The dual burden of gender-based violence and HIV in adolescent girls and young women in South Africa

The 16 Days of Activism is an international awareness-raising campaign that promotes no violence against women and children. Each year the campaign runs between 25 November and 10 December and overlaps with World AIDS Day on 1 December. Adopted by South Africa (SA) in 1998, the campaign aims to raise awareness among South Africans about the negative impact of violence against women and children on all members of the community. This campaign is particularly relevant in the SA context, as young women aged 15 - 24 years, who have the least power in society, bear an enormous burden of both intimate partner violence (IPV) and HIV.

Violence against women takes many forms – physical, sexual, economic, and psychological – with IPV being a particularly significant public health problem. Although population-based surveys show that prevalence of IPV among ever-married or partnered women aged 15 - 49 years has declined between 2000 and 2014 in some countries, the global prevalence of recent IPV remains unacceptably high. Globally, about 1 in every 3 women has ever experienced physical and/or sexual violence inflicted by an intimate partner.[1] Interestingly, the prevalence of IPV among young women aged 15 - 19 years is similar (29%) to the average lifetime prevalence of IPV, suggesting that violence commonly starts early in women's relationships.[1] A study undertaken by the South African Medical Research Council shows that about 1 in every 4 women aged 18 - 49 years in SA has experienced IPV.[2] A recent community-based study in SA among 3 515 children aged 10 - 17 years revealed that 31.2% of adolescent girls had ever experienced physical abuse in their lifetimes, with 8.4% reporting sexual abuse or rape.[3]

Despite being a fundamental violation of women's human rights, gender-based violence (GBV) is often rooted in socially accepted gender inequality and discrimination and is therefore condoned.[4,5] The power imbalances between men and women, at both societal and individual relationship levels, are often established during adolescence.[6] Unfortunately, feelings of shame, stigma and discrimination, whether real or perceived, keep women from reporting experiences of violence, and all too often survivors of violence are not effectively supported by health and public services.[7]

Women who have experienced physical or sexual violence by their partners have increased rates of adverse health outcomes, including unwanted pregnancies and adverse maternal and newborn health outcomes, as well as other short- and long-term physical, psychological and social impacts.[1,8,9] Teenage pregnancies, an outcome of sexual abuse in some instances, result in curtailment of secondary schooling, leading to vicious cycles of poverty and dependency.[10] In some regions, experiences of IPV have been shown to be an important determinant of women's HIV risk.[11-13] A systematic review that included 28 studies involving 331 468 individuals from 16 countries showed that IPV was associated with a 1.2-fold increased risk of HIV infection among women.[14] In SA, women with violent or controlling male partners were 1.5 times more likely to acquire HIV compared with women who had not experienced partner violence.[11,15] GBV is regarded as a major problem in SA communities, and is seen to be exacerbated by unemployment, poverty and alcohol abuse.[16]

Although SA has made significant progress in transforming AIDS from an inevitably fatal condition to one that is chronic and manageable through the use of antiretrovirals, young women continue to experience high rates of new HIV infections. In SA, the prevalence of HIV among adolescent girls and young women is up to six times higher than that of their male peers.[17] One of the reasons for this age-sex disparity in HIV infection rates is that young girls often partner with men 5 or more years older and who are more likely to be living with HIV.[18-21]

