in the year prior to the study, reported the matter to the police (Jewkes 1999b); NICRO assumes that one in 20 cases are reported (see Smith 2002). The degree of under-reporting of incidents of domestic violence and sexual coercion in same-sex relationships can be assumed to be even higher, due to exacerbated experiences of stigmatisation and secondary victimisation.

Non-representative samples

Much of the quantitative research on gender-based violence is bedeviled by the problem of non-representative samples. In some cases, the samples are based on women attending VCT or STI or community health centres. This would have affected the findings: 'Because most early studies on abuse and health involved women seeking medical treatment, their findings would have overstated the relationship between violence and poor health.' (Heise et al. 1999: 19). However, recent studies with more representative groups – with random samples of women in the community and women visiting primary health care facilities – have confirmed the links between gender-based violence and ill health.

In other cases, studies investigating sexual decision-making concentrate on women whose socio-demographic profiles would predispose them to risk-taking (Varga 1997: 51).

Neglect of sexual negotiation

…there still is little research on the dynamics of the interaction of partners in a sexual relationship.

While the bemoaned 'gender gap' that dominated earlier sexuality research (with an almost exclusive focus on women and the absence of men's perspectives), has been addressed through male-focused sexuality research, there still is little research on the dynamics of the interaction of partners in a sexual relationship. 'Thus, most works examine sexual decision-making but neglect sexual negotiation' (Varga 1997: 51).[21]

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21   Varga distinguishes between sexual decision-making and sexual negotiation, in order to highlight the importance of sexual negotiation in determining the circumstances of sex. Sexual decision-making is defined as 'decisions, preferences and resolutions made by an individual regarding the conditions under which sexual relations occur.' It is often conflated and confused with sexual negotiation. Sexual negotiation, in contrast, includes 'the dynamic between partners in deciding how and when intercourse will take place' (1997: 52).

Blindspot: Gender categorisations

The categorisation of 'male' and 'female' in surveys is very limited, and is bound to have a distorting effect on the findings.

Gender roles and gender identifications do not necessarily correspond to gender identities.

Categories of epidemiology have erased the circulation of 'heterosexual men' across categories (such as lovers of other men). 'Homosexual men' are cross-listed with 'bi-sexual men', but 'bisexuality is not cross-referenced with 'heterosexuality', thus not accounting for a significant number of 'heterosexual men'. The latter blindspot arises from the stereotypes by which 'bisexuality' and 'homosexuality' are taken to refer to non-monogamous practices, while 'heterosexuality' is taken to designate 'monogamy' (J Lewis 2000: 21).

Gender roles and gender identifications do not necessarily correspond to gender identities.

Blindspot: Gender-based violence and HIV-prevalence in female same-sex relationships

Recent studies have contributed to closing the 'gender gap' in terms of gender-based violence and its implications for HIV risk in male same-sex relationships (for example, Gear 2002; Reddy and Louw 2002; Jenkins 2002). Organisations addressing gender-based violence are taking on board rape, abuse, and domestic violence in same-sex relations (for example, POWA, National Coalition for Gay and Lesbian Equality). However, very little is known as yet about violence and about HIV prevalence in female same-sex relationships.

Organisations such as the Tshwane-based OUT, and the Durban Lesbian and Gay Community and Health Centre are distributing information on safe same-sex and are intent on countering myths of reduced or absent HIV risks in same-sex relations and the myth of the inherent safety of oral sex. They also point out that while the sexual practices of lesbians are generally less risky than those of gay men, this does not mean that women in same-sex relationships are not at risk for HIV/AIDS, particularly in South Africa, with its high levels of rape and sexualised violence.

Behaviourally specific questions in surveys on gender-based violence

In quantitative research on gender-based violence, surveys would have to bear in mind that there are multiple understandings of forms of violence. Behaviourally specific questions about abuse are likely to solicit a greater number and greater degree of differentiation of responses about frequency and type of experienced abuse, as opposed to simply asking about 'rape', 'violence', or 'abuse' generically (Krug 2002: 91-92). Specifying behavioural indicators in a questionnaire would go some way to bypass the problem of a bias toward physical violence (which is more easily measurable), when most women indicate that psychological abuse and degradation are more intolerable (Krug et al. 2002: 92).

CHARTING TRANSFORMATIVE INTERVENTIONS

Theoretical and methodological issues

In devising interventions to change the conditions of gender-based violence and the risks that it poses of HIV infection, we would need a map of different types of interventions, indicators, and criteria and the kinds of action, policies, and programmes that they envision and facilitate.

Gender neutrality, gender sensitivity, empowerment, and transformation of gender relations

Such a conceptual grid is provided in the much-quoted address by Geeta Rao Gupta to the 13th International AIDS Conference in Durban in 2000, in which she distinguishes between and characterises the different kinds of interventions in gender, sexuality, and HIV/AIDS. Because of its implications for interventions at the level of programmatic and normative change, and its wide reception in activist and policy-analyst circles, it is worth quoting at length.

