THE GENDERED POWER DIFFERENTIAL: ITS ROLE IN HIV AND INTIMATE PARTNER
VIOLENCE AMONG WOMEN IN SUB-SAHARAN AFRICA

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Abstract

This paper will discuss the power differential between women and men and its role in

the intersection of HIV/AIDS and intimate partner violence among women in sub-

Saharan Africa. Both HIV and intimate partner violence are of tremendous public

health relevance. Since its "discovery" over 20 years ago, HIV has been and

continues to be a world health problem. Nearly 40 million people worldwide are

living with HIV/AIDS; about half of them are women. Fifty seven percent of the

people living with HIV/AIDS in Sub-Saharan Africa are women. HIV prevention

continues to be an urgent health priority in sub-Saharan Africa and throughout

developing countries around the world; yet interventions preach abstinence and

safer sex practices without recognizing the sociocultural context of HIV/AIDS or of

sexual behavior and practices. Traditional concepts of gender roles and the power

differential intrinsic in relationships between women and men must be accounted for

– not only in the design of HIV interventions, but also acknowledged as risk factors

for violent relationships. Suggestion of condom use by the female partner, for

example, is often met with suspicion, hostility, even violence from her male partner.

Intimate partner violence is researched in this paper because it is the ultimate

manifestation of the gendered power differential.

This paper will critically review existing HIV interventions targeting women, explore different gender norms throughout sub-Saharan Africa and the gendered power differential as exemplified by IPV. The paper will conclude with recommendations for future public health efforts and a proposal for an intervention that addresses both public health issues.

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Introduction

Nearly 40 million people worldwide are living with HIV/AIDS. About half of these individuals are women. Fifty seven percent of the people living with AIDS in Sub-Saharan Africa are women (UNAIDS, 2004). Incidence rates of HIV are climbing into the 20-30% range in some cities within sub-Saharan Africa (Gupta, 2000).

The speed and tenacity with which HIV/AIDS has penetrated countries worldwide during the past two decades is astounding. Many communities and governments have been overwhelmed by HIV/AIDS; it will continue to be a major health concern with which many more will grapple. Tackling the HIV/AIDS epidemic requires a breadth of strategy that transcends even the broad discipline of public health. Strategies must encompass the many dimensions of this epidemic, involving many different disciplines including anthropology, sociology, economics, politics, even finance. Hence, strategies to contain the spread of HIV must be multi-faceted and interdisciplinary. Of dire need are HIV interventions directed at all levels of society: governmental, community, family and finally, at individual levels.

Prevalence of HIV in Africa among Women

Poverty is risk factor for HIV

> *Poverty is the central factor that characterizes HIV/AIDS vulnerability throughout the world which, on an individual level, manifests as lack of access to and control over actions, resources, and self-determination. (Sherman, German, Cheng, Marks, Bailey-Kloche, 2006, pg 1)*

Poverty has been described as a predictor of biological susceptibility to disease and of limited access to care (Stillwaggon, 2002 in Fenton, 2004). The World Health Organization declared that "poverty is the leading cause of death and poor health worldwide" (Sherer, Bronson, Teter, Wykoff, 2004, pg 110). Poverty has also had a direct impact on health.

The interplay between poverty and the HIV/AIDS epidemic has been particularly tragic, wreaking havoc on the economies and people of developing countries. A disproportionate percentage of people with HIV/AIDS live in the world's poorest countries (Fenton, 2004). The scarcity of resources has resulted in few successful, cost-effective prevention efforts, while governing bodies have interfered with other efforts. Economic decline spurred by structural adjustment programs throughout much of Africa has led to widespread rural-to-urban migration and a growing number of sex workers, both factors that have contributed to the spread of HIV. Development efforts have therefore been undermined by populations decimated by AIDS (Sweat and Denison, 1995). Malnourishment, which is prevalent in sub-Saharan Africa, leaves countless individuals with compromised immune systems and therefore, more vulnerable to infection; childbearing women in particular are susceptible to infection (Ulin, 1992). Finally, heterosexual transmission of HIV/AIDS is the primary mode in sub-Saharan Africa, which merits urgent attention (UNAIDS, 2004).