Multiple complex pathways connect IPV with HIV. Gender inequality, the threat of IPV and male controlling behaviour can increase a young woman's vulnerability to HIV[11,14,22] by limiting her ability to successfully negotiate consistent condom use with her male partner(s), insist on mutual monogamy or refuse unwanted sex, thus constraining her ability to control her own HIV risk. Studies have shown that women who have been subjected to GBV often adopt risky behaviors such as alcohol abuse, which in turn can lead to more unprotected sex and an increased risk of acquiring HIV.[23-25] The fear of IPV can also discourage women from getting tested for HIV,[26] discourage disclosure of their HIV-positive status[27] and serve as a barrier to treatment uptake and adherence,[27,28] and may disrupt HIV prevention services[29] and result in poorer HIV outcomes.[28,30] The relationship between IPV and HIV is also bidirectional. Some women are at increased risk of IPV following disclosure of their HIV-positive status[27,31-35] or following screening during pregnancy.[31,35,36] With the implementation of Option B+ in antenatal services, where antiretroviral treatment is initiated on HIV-positive status confirmation in pregnant women, adherence rates decline after delivery, particularly in women who have not disclosed their HIV status to their partner, thereby enhancing their risk of progressing to AIDS and dying.[37]

Numerous interventions aimed at addressing IPV and sexual violence among adolescents have been assessed. A review of the evidence to support these interventions shows that school-based programmes that address dating violence, community-based interventions to promote gender-equitable attitudes, and interventions aimed at adolescents who have been maltreated and at their parents to be the most promising.[38] An example of a successful intervention is the cluster-randomised study in Uganda known as the SASA!, which showed that harmful gender norms can be changed through a community mobilisation intervention. After 4 years there was a 58% reduction in physical IPV in the intervention communities and a significant decrease in the social acceptance of IPV among men and women.[39,40]

Education of adolescent girls and young women is regarded as a fundamental intervention to prevent GBV.[5,41] Keeping girls in school has also been shown to have other beneficial health outcomes, including lower rates of HIV infection, delayed childbearing, lower infant and maternal mortality rates, and improvement of other development outcomes.[10,42] Novel social protection interventions that provide cash transfers/incentives have been shown in some settings to improve school attendance, decrease risky sexual behaviour and activity and improve income and social opportunities for women.[43]

Given that IPV and HIV are so intimately intertwined, efforts to eliminate GBV/IPV have the potential also to improve sexual and reproductive health outcomes and HIV prevention among adolescent girls. Primary healthcare/antenatal care clinics provide the opportunity to assess GBV among clients and offer post-exposure prophylaxis for those who have experienced GBV, as well as pre-exposure prophylaxis for young girls and women who experience IPV. These clinics could also serve as an opportunity to establish whether pregnancies are planned or unplanned and to quantify what

Did you know?

- SA bears 18% of the global burden of HIV infection and yet is home to <1% of the world's population.[4]
- Four out of the five districts in SA that have an HIV prevalence of >40% among pregnant women are in KwaZulu-Natal Province. The remaining seven districts in KwaZulu-Natal have HIV prevalence rates ranging between 33.7% and 40.0% among pregnant women, compared with the overall prevalence of 30% in SA.[46]
- Young women between the ages of 15 and 24 years have up to six times more HIV infection than their male peers, and are experiencing the highest death rates.[17]
- Men and women who have experienced GBV are more likely to have behaviours that increase their risk of acquiring HIV infection.
- Compared with an HIV-negative women, a woman who discloses her HIV-positive status to a partner of unknown HIV status is more likely to experience physical and emotional abuse.

proportion of pregnancies result from GBV/IPV v. unprotected sex with a partner.

Changing the face of these two epidemics will require substantial rethinking and conceptualisation at a structural level on constructions of masculinity and femininity and the value placed on women and their rights. The World Health Organization and UNAIDS have developed programming tools to address violence against women in the context of the HIV epidemic.[44,45] The coercive arm of the law also offers some hope and protection to vulnerable women experiencing both epidemics, but it is social mobilisation and solidarity that will enable true transformation and the real possibility for all women to reach their full potential in a safe and healthy manner.