Gender-neutral approaches do not distinguish between the needs of men and women. Some messages in HIV/AIDS prevention campaigns that are gender-neutral could lead to the increased vulnerability of women to HIV infection. For instance, messages such as 'be faithful', 'stick to one partner', could make women who are faithful to one partner believe that their loyalty will mean that they are safe from HIV infection. The advice of using condoms has different behavioural implications for women and for men. For a woman to purchase and carry condoms and negotiate condom use involves a degree of awareness and social skill different from that required from a man equipping himself with condoms and being prepared to use them.

… antiretroviral treatment and opportunistic infection management needs to be tailored for women and men differently.

Another draw-back of gender-neutral approaches in HIV research lies in the fact that there is very little research that specifically investigates the implications of the differences between men and women in the progression of HIV/AIDS and its medical management. This is in contrast to some recent research that has shown 'that there are differences in length of survival, levels of viral load and drug toxicity between men and women…' Therefore '… antiretroviral treatment and opportunistic infection management needs to be tailored for women and men differently' (in Tallis 2002: 29-31; see also Morrell et al. 2002).

Gender sensitivity responds 'to different needs and constraints of individuals based on their gender and sexuality' (Where needs are the same, the same programme or intervention is used; where needs are different, these must be met through different interventions). Examples of gender-sensitivity at the level of service delivery are the provision of the female condom, income generating projects for women, and improved access to health services for women. For men, gender-sensitivity would mean addressing them in their roles as decision-makers in their relationships with women, enabling them to make safer decisions through which they can protect themselves, their female partners, and future children.

However, while gender-sensitive programmes are designed to impact on the lives of women, they do not necessarily challenge the status quo of gendered power relations, through which 'men hold decision-making power and use this power to control the sexuality and sexual rights of their partners' (in Tallis 2002: 32).

Empowerment focuses on improving women's access to information, skills, services, technologies, while ensuring women's participation in decision-making at all levels (Tallis 2002: 32-33). It seeks to eliminate laws that discriminate against women and children, strengthen women in leadership and decision-making, increase access to education for women and girls, increase women's access to and control over economic resources, increase women's access to health information, and increase women's self-esteem and sense of personal power.

The limitation of policies aimed at empowerment lies in their easy appropriation of gender-mainstreaming rhetoric, whereby women become 'the gender problem': disempowered, weak, and victims in need of protection.

> *The problem here is that the discourses that name the terms of women's victimisation, invoke women's situation as the problem to be solved, and chart women as the objects of exploitative or abusive male behaviours needing protection and special support. This kind of 'gender strategy' provides crucially needed local responses to the real situations of women affected by discrimination, male violence and control. But the ensuing emphasis has often been to deal with the damage in the victims' lives, emphasising the importance of legal protection or survival support for women, at [sic] the detriment of engaging with the conditions that facilitate and reproduce the causes of damage. (J Lewis 2000: 19)*

Transformation of gendered power relations receives added impetus from the limitations of exclusive female- and male-targeted approaches:

> *Focusing on women alone may add to women's burden of HIV and often leads to the view that women are to blame. However, the involvement of men does not in itself improve the lives and health of women, and may in fact entrench the gender inequalities that exist in society. (In Tallis 2002: 38)*

Power and empowerment: 'power over' and 'power to'

In close correspondence to Hannah Arendt's distinction between primary and secondary power, Ann Blanc distinguishes between the 'power to' (i.e. the ability to act) and 'power over' (i.e. the ability to assert wishes and goals even in the face of opposition from another) (in Interagency Gender Working Group 2001: 2).

In analysing the power play in sexual relationships, it is not the absolute power of either partner, but the comparative influence of members relative to each other, that should be stressed (see also Varga's parallel distinction between sexual decision-making and sexual negotiation referred to under the section 'Methodological problems in research on gender-based violence', subsection 'Neglect of sexual negotiation').

Most programmatic and policy documents on the conditions of women in South Africa would pitch their analysis of oppression at the level of 'power over' (domination), with recommendations for women's 'power to' (empowerment). Testimony given by women at various hearings, and interviews conducted with women, who describe their circumstances in terms of overwhelming oppressive structures and violent practices (see Joint Monitoring Committee on the Improvement of Quality of Life and Status of Women 2002), would seem to validate this approach. Women's oppression in this country has, accordingly, been cast in the mode of deprivation and disempowerment: poverty, lack of access to

employment and education; to health, welfare, child care, housing, transport and other services; discrimination and gender-based violence.

However, there is one aspect that the distinction between 'power over' (domination) and 'power to' (empowerment) ignores: viz. the possibility of consenting to structures that constrain. This possibility has largely been disavowed by feminist theory until relatively recently. The complexities of social/economic/sexual/symbolic exchanges would defy any description in terms of domination vs. empowerment or coercion vs. consent.