The HIV/AIDS epidemic transcends the biological world of infectious diseases and bears vast social, cultural and economic implications, particularly in the developing world. As a direct reflection of this, a complex system of socially-, culturally- and economically-driven practices renders the poor and the less educated more at risk of contracting HIV; these are largely women, who make up 70% of the world's poorest (Gupta, 2000), who are overwhelmingly more susceptible to HIV than their male counterparts. Firstly, the systemic impact of the HIV epidemic exacerbates the epidemics of intimate partner violence and substance abuse (Burke et al., 2005). Secondly, females are physiologically more susceptible than men to the transmission of sexually transmitted diseases because male-to-female transmission occurs more "efficiently" than vice versa (Campbell, 1995). An existing condition of sexually transmitted infection also increases their susceptibility to HIV dramatically (Ulin, 1992).

Thirdly, a depressed socioeconomic status often predisposes individuals to engage in high-risk behavior. The literature cites evidence that women, both unmarried and married, engage in sex in exchange for food, money, shelter or other resources. Women who are mothers are often forced into this situation to provide for their own families. Because opportunities for educational and employment advancement exist in rural areas, young African women migrate to urban areas draw young African women. Once there, however, many of them are compelled to pay the highest possible price for their employment or education: sex in exchange for resources and increased risk of HIV in exchange for freedom, as discussed by Ulin (1992). Finally, the patriarchal societies that prevail throughout much of sub-Saharan Africa prohibit women from greater access to sexual education as well as limit their ability to voice their sexual concerns or negotiate protective sexual behaviors.

Critical review of literature of HIV interventions targeted at women

History of HIV Interventions

Since HIV's "discovery," interventions have been conducted worldwide for nearly two decades. Because the earliest identified victims of AIDS were predominantly white gay males in the United States and other countries in the Western hemisphere, the first interventions were directed towards educating this population. As HIV/AIDS moved on to ravage people across ethnic and socioeconomic groups, interventions were developed to target broader populations (Campbell, 1995). In the design of earlier interventions, elements of cultural sensitivity and gender specificity were often absent: what seemed to work with one population was applied automatically to another. However, research on HIV interventions suggests that successful interventions target specific populations: only men,

only women, or only couples; for each case the intervention structure and content must be altered accordingly (Mize, Robinson, Bockting, Scheltema, 2002).

The earliest population-specific AIDS interventions arose out of the recognition of the susceptibility of female sex workers in countries throughout Asia, South America and Africa. These strategies involved empowerment of sex workers to insist on condom use as part of transactions with an interested client and coordination with hotel owners to vouch for sex workers by stabilizing room fees. Because these interventions were tailored specifically to sex workers, they are not necessarily designed to work with married women or women who are in monogamous relationships and who are often financially dependent on the partner. The lack of success of some interventions may also arise from the fact that the environment does not encourage frank and open discussion of issues deemed to be as private and taboo as sexuality and sexual behaviors, particularly in the presence of the opposite sex (Amaro, 1995). Given this hurdle, a crucial consideration of interventions is that program practitioners mirror their population, especially with regard to gender.

Many interventions, particularly during the early era of AIDS prevention, were educational in nature and emphasized increasing knowledge and changing attitudes and practices (KAP). Health messages on various issues often feature this KAP-centered quality: reproductive health programs in Kenya, for example, have been criticized for over-reliance on KAP qualities (Muturi, 2005). Although knowledge of HIV transmission and prevention are vital components of an intervention, the limitation in this approach is that education does not always translate seamlessly into practice or usability. These interventions falter, not because of a failure to transmit information on life-saving practices but because of the limited ability of participants to apply these practices. For example, data from work in Kenya demonstrate that knowledge of modern contraceptive methods among married women is as high as 98% (Muturi, 2005), but only 32% of the women actually use contraceptives with their spouses. A clear disconnect exists here. Interventions based on

HIV education are still crucial and relevant since countless regions are still unaware of methods of HIV transmission and preventative measures. However, these educational tools must fit within a broader plan of prevention characterized by social and cultural awareness.