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1. World Health Organization. Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence. Geneva: World Health Organization, 2013. http://www.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf (accessed 26 September 2016).
2. Jewkes R, Penn-Kekana L, Levin J, Ratsaka M, Schrieber M. Prevalence of emotional, physical and sexual abuse of women in three South African provinces. S Afr Med J 2001;91(5):421-428.
3. Meinck F, Cluver LD, Boyes ME, Loening-Voysey H. Physical, emotional and sexual adolescent abuse victimisation in South Africa: prevalence, incidence, perpetrators and locations. J Epidemiol Comm Health 2016;70(9):910-916. http://dx.doi.org/10.1136/jech-2015-205860
4. Joint United Nations Programme on HIV/AIDS (UNAIDS). Global AIDS Update – 2016. Geneva: UNAIDS, 2016. http://www.unaids.org/en/resources/documents/2016/Global-AIDS-update-2016 (accessed 2 November 2016).
5. Garcia-Moreno C, Zimmerman C, Morris-Gehring A, et al. Addressing violence against women: A call to action. Lancet 2015;385(9978):1685-1695. http://dx.doi.org/10.1016/S0140-6736(14)61830-4
6. Abdool Karim Q. Heterosexual transmission of HIV – the importance of a gendered perspective in HIV prevention. In: Abdool Karim SS, Abdool Karim Q, eds. HIV/AIDS in South Africa. Cape Town: Cambridge University Press, 2005:243-261.
7. World Health Organization. Global Plan of Action to Strengthen the Role of the Health System Within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children, Building on Existing Relevant WHO Work. Geneva: WHO, 2016. http://www.who.int/topics/violence/UNFPA-GAP2-violence.pdf (accessed 2 November 2016).
8. World Health Organization. Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence. Geneva: WHO, 2013. http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf (accessed 22 September 2016).
9. Dellar R, Waxman A, Abdool Karim Q. Understanding and responding to HIV risk in young South African women: Clinical perspectives. S Afr Med J 2015;105(11):952. http://dx.doi.org/10.7196/SAMJ.2015.v105i11.10099
10. De Neve JW, Fink G, Subramanian SV, Moyo S, Bor J. Length of secondary schooling and risk of HIV infection in Botswana: Evidence from a natural experiment. Lancet Glob Health 2015;3(8):e470-e477. http://dx.doi.org/10.1016/S2214-109X(15)00087-X
11. Jewkes RK, Dunkle K, Nduna M, Shai N. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. Lancet 2010;376(9734):41-48. http://dx.doi.org/10.1016/S0140-6736(10)60548-X
12. Van der Straten A, King R, Grinstead O, Serufilira A, Allen S. Couple communication, sexual coercion and HIV risk reduction in Kigali, Rwanda. AIDS 1995;9(8):935-944.
13. Maman S, Mbwambo JK, Hogan NM, et al. HIV-positive women report more lifetime partner violence: Findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania. Am J Public Health 2002;92(8):1331-1337. http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.92.8.1331 (accessed 7 November 2016).
14. Li Y, Marshall CM, Rees HC, Nunez A, Ezeanolue EE, Ehiri JE. Intimate partner violence and HIV infection among women: A systematic review and meta-analysis. J Int AIDS Soc 2014;17:18845. http://dx.doi.org/10.7448/IAS.17.1.18845
15. Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet 2004;363(9419):1415-1421. http://dx.doi.org/10.1016/S0140-6736(04)16098-4
16. Strebel A, Crawford M, Shefer T, et al. Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa. SAHARA J 2006;3(3):516-528. http://dx.doi.org/10.1080/17290376.2006.9724879
17. Joint United Nations Programme on HIV/AIDS (UNAIDS). Global Report: UNAIDS Report on the Global AIDS Epidemic 2013. Geneva: UNAIDS, 2013. http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf (accessed 25 September 2016).
18. Gregson S, Nyamukapa CA, Garnett GP, et al. Sexual mixing patterns and sex-differentials in teenage exposure to HIV infection in rural Zimbabwe. Lancet 2002;359(9321):1896-1903. http://dx.doi.org/10.1016/S0140-6736(02)08780-9
19. Kelly RJ, Gray RH, Sewankambo NK, et al. Age differences in sexual partners and risk of HIV-1 infection in rural Uganda. J Acquir Immune Defic Syndr 2003;32(4):446-451. http://dx.doi.org/10.1097/00126334-200304010-00016
20. MacPhail C, Williams BG, Campbell C. Relative risk of HIV infection among young men and women in a South African township. Int J STD AIDS 2002;13(5):331-342. http://dx.doi.org/10.1258/0956462021925162
21. Pettifor AE, Rees HV, Kleinschmidt I, et al. Young people's sexual health in South Africa: HIV prevalence and sexual behaviors from a nationally representative household survey. AIDS 2005;19(14):1525-1534. http://dx.doi.10.1097/01.aids.0000183129.16830.06