The relationship of coercion and consent in these transactions can possibly be described through an analysis of 'how power compels us to consent to that which constrains us' (Butler 2000: 29). Butler elaborates on this 'age-old problem of identifying with the oppressor', by complicating the picture in ways which might be relevant for gendered identifications:

> *The salience of psychoanalysis comes into view when we consider how it is that those who are oppressed by certain operations of power also come to be invested in that oppression, and how, in fact, their very self-definition becomes bound up with the terms by which they are regulated, marginalised, or erased from the sphere of cultural life. In some ways, this is the age-old problem of identifying with the oppressor, but it takes a different turn once we consider that identifications may be multiple, that one can identify with various positions within a single scene, and that no identification is reducible to identity. (Butler 2000: 150)*

'Consent to constraint' falls into the domain of the interface between psychoanalysis and social theory. This broad direction for an analysis of power could be particularly fruitful in accounting for the various modes of transactional sex, for responses to the trauma of sexualised violence in male same-sex relations, and for the interaction of constructions and norms of masculinity, femininity, and heterosexuality (even in same-sex relations). This would, among many other research directions, open the field for re-connecting economic anthropology with cultural analysis, with psychoanalysis and theory of ideology.

This approach could also qualify any policy of 'empowerment': '… the question is not simply what an individual can figure out about his or her psyche and its investments (…), but to investigate what kinds of identifications are made possible, are fostered and compelled, within a given political field, and how certain forms of instability are opened up within that political field by virtue of the process of identification itself' (Butler 2000: 150).

Institutionalised power and perceived power

Geeta Rao Gupta distinguishes between 'real' and 'perceived' power. 'Real power' coincides with power as institutionalised social fact, materialised in institutions and positions. 'Perceived power' is a derived form of power, based on the association between a status, a role, a subject position, and specific attributes of institutionalised power. While changes in perceived power are necessary for gender equality and equity, they can be sustained only if accompanied by changes in 'real' power:

> *[W]e must argue for changes in policies and programs that seek to increase women's access to key resources and positions of leadership rather than just trying to alter perceptions of male and female roles… increasing*

individual women's access to economic resources and social status in a context where such access is not the (aggregate) norm will not necessarily afford them greater power in sexual relations. For women to accrue such power, individual interventions must be complemented with efforts to alter the aggregate picture of women's socioeconomic status. (In Interagency Gender Working Group 2001: 11)

Gender and HIV Training

One of the factors fundamentally conditioning gender-based violence is the sex-gender system. Its pervasiveness, as outlined above in relation to the sexual 'cultures' of youth, miners, and prisoners, as well as in the normative constructions of masculinity, femininity, and heterosexuality, attest to the difficulty of theorising the social in relation to the natural. Any gender analysis would have to take account of the relationship between sex and gender in particular ideologies, beliefs, values, role expectations, social structures, institutions, practices and policies. It would be important to raise awareness about gendered role expectations, and differentially gendered power relations. In group work, there are possibilities for simulating gendered role expectations and to experiment with their reversal, as well as for practicing different models of masculinity (see for example, the Gender Game in de Bruyn and France 2001: 27, 28, 32).

There are several initiatives currently being carried out in South Africa who embrace these insights and aspects of 'Beyond Awareness'.

DramAidE has done important work in lifeskills workshops through drama, in which young people are encouraged to act out gender roles in the context of HIV/AIDS, and to discuss their responses to different roles and role expectations. Operating since the early 1990s in educational institutions in KwaZulu-Natal, it has pioneered culturally sensitive approaches to lifeskills and HIV/AIDS education, based on participatory learning methods of Paolo Freire and the performance techniques of Augusto Boal's 'theatre of the oppressed'.

Another training package dealing with issues of gender, HIV, communication and relationship skills which has been instrumental in contesting gender norms and aiding communicative decision-making in sexual relations, has been developed under the title of 'Stepping Stones'. Originating from educational work mainly in rural communities in Uganda between 1993 and 1995, it has since been adapted to local contexts in many different countries. The package was initially developed in response to the vulnerability of women and young people because of gender and age relations. As Alice Welbourn explains, it has shifted its perspectives on the situation of women to a more inclusive approach to gender issues: '… it has become evident that men also become vulnerable because of these relations – through the gender stereotypes which expect them to have multiple sexual partners, to act violently towards women and children and each other, therefore putting themselves, as well as others, at risk … therefore developing new, more equitable gender roles is important for everyone' (2002: 59n.2). Role-play and behavioural modelling are part of its approach based on social learning theory. It has been specifically adapted for South Africa, with additional material included on gender, gender violence, and reproductive health.

Unique among faith-based organisations which are contesting heterosexual gender norms in same-sex relations, is the Hope and Unity Metropolitan Church

One of the factors fundamentally conditioning gender-based violence is the sex-gender system.

in Hillbrow, which aims to provide a spiritual home and affirmation to gay men and to lesbians. It attempts to counter myths about homosexuality (see Reid 1998: 57-65).

Resources and facilities for men who abuse women

As Abrahams, Jewkes, and Laubsher point out:

> *Despite the fact that gender violence involves men abusing women, it has largely been regarded as a women's problem'. As a consequence very little is known about men who abuse women, especially those aspects of their abusive behaviour which have the potential for change. South Africa has few structured and organised programmes for abusers. Some welfare departments and Non-Governmental Organisations offer counselling services for men who attend these clinical settings at the request of their partners or court orders. Most of these programs have been adopted from other countries and therefore do not take into account the needs and resources of the South African environment. (1999: 3)*

DramAidE has developed a programme, 'Mobilising Young Men to Care' (2000), in which gender role models and expectations are discussed, enacted, and challenged.