HIV interventions were and continue to be grounded in popular psychology-based health theories such as the health belief model, the social cognitive theory, and the theory of reasoned action (Amaro, 1995). The health belief model and theory of reasoned action rely on cognitive models of behavior change, (Amaro, 1995) emphasizing that increases in knowledge, attitudes and beliefs can result in modification of behaviors. The social cognitive theory accounts for human behavior further by emphasizing an increase in self-efficacy and an increase in skill-building acquired through modeling of behaviors.

These theories have been successful with more individual-focused health interventions, such as reducing obesity and smoking cessation. Ultimately, they are built on a paradigm of "individualistic conceptualization of behavior" (Amaro, 1995, pg 440) and assume that sexual behavior is within an individual's locus of control. These theories fail to recognize the broader social and cultural context of human behavior, particularly sexual behavior; hence their applicability to modifying high-risk sexual behaviors is short-sighted. A similar argument can be made against interventions that preach the "ABCs" – to be Abstinent, Be faithful, and Condomize – all behaviors that rarely lie in an individual woman's control (Müller, 2005). In fact, many women worldwide have limited control over their sexual practices, regardless of whether they are unmarried or married. Other messages such as "Stick to your Partner" or "Love Faithfully" that emphasize individual-controlled behavior give women the impression that remaining monogamous will protect them from HIV, without accounting for the sexual behavior of their partner (Heise and Elias, 1995).

The irony of many HIV interventions is the emphasis placed on targeting behavior change in women, when in fact HIV prevention requires modification of the behaviors of both partners in a relationship. This woman-specific strategy often translates into exonerating men from adopting responsible sexual practices (Campbell, 1995). Additionally, women are often powerless to carry out the intervention's practices. Much criticism has been leveled at HIV interventionists on the asymmetry of this effort. Campbell (1995) refers to the Eighth Annual International Conference on AIDS Conference Summary report, which states that prevention efforts are largely targeted at women because they are "easier to reach and more approachable" (pg 204). Education-based interventions have traditionally targeted women because of evidence of the relationship between mother's education levels and those of her children: the more educated a mother is, the more educated her children will be (http://www.unicef.org/girlseducation/ index_bigpicture.html). Women are also targeted because they are more conspicuous due to their more frequent use of social services; and as caretakers, women actively and visibly seek treatment for their children and parents (Campbell, 1995). Ultimately, however, couples must be targeted by HIV education interventions; ideally, both partners would be willing to modify their high-risk behavior.

The Gendered Power Differential

I would like to open this section by first acknowledging that I have made broad generalizations about sociocultural practices in sub-Saharan Africa based on the literature that I reviewed. Sub-Saharan Africa is inarguably a vast region with hundreds of different tribes, dialects, and therefore behaviors. The norms and practices that are discussed below certainly do not pertain to every region and no such intimation is meant by statements herein. Due to limited data and time constraints I have reviewed a body of literature covering different populations within sub-Saharan Africa and have collected all of them to present in one paper.

Sexism prevails throughout most of the world and is operationalized in part through the power differential between genders. The patriarchal structure of many communities in sub-Saharan Africa supports and maintains this power differential. This power differential has played out in society for multiple generations and continues to be seen today.

The socio-cultural norms that bind

In reviewing the literature on HIV interventions worldwide that target women, a very pronounced issue has emerged: the need to acknowledge that certain social and cultural norms oppress women. Sociocultural norms are powerful forces that confine people to certain practices. Norms are often so embedded in a society's identity that individuals may support and abide by them without questioning the rationale behind or appropriateness of these norms. Influencing or shaping norms is a delicate matter, not only because people resist normative change, but also because these influences may be interpreted as the imposition of foreign values on others, imposing an (often) unwelcome infringement upon their cultural fabric. However, it appears from the literature that the very norms that contribute to the identity of a society also pose health-compromising obstacles for HIV interventions. In particular, gender-based norms compromise women's health by preventing women from asserting or protecting themselves. In fact, these norms not only limit the behavior of women, but also limit that of men: for example, men are discouraged from having more egalitarian relationships with their wives: to do so would literally be considered "out of the norm."