22. Durevall D, Lindskog A. Intimate partner violence and HIV in ten sub-Saharan African countries: What do the demographic and health surveys tell us? Lancet Glob Health 2015;3(1):e34-e43. http://dx.doi.org/10.1016/S2214-109X(14)70343-2
23. Pitpitan EV, Kalichman SC, Eaton LA, Sikkema KJ, Watt MH, Skinner D. Gender-based violence and HIV sexual risk behavior: alcohol use and mental health problems as mediators among women in drinking venues, Cape Town. Soc Sci Med 2012;75(8):1417-1425. http://dx.doi.org/10.1016/j.socscimed.2012.06.020
24. Joint United Nations Programme on HIV/AIDS (UNAIDS). Together We Will End AIDS. Geneva: UNAIDS, 2012. http://www.unaids.org/en/resources/campaigns/togetherwewillendaids/ (accessed 14 October 2016).
25. Gupta GR, Weiss E, Whelan D. Male-female inequalities result in submission to high-risk sex in many societies. Special report: women and HIV. AIDS Analysis Africa 1995;5(4):8-9.
26. Adams JL, Hansen NB, Fox AM, et al. Correlates of HIV testing among abused women in South Africa. Violence Against Women 2011;17(8):1014-1023. http://dx.doi.org/10.1177/1077801211414166
27. Medley A, Garcia-Moreno C, McGill S, Maman S. Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes. Bull World Health Organ 2004;82(4):299-307. http://www.who.int/bulletin/volumes/82/4/299.pdf?ua=1 (accessed 7 November 2016).
28. Hatcher AM, Smout EM, Turan JM, Christofides N, Stockl H. Intimate partner violence and engagement in HIV care and treatment among women: A systematic review and meta-analysis. AIDS 2015;29(16):2183-2194. http://dx.doi.org/10.1097/QAD.0000000000000842
29. Roberts ST, Haberer J, Celum C, et al. Intimate partner violence and adherence to HIV pre-exposure prophylaxis (PrEP) in African women in HIV serodiscordant relationships: A prospective cohort study. J Acquir Immune Defic Syndr 2016;73(3):313-322. http://dx.doi.org/10.1097/QAI.0000000000001093
30. Schafer KR, Brant J, Gupta S, et al. Intimate partner violence: A predictor of worse HIV outcomes and engagement in care. AIDS Patient Care STDs 2012;26(6):356-365. http://dx.doi.org/10.1089/apc.2011.0409
31. Hatcher AM, Woollett N, Pallitto CC, et al. Bidirectional links between HIV and intimate partner violence in pregnancy: Implications for prevention of mother-to-child transmission. J Int AIDS Soc 2014;17:19233. http://dx.doi.org/10.7448/IAS.17.1.19233
32. Mulrenan C, Colombini M, Howard N, Kikuvi J, Mayhew SH, Integra I. Exploring risk of experiencing intimate partner violence after HIV infection: A qualitative study among women with HIV attending postnatal services in Swaziland. BMJ Open 2015;5(5):e006907. http://dx.doi.org/10.1136/bmjopen-2014-006907
33. Olowookere SA, Fawole OI, Adekanle DA, Adeleke NA, Abioye-Kuteyi EA. Patterns and correlates of intimate partner violence to women living with HIV/AIDS in Osogbo, Southwest Nigeria. Violence Against Women 2015;21(11):1330-1340. http://dx.doi.org/10.1177/1077801215594889
34. Shamu S, Zarowsky C, Shefer T, Temmerman M, Abrahams N. Intimate partner violence after disclosure of HIV test results among pregnant women in Harare, Zimbabwe. PLoS One 2014;9(10):e109447. http://dx.doi.org/10.1371/journal.pone.0109447
35. Ezechi OC, Gab-Okafor C, Onwujekwe DI, Adu RA, Amadi E, Herbertson E. Intimate partner violence and correlates in pregnant HIV positive Nigerians. Arch Gynecol Obstet 2009;280(5):745-752. http://dx.doi.org/10.1007/s00404-009-0956-9
36. Hatcher AM, Stockl H, Christofides N, et al. Mechanisms linking intimate partner violence and prevention of mother-to-child transmission of HIV: A qualitative study in South Africa. Soc Sci Med 2016;168:130-139. http://dx.doi.org/10.1016/j.socscimed.2016.09.013
37. Phillips T, Thebus E, Bekker LG, McIntyre J, Abrams EJ, Myer L. Disengagement of HIV-positive pregnant and postpartum women from antiretroviral therapy services: A cohort study. J Int AIDS Soc 2014;17:19242. http://dx.doi.org/10.7448/IAS.17.1.19242
38. Lundgren R, Amin A. Addressing intimate partner violence and sexual violence among adolescents: Emerging evidence of effectiveness. J Adolesc Health 2015;56(1 Suppl):S42-S50. http://dx.doi.org/10.1016/j.jadohealth.2014.08.012
39. Abramsky T, Devries K, Kiss L, et al. Findings from the SASA! Study: A cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. BMC Med 2014;12:122. http://dx.doi.org/10.1186/s12916-014-0122-5
40. Abramsky T, Devries KM, Michau L, et al. The impact of SASA!, a community mobilisation intervention, on women's experiences of intimate partner violence: Secondary findings from a cluster randomised trial in Kampala, Uganda. J Epidemiol Community Health 2016;70(8):818-825. http://dx.doi.org/10.1136/jech-2015-206665