Lifeskills training

In some schools, lifeskills training includes self-defence classes and assertiveness training for girls, and self-reliance and self-esteem for both girls and boys. However, such programmes target the individual for change (by aiming to increase knowledge and skills), rather than changing the group social norms and gender regimes of schools. In HIV prevention, in contrast, it is change in gender norms in condom use, in relationships and in gender roles that is of the essence. In the light of this aim, creating a link between the awareness of gender roles and HIV prevention would be a priority. Lifeskills approaches should be placed within a human rights framework, of which sexual rights and sexual health are an integral part. In order to enhance the ability to negotiate safer sex and safe dating, adolescents would have to be taught refusal skills beyond saying 'no', and conflict resolution skills (Harrison 2002: 48-49).

In HIV prevention, in contrast, it is change in gender norms in condom use, in relationships and in gender roles that is of the essence.

Examples for issues to be fielded within such a framework are provided in the recommendations of the Joint Monitoring Commission on the Improvement of Quality of Life and Status of Women (2002):

❑ What is love? In what ways can it be demonstrated?

❑ What kinds of relationships can young people have?

❑ What kinds of sexual practices are there?

❑ How can men and women communicate about sexual matters?

❑ How can men and women ask for sex, or say no to sex?

❑ What is sexual abuse and violence?

❑ How does violence in relationships come about?

❑ How can potentially violent situations be constructively dealt with?

One of the resources for honing negotiation skills is Women's Health Exchange (no. 4, 1999). It provides ideas for activities and games on risk-taking and avoidance (for example, the bead game, and the condom comeback wheel: 4-6, 8).

Health communications

The limitation of national HIV prevention programmes lies in their universalist, heterosexist assumptions and messages, that cannot take account of the variations in the contexts of the social relations of sex. This is evident particularly in gender categorisations that do not take account of the proliferation of object choices, gendered identifications, sexual practices, and gender roles.

This limitation also applies to the classification of risk behaviour, which tends to lose sight of the range of normal sexual activity (see Jenkins 2002). This limitation can be illustrated through the problems with messages advocating delay, for instance. Advocating sex within marriage (for women) does not offer any protection if young men are not similarly delaying sexual initiation; or if there is a significant age difference between heterosexual partners (see Jenkins 2002; Qakisa 2001: 2; Heise and Elias 1995: 933). The message of 'faithfulness' will not be preventive in conditions where men have multiple partners in different locations. It is not uncommon for a man to have a stable relationship with one 'home wife' and one 'city wife'.

> *These 'city wives' do not regard themselves as prostitutes and therefore they are unlikely to respond to messages linking AIDS with multiple partners. As far as they are concerned, they are faithful to one man even if they know that the man is married. (Qakisa 2001: 4)*

Thus, caution needs to be exercised so as not to generalise assumptions of risk, and not to homogenise target audiences/readerships/viewerships. In addition, language differentials, cultural differentials, differences in gender identifications and sexual orientations, and differences arising from varied socio-cultural contexts would have to be taken into account. This is virtually impossible for high intensity mass media interventions. Mass communication (for example, broadcast, print, outdoor) is by definition linear and unidirectional, with little opportunity for audience feedback.

Therefore a range of different media interventions should be considered, that provide the possibility of communication with a range of specific target audiences/readerships/viewerships. Small media (for example, posters, leaflets, utility items), folk media (songs, drama, events), dialogue-oriented approaches (helplines, participatory theater), and social networking (dialogue at peer and community level) could be combined to achieve a variety of responses and types of communication (see SABSS 2002: 9, 93, 95, 98, 99). This becomes particularly important in the light of the following finding:

> *Although there is a general awareness of HIV/AIDS, most respondents still require further and more detailed information. This suggests that mass media campaigns are insufficient as systems of delivery, and other communication channels, particularly dialogue-oriented approaches should be considered. (SABSS 2002: 100)*

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Media reporting on HIV/AIDS and gender-based violence

What Parker and Kelly observe in relation to the media coverage of aspects of the HIV/AIDS epidemic can be said to pertain to the coverage of gender-based violence as well. There is a tendency in the press to sensationalise (for example, by focusing on rape of 'innocent' children and babies as one of the few 'newsworthy' items in the field of gender-based violence; or by focusing on 'criminal' aspects of a particular incident of gender-based violence), and to perpetuate inaccurate information (for example, statistics that have not been validated, soliciting alarmist responses). Within the spectrum of gender-based violence, it is sensationalist cases that are considered 'newsworthy': while rape receives the most coverage, domestic violence goes largely unreported. News values tend to obscure the issues that people grapple with in their everyday lives (Parker and Kelly 2001: 3). A challenge for journalists is to find news values in social responses to and positive action on HIV/AIDS (Parker and Kelly 2001: 4), and on gender-based violence.

