Dismantling the Chain: The Link between Gender-based Violence and HIV in South African Women

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South Africa is home to the largest number of people living with HIV compared to any other country, with an estimated 5.6 million people in 2011 (1). Compared to other regions like Eastern Europe where injection drug use primarily drives HIV, heterosexual sex primarily drives the HIV epidemic in South Africa. The HIV prevalence in Cape Town, South Africa's second largest city, is 13%, with prevalence reaching as high as 25% in impoverished urban townships and informal settlements (2). All around the world, the populations that are most vulnerable to and affected by disease, including HIV, are the poor, marginalized, and/or individuals with relatively low access to economic, political, and social resources. Such is the case with women in South Africa, who continue to comprise the majority of HIV infections in this country, and who have low power and status relative to men. In an effort to curb the HIV epidemic, scientists have conducted behavioural research to develop interventions or programs that aim to reduce heterosexual risk behaviour, or raise women's status and access to resources. In this article, some of these recent HIV prevention efforts in South Africa are described. In general, HIV behavioural research and prevention efforts targeted at South African women has focused on increasing gender equality and reducing gender-based violence.

Gender-based violence

Violence against women, or gender-based violence remains a serious problem globally. In South Africa, it is estimated that at least one-quarter of women have ever been in an abusive relationship (3). Previous research using cross-sectional methods has shown that the experience of violence from an intimate partner, including psychological, physical, or sexual abuse, is correlated with HIV in women (4). In 2010, Jewkes and colleagues published a longitudinal study in the *Lancet* that showed that over time, experiencing violence in an intimate relationship is related to increased risk of becoming infected with HIV (5). Thus, they provided some of the first evidence that suggests that violence causes HIV infection in women. Establishing causal or temporal links between two variables is important for theoretical and practical scientific advancement. However, it is also important to explain *how* or *why* two variables, like violence and HIV, are linked (6). This understanding of the mechanisms underlying a relationship guides prevention and intervention efforts. In the case of South African women, it may be that alcohol use or poor mental health may explain the link between experiencing abuse and HIV infection. For example, a woman who experiences violence may increase her consumption of alcohol in an effort to cope with the abuse, and/or she may experience depression or posttraumatic stress, which in turn may predict her being less likely to use condoms during sex. We tested these predictions in a study published in *Social Science and Medicine* (7). Our predictions were based on theory, and on the fact that hazardous alcohol use is prevalent among those who consume alcohol in South Africa.

Alcohol use

Syndemic Theory argues that multiple psychological, social, and health problems tend to exist together, or co-occur among marginalized populations, and that this co-occurrence increases risk for HIV (8). For example, it has been shown that men who have sex with men (MSM) who report depression, intimate partner violence, drug use, and other problems are more likely to engage in unprotected sex than MSM who experience little or none of these problems (9). Our own research in South Africa has provided evidence that the same type of phenomenon occurs among resource-poor women in Cape Town (10). In addition to the co-occurrence of depression and violence in South Africa, alcohol use remains a problem in this country. South African drinkers consume an average of 20 litres of alcohol per year, a rate among the highest in the world (11). This may be attributed to the history of alcohol in the country, as it was used as a form of currency to pay indigenous workers, which had the effect of fostering alcohol, and arguably economic dependence. Thus, given the co-occurrence of mental health problems, violence, and HIV, as well as the context of alcohol use in South Africa, we examined whether alcohol use and mental health problems (depression and posttraumatic stress) explained the link between experiencing violence and HIV in South African women.

Link between violence and HIV

In our study, we surveyed a total of 560 women from twelve different shebeens (informal alcohol drinking venues) or taverns in a Cape Town township. These women completed an audio and computer assisted interview in their preferred language (Afrikaans, Xhosa, or English) and answered questions about their alcohol use, mental health, sexual risk behaviours, and experience of intimate partner violence. Some examples of the types of abuse we asked about include a partner kicking, punching, or using a knife or gun, forced sex, and gang rape. Using analytical methods that allows us to test variables that may explain or "mediate" the relationship between two other variables, in this case ever experiencing violence and then unprotected sex 4 months later, we showed that alcohol use, but not depression or posttraumatic stress, explained the link between violence and unprotected sex. Women who have ever experienced physical or sexual abuse were more likely to report drinking more alcohol, and drinking more was predictive of more unprotected sex. Thus, it is important to not only address gender-based violence, it is necessary to also address subsequent alcohol use among women in South Africa.

Microfinance and other intervention programs

Altogether, the research described here has important implications for program development aimed at reducing HIV risk and curbing the epidemic in South Africa. Generally, reducing the gender-power imbalance between men and women is essential. Microfinance programs have been tested as one strategy for increasing gender equality and reducing partner violence. In these programs, loans are provided to individuals in poor households, mainly women, which help facilitate business development, income generation, and increase economic and social benefits, including reduced reliance on male partners and greater economic independence for women. The Intervention with Microfinance for AIDS & Gender Equity (IMAGE) was a study trial testing a microfinance program combined with education and counselling in gender issues and HIV, including gender roles, partner violence, and empowerment (12). Results showed that this combined intervention program can reduce rates of gender-based violence, which may ultimately reduce HIV risk.

In addition to more research on these types of programs, increased access to health and human services, particularly for women, are vital. These services must take a holistic, person-centred approach – rather than a disease-focused approach – to understanding HIV risk. A recognition and understanding of the multiple aspects of women's lives, including relationship power and violence, mental health, and substance use, that contribute to vulnerability to HIV is needed to effectively reduce risk behaviour, and help ensure sustainable behaviour change. In relation to that HIV prevention interventions should be multi-faceted in addressing the multiple routes to HIV infection. For example, a combined microfinance and alcohol use intervention may be more efficacious than an intervention that focuses on economic or substance use problems alone. Finally, *both* women and men in South African communities should be engaged in the dialogue to end HIV in South Africa. While services to help women deal with violence in their relationships remain essential, efforts for men to stop violence against women, not only in South Africa but globally, are fundamental.

Dr. Pitpitan is currently supported by a training fellowship from the National Institutes of Health, United States Department of Health and Human Services (T32DA023356).

Note that the views expressed in this article are those of the author(s) and do not necessarily represent the views of PHASA.

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