41. Heise LL, Kotsadam A. Cross-national and multilevel correlates of partner violence: An analysis of data from population-based surveys. Lancet Glob Health 2015;3(6):e332-e340. http://dx.doi.org/10.1016/S2214-109X(15)00013-3
42. UNICEF. Goal: Promote gender equality and empower women. UNICEF-Millennium Development Goals. http://www.unicef.org/mdg/index_genderequality.htm (accessed 28 September 2016).
43. Taaffe J, Cheikh N, Wilson D. The use of cash transfers for HIV prevention – are we there yet? Afr J AIDS Res 2016;15(1):17-25. http://dx.doi.org/10.2989/16085906.2015.1135296
44. World Health Organization, United Nations Joint Programme on HIV/AIDS. 16 Ideas For Addressing Violence Against Women in the Context of the HIV Epidemic: A Programming Tool. Geneva: WHO, 2013. http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf (accessed 26 September 2016).
45. World Health Organization, United Nations Office on Drugs and Crime (UNODC). Strengthening the Medico-legal Response to Sexual Violence. Geneva: WHO, 2015. http://www.who.int/reproductivehealth/publications/violence/medico-legal-response/en/ (accessed: 26 September 2016).
46. National Department of Health, South Africa. The 2013 National Antenatal Sentinel HIV Prevalence Survey South Africa. Pretoria: National Department of Health, 2015. https://www.health-e.org.za/wp-content/uploads/2016/03/Dept-Health-HIV-High-Res-7102015.pdf (accessed 2 November 2016).

S Afr Med J 2016;106(12):1151-1153. DOI:10.7196/SAMJ.2016.v106i12.12126