A challenge for journalists is to find news values in social responses to and positive action on HIV/AIDS, and on gender-based violence.

Sensationalisation and inaccuracy in reporting on gender-based violence and HIV/AIDS is partly the result of deriving material from a single source. In the case of gender-based violence, this source would often be police files or court cases. Journalists rarely follow up these cases. The experiences of the survivor, or those of organisations addressing issues of gender-based violence and HIV/AIDS, hardly feature. Instead, women and girls are often portrayed as victims – passive and in need of protection (Media Monitoring Project 1998 in Soul City: 14).

This also highlights the importance of reporting on HIV/AIDS and gender-based violence in a language that does not lend itself to mythologisation and metaphorisation. The discourse of AIDS is laced with metaphors that have been coined in the history of bacteriology, virology, and immunology in the course of establishing the aetiology and treatment of infectious diseases such as TB and syphilis. Metaphors of war abound, in which 'aggressive', 'foreign' organisms invade the body from the outside, against which the immune system mounts 'defences' in the form of anti-bodies that fight the invading virus. In this terminology, a person living with HIV – which is designated as 'the enemy' – might him or herself, through a personification of the attribution to the virus, become the dreaded 'enemy'. To label AIDS as a scourge is to conjure up notions of divine punishment for sexual behaviour that is thereby marked as 'evil'. To put HIV/AIDS on par with a natural catastrophe means a refusal to engage with individual and social responses.

Talk of 'innocently infected AIDS victims' – applied mostly to children and sometimes to men – implies that the transmission of HIV is the 'fault' of other individuals, specifically women. Casting infection in terms of 'pollution' and 'contamination' (of blood and through contact with blood and other body fluids) is associated with moral condemnation, of which women are frequently the targets. Naming of 'risk groups' constructs communities of the stigmatised and ostracised. All of these discursive strategies have the effect of blaming people living with HIV/AIDS, demonising the disease and stigmatising those who live with it (see Sontag 1988).

In South Africa, the metaphoricisation of HIV/AIDS has been politically inflected in particular ways. Through metaphors of war, (national) mobilisation, and of victims, HIV/AIDS has been connected with the history, popular memory and iconography of political struggles and popular movements, importing the politics

and problematics of those movements into individual and social responses to the disease. In the process, the aetiology of HIV/AIDS and the needs of people living with HIV/AIDS tend to become obscured.

A Soul City Resource for Journalists develops guidelines for journalists to report on gender-based violence, which could be extended to pertain to include HIV/AIDS:

❑   use more than one source

❑   use people opposed to gender-based violence as sources, rather than relying solely on the police

❑   follow up the survivor of violence/the person living with HIV

❑   use different kinds of stories

❑   be aware of the implications of language and of particular terms to describe the perpetrator, victim, motive, effects

❑   do not focus on appearance in the description of the parties involved

❑   provide antidotes to the 'woman as perpetual victim' stories. Highlight different aspects of gender-based violence and HIV/AIDS, for example, information on new legislation and policy, descriptions of initiatives to prevent gender-based violence and HIV

❑   highlight gender-based violence as a fundamental human rights violation

❑   contextualise reported events

❑   give the national toll-free Helpline numbers

❑   include stories about people who have left abusive relationships, who have become active in addressing issues in HIV and gender-based violence

❑   be cautious in reporting on matters that remain sub judice

❑   respect the right to privacy of survivors of violence and people living with HIV

❑   do not reveal the identity of children under 18 who have reported an incident of sexualised violence (adapted from Soul City: 17).

Sexual and reproductive health services

Health services are learning that a response to HIV and gender-based violence requires more than training. They have had to make procedural changes in client care, and adopt an approach of intersectoral planning and collaboration. They have also had to confront gender-stereotyping and discriminating attitudes and beliefs, and provide opportunities to model new behaviour (Heise et al. 1999: 36).

In South Africa, urgent attention has to be given to women's – especially rural women's – access to health care.

The Joint Monitoring Committee on the Improvement of the Quality of Life and Status of Women further recommends the incorporation of the protocols for the treatment of survivors of gender-based violence into the curriculum for the training of doctors, nurses (especially forensic nurses), and other health workers (2002).

Health services are learning that a response to HIV and gender-based violence requires more than training. They have had to make procedural changes in client care, and adopt an approach of intersectoral planning and collaboration.

In view of the fact that it is women in their biological and social reproductive roles are the primary users of sexual and reproductive health services, gender-sensitive and gender-transformative approaches would have to be adopted to respond to HIV/AIDS and gender-based violence. In their role as caregivers, they are looking after sick partners and children. This role could potentially widen the gender gap. While many women now have access to nevirapine to prevent vertical transmission, and see their babies developing healthily, they themselves miss out on treatment and concern for their own quality of life. As they attend to the needs of other household members, they are likely to neglect their own. The enormous burden of care shouldered by women should raise some caution about the development of home-based care programmes (UNIFEM nd: 2).

In order to shift the responsibility for family planning, contraception, ante-natal classes, safe sex, reproductive health and care for people living with HIV/AIDS from women to their partners, sexual and reproductive health services would need to involve men.

Health services would also have to be designed to respond to specific needs of gay, lesbian, bisexual and transgendered people. This gap is currently being addressed by the Tshwane-based organisation OUT (with offices in Sunnyside/Pretoria, and Mamelodi), which offers counselling in their offices and through a telephone counselling line and an e-mail address. It publishes a quarterly newsletter, with information on health issues, safe sex, HIV/AIDS, and events columns. Similar work is being done by the Durban Lesbian and Gay Community and Health Centre, which organises health education workshops, distributes condoms, and publishes guides for safe sex in same-sex relationships.

Young people should be able to access health services that provide friendly, confidential and non-judgemental information, counselling, and treatment, including antiretrovirals, VCT, contraception, condoms, and choice of termination of pregnancy. The fact that more than 100 000 babies are born HIV-infected every year, and that there is a high incidence of new HIV infections in young women, necessitates accessible, safe, and friendly termination of pregnancy services (see minuted speech by Helen Rees: Public Health and Reproductive Rights in Reproductive Health Alliance 2002: 16).

It is important to note that there are circumstances that are legally recognised which are based on the principles of 'best interests' and 'informed choice', in which young under-age women can make independent decisions about their health (Gerntholtz and Richter 2002: 101). This includes, for example contraception (from age 14 onwards) and termination of pregnancy.

HIV prevention campaigns should be co-ordinated between schools and health facilities, and peer education and communication should be promoted, to allow young people to tackle and re-work social norms on a collective rather than on an individual level.

Voluntary Counselling and Testing (VCT)

Counselling is the key element in VCT programmes. A study in Uganda showed that for many young people, it is a friendly way of receiving information, advice, and support, which is sought even by young people who are not sexually active (MacQuarrie 2001: 6).

VCT programmes need to help couples come to terms with their test result, to maintain the relationship (especially in the case of sero-discordant couples), and to inform about safe sex practices. They would need to consider and weigh up with their clients the possibility of violent responses to disclosure, and devise safe disclosure plans. More detailed studies on women's experience of disclosing their serostatus to their partners are needed, in order to be able to address the link between disclosure and violence at the levels of counselling, legal protection, education, and social support.

Rape and Post-Exposure Prophylaxis (PEP)

Given the difficulties in getting a rape suspect arrested and HIV-tested within 72 hours of a rape, and given the reluctance expressed by many women to report a rape to the police, access to PEP treatment for all persons who have been raped and who come to a health facility for information, counselling, and treatment, seems the appropriate policy. In those cases where rape survivors consent to be tested for HIV, and are diagnosed as HIV-positive, more general ARV treatment should be made accessible where medically indicated, and counselling and referral should be offered. The period within which treatment would have to commence for optimal effectiveness, is controversial and would require more research.[22] Much remains to be done to implement comprehensive PEP programmes, both in terms of extending the number of PEP facilities within the health services, and in terms of providing appropriate, accessible, and acceptable PEP testing, counselling, treatment and support services. Delays in treatment due to transport problems and long waits in police stations and hospitals would have to be cut down. Health workers would need to be trained in treatment and counselling protocols, and in providing a non-judgemental, friendly, and supportive service. Men and women need to be educated about their rights, about the need to present themselves to a health facility as soon as possible (within 72 hours maximally) after the rape incident, and to comply with the prescribed drug regimen for 28 days. In the light of the fact that the drug combination indicated for PEP can have severe side-effects, and that non-adherence to the drug regimen carries a risk of drug resistance and suboptimal levels of antiretroviral agents, counselling, information and informed consent are of the utmost importance.[23] The police would need to be trained to respond quickly and efficiently. Crime kits need to be available for rape examiners, who would need to be informed of procedures and protocols for gathering forensic evidence.

In addition to the provision of PEP, rape survivors would need to be tested for pregnancy, and for other STIs. Emergency contraceptives and STD prophylaxis would need to be available.

More detailed studies on women's experience of disclosing their serostatus to their partners are needed, in order to be able to address the link between disclosure and violence at the levels of counselling, legal protection, education, and social support.

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22   See footnote 13

23   The difficulty of adherence to a drug regimen under conditions of social dislocation are not insurmountable. A set of Guidelines for the use of ART developed by the Panel on Clinical Practices for treatment of HIV Infection mentions a study conducted in the United States, which lists one programme that 'achieved a 70% adherence rate among the homeless utilizing flexible clinic hours, accessible clinic staff, and incentives' (2002: 10).
Predictors of poor adherence to ARV drug regimens identified in that study, include:
- poor clinician-patient relationship
- lack of patient education and inability of patients to identify their medications
- lack of reliable access to primary medical care or medication.
Predictors of good adherence to ARV drug regimens included:
- availability of emotional and practical life supports
- the ability of patients to fit the medications into their daily routine
- the understanding that poor adherence leads to resistance
- the recognition that taking all medication doses is important
- feeling comfortable taking medications in front of people
- keeping regular clinic appointments (2002:10).

As the first (or second, after the police) resort of rape survivors, health facilities need to gear themselves for intersectoral collaboration, and for providing psychological support and referral.

Particular attention would have to be given to children's needs in counselling and providing PEP in cases of rape.

Planning violence prevention strategies

There is a need for comprehensive violence prevention strategies that integrate public health and education approaches, with an emphasis on addressing the causes of violence.

Drawing together some of the individual indicators and predictors of violent actions and behaviours, violence prevention has been envisaged in terms of a developmental model: interventions before birth (parenting skills, gender role expectations, and stereotyping, stress, conflict and violence), during childhood (use of non-sexist education materials and methods, modeling behaviours and attitudes that avoid stereotyping, enhancing children's sense of their own bodies and developing their confidence about assertions about their own bodies) and adolescence (talking about myths of rape, about how to set boundaries for sexual activity) (Schwartz 1991).

However, the socialisation of the individual is not the only factor in the explanation and prevention of violence. The analyses of violence presented in this survey point to the need for comprehensive violence prevention strategies that integrate public health and education approaches with an emphasis on addressing the causes of violence. For addressing the interface between gender-based violence and HIV, violence prevention should be integrated into social, health and educational policies to promote gender and social equality (see also Krug et al. 2002). It could involve a range of initiatives, individuals and groups, for example, people living with HIV/AIDS, survivor groups and rape crisis centres, women police officers and district surgeons, lifeskills education in schools, drama education, telephone helplines, local media and communications initiatives.

DIRECTIONS FOR FURTHER RESEARCH AND INTERVENTION

Levels of gender awareness

A recent survey conducted by Cadre among government health and education departments, AIDS counsellors, NGOs and CBOs in the fields of HIV/AIDS awareness training, gender-based violence counselling and training, and youth projects revealed that there was virtually no understanding of gender issues beyond a vague notion that 'gender' designates the relations between women and men, girls and boys.

As the responses to the questions proceeded, a few respondents mentioned the terms, 'gender sensitivity', 'empowerment', and 'gender equality'. 'Gender-sensitivity' was defined as 'addressing both males and females'; 'bringing women's and men's experiences together'; 'representing both sexes'. 'Empowerment' was associated with women's assertiveness, and the possibility that 'a man is [not] always the boss of the house'; and with the power to negotiate sex. 'Gender equality' was thought to entail, once more, that the man is not necessarily always the boss of the house, and that women and men are equal.

These responses show no deeper understanding of gendered relations of power. It would appear that the definitions of, and the attributes to these concepts, are derived from gender-for-policy-makers workshops, from the format of funding proposals, from attempts to comply with legal requirements of employment equity, from organisational requirements of proportional representivity, and from assertiveness training in lifeskills programmes. The understanding of these concepts, while indicating the extent of gender mainstreaming policies, does not seem to be embedded in organisational culture, in the analysis of gendered social structures and power relations, and in self-understanding.

While 'gender mainstreaming' has become part of the workaday discourse of government departments, policy makers, funding agencies and NGOs, the structures of gendered power have not been widely understood. In the face of the fact that gendered power is integrally tied up with the spread of HIV/AIDS, with violence and with poverty, much work remains to be done in this arena.

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Specific research questions

While the intersection of HIV/AIDS and gender-based violence is increasingly coming into the purview of organisations providing services to survivors of gender-based violence, there are as yet few interventions aimed at normative change beyond the individual client, few intersectoral linkages, and little research to investigate this intersection systematically.

There is a lack of community-based data on gender-based violence, compounded by the fact that incidents of domestic violence are listed as 'common assault' or 'assault with the intent to do grievous bodily harm'; by the fact of under-reporting; by the fact of absent or incomplete police and court records; and by the fact that violence is widely accepted as normative. Most of the research undertaken on violence against women in South Africa has been localised or has focused on particular sub-groups, for example, health service users (resulting

in non-representative samples and non-generalisable findings). This highlights the need for a national strategy on gender-based violence, and a comprehensive database.

In the face of a high incidence of child rape and other types of child sexual abuse, research is urgently required into the economic, social and familial parameters of child abuse, and into prevention strategies at individual, communal, social and political levels. The question frequently asked is whether child sexual abuse is on the increase, or whether it has simply been hidden previously. Children's responses to trauma, and those of their families, and to therapy would have to be documented, with a view to identifying recovery strategies that can prevent risk-taking behaviours later in life. Research is presently being conducted under the auspices of the Save the Children Campaign, at one site in Windhoek (Namibia) and one site in Mpumalanga, to 'explore the range or practices of child sexual abuse that do not necessarily involve rape, but may involve long-standing practices between adults and young children in terms of a 'sexualised upbringing' (Junius in Hall & Samuwiro 2002: 13). In the light of the fact that the number of reported rape incidents where not only the rape survivors but also the rapists are children of as young as ten years of age,[24] the expansion and fast-tracking of such research efforts seems imperative.

More generally, the question has been raised as to how people in early adolescence and even childhood come to enter sexual relationships. While current research investigated this mainly under the heading of age differentials, other social factors might be involved, and would require specific research, viz. lack of social cohesion, lack of parental concern and guidance, and lack of social support and crisis intervention.

While there are a great number of studies on various aspects of gender-based violence in South Africa, they are largely descriptive and experiential. Many of the studies list poverty and discrimination as major conditions and corollaries of gender-based violence. However, few studies have identified the structural conditions of gender-based violence in South Africa.

While much research focuses on violent relations of sex, the converse issue would have to be investigated as well: viz. the sexualisation of violence. This issue could be explored in looking at patterns of sexualisation in socialisation, and in analysing the aestheticisation of gendered violence in the media.

There is an increasing volume of research conducted recently on the terms and modes of transactional sex. However, more research is required into the structures of a social/sexual economy that link cultural, social, and symbolic exchanges with economic exchanges.

While the Constitution and a range of equality-promoting laws have been passed since 1996, South African women have given testimony to continued pressures, discrimination and violence through 'customary' marital arrangements (including lobola, inheritance, levirate, sororate, polygamy, etc). This discrepancy between the legal provisions and the experience of customary marital relations would have to be more closely investigated.

Children's responses to trauma, and those of their families, and to therapy would have to be documented, with a view to identifying recovery strategies that can prevent risk-taking behaviours later in life.

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24 See for example, the front-page report in *The Star* (13.01.03) by Jillian Green and SAPA: 'Can it get any worse than this? First it was adults raping little kids and babies, now the offenders are little kids themselves'. The article reports on a ten-year-old Eastern Cape boy arrested for raping a five-month-old baby relative.

There is a weight of anthropological and feminist-theoretical literature on the sex/gender system which is probably one of the most pervasive themes in feminist debates since the end of the eighteenth century. However, it would have to be investigated how the relation between sex and gender is played out in particular types of relationships, and how gender-based violence is implicated in particular forms of the relation between sex and gender.

From the international literature, we know that women migrants and refugees are highly vulnerable to both gender-based violence and HIV/AIDS. Little, however, is known about the situation of refugee women in South Africa.

Coercion in same-sex relationships in South Africa is shrouded in silence. We can assume that there is vast under-reporting and it is not practically recognised by law enforcement agencies. Research is required to investigate this, and into the possibility of a correlation between homophobic external responses and violence within the relationship.

Due to vast underreporting, little is known about gender-based violence and HIV prevalence in female same-sex relationships.

Scholars have studied gender-based violence in same-sex relationships, or in fact same-sex relations among African men as a whole – mainly within the context of total institutions (i.e. prisons and mining hostels), giving rise to the problematic and mistaken notion that same-sex relations are exclusively or typically formed under coercive conditions and/or under conditions of restricted choice. To counter this notion, same-sex relations in the broader social arena would have to be described.

In relation to same-sex relations in total institutions, one of the questions that has been raised relates to the continuities and discontinuities between lived gender categorisations inside and outside of the prisons.

While it is generally known that physical abuse seldom comes alone, the relationship between physical abuse and other forms of abuse would need to be more closely investigated, particularly in relation to responses to HIV/AIDS.

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There is as yet no clarity on PEP treatment protocols. The guidelines stipulate mandatory testing and counselling within 72 hours of the rape incident as a condition for the provision of PEP. The time lag between rape incident and commencement of treatment is a matter of controversy. Research is required into the optimal effectiveness of PEP drugs. Present guidelines stipulate that if the rape survivor tests HIV-negative, PEP will be provided; if the result is positive, PEP will not be provided. This policy would need to be reconsidered in the light of research that would have to be collated on the possibility that re-infection (through an incident of rape) carries the risk of increased viral loads.

Members of the Department of Health report poor compliance with PEP drug regimens. Research would have to be conducted on optimal methods of drug administration, coupled with information, counselling and support.

In the light of anecdotal evidence that many men respond to HIV-positive test results by vowing to infect women, so as 'not to die alone', or out of a sense of revenge, more systematic research would be required into men's responses to an HIV-positive diagnosis; and this would have to be taken up in counselling, education, and communications.

Anthropological and medical-historical research would be required into the roots of the perception that women are the source of contagion, so as to be able to address this notion in counselling, education, and communications.

More generally, more research is required into the historical lineages and linkages of stigma, racism, gender and discrimination.

The relationship between anticipated partner violence on disclosure of HIV test results, and the actual experience of disclosure would have to be researched and documented. It has important consequences for organised efforts of de-stigmatisation, and for counselling and support. Experiences with, and attitudes and responses towards disclosure of HIV status more generally would have to be documented to inform counselling and communications.

The dynamics of sexual negotiation are an under-researched area. It would be important to learn about the processes of negotiation, so as to be able to model it in educational work, and in counselling and support.

The human rights framework for addressing HIV/AIDS and gender-based violence requires fine-tuning beyond the programmatic general statements of the treaties, codes, and conventions. The blueprints that they aim to provide for educational, social support, counselling and treatment interventions in matters of HIV/AIDS, usually include recommendations for culturally sensitive approaches, without, however, considering how the endorsement of practices labeled 'cultural' might create, entrench, and perpetuate gender-based violence.

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