The following norms and beliefs impact women's risk for HIV and will be discussed in this section: a deeply-ingrained stigmatization of HIV and people with HIV; cultural norms governing limited sexual knowledge of women; multiple sexual partners encouraged for men but monogamy for women; perception that HIV is a disease brought to men by

women; women's limited control over sexual activity; challenges faced by women in discussion of safe sex practices.

Sexual norms are among the more difficult to modify, especially in societies where sexual practices are not openly discussed. Many parents rarely discuss sex with their children for fear of appearing as though they advocate sexual activity; one father stated that discussing condom use with his sons would be akin to discussing "pornography" with them (Campbell, Foulis, Maimane, Sibiya, 2005, pg 811). Mary Crewe, of the Centre for the Study of AIDS at Pretoria University has said: "We have no language to talk candidly about sex, so we have no civil language to talk about AIDS." (McGeary, 2001).   Discussion of HIV/AIDS itself continues to be painfully taboo in many parts of the world. Despite the prevalence of sexual norms that may tolerate promiscuity, the association of promiscuity with AIDS is too powerful a stigma (Muturi, 2005), and frequently this stigma is the reason why voluntary counseling and testing (VCT) rarely takes place. Entire families will reject members who reveal that they are HIV-positive. When a family member dies of AIDS, surviving loved ones rarely attribute the death to AIDS. Tuberculosis is a commonly-used substitute for HIV as a reason for illness or death.   In fact, physicians often do not properly discuss the news of seropositive status with their patients. Physicians also do not appropriately advise patients on how to share this information with their partners, do not urge HIV testing of the partners, or warn patients to practice protected sex (Muturi, 2005). Physicians attribute this practice to a lack of training and fear of the backlash response of patients to such news. Finally, people in sub-Saharan Africa do not want to get tested because they simply do not want to know that they are dying. An article written in a February, 2001, issue of *Time Magazine* states: "Rare is the man who even knows his HIV status: males widely refuse testing even when they fall ill….women are the ones who progress to full blown AIDS first and die fastest, and the underlying cause is not just sex but power" (McGeary, 2001, pg 42).

HIV/AIDS continues to be perceived in many parts of Africa as a disease given to men by women. By virtue of the widely-held belief that women have inferior social status and that many of the earliest HIV interventions concerned female sex workers, HIV has become stigmatized as a woman's disease. This stigmatization is reflective of the general context of gender inequities among many cultures (Campbell, Foulis, Maimane and Sibiya, 2005). Given these perceptions, it is not uncommon for a man who is seropositive to blame his status on his female partner (whose serostatus may be positive because of his) because of her alleged sexual transgressions (Müller, 2005).

Sociocultural norms often place greater value on the male's pleasure over the woman's and his ability to dominate in all sexual interactions (Gupta and Weiss, 1993). Multiple sexual relations are often condoned for men (Gupta and Weiss, 1993), as recorded in Uganda (Koenig et al., 2004) and South Africa (Pettifor, Measham, Rees and Padian, 2004). Women often live in polygamous unions (Koenig et al., 2004). Throughout much of Africa, the more affairs a man has the more his masculinity is affirmed. However, the opposite applies for women throughout much of Africa: promiscuity by women is frowned upon very severely and may even be punishable by death. Single status of a woman is also socially undesirable in some African societies; therefore women will often forego their desire for monogamy and accept their husband's polygamy in an effort to preserve their status (Jewkes et al., 2003).

As much as the Western world may not want to impose Western values and practices on sub-Saharan Africa, certain African sociocultural norms do not support women; arguably, some of them violate women's most natural human rights. For example, women rarely have a say in terms of when sexual activity may occur. A participant in a series of discussions among women on their perceptions of HIV/AIDS stated, "We are just vessels for our husbands'" (Lindgren, Rankin and Ranking, 2005, pg 75). A Ugandan proverb cited frequently in a focus group among market women was "'It is taboo to deny a man sex!

Serve him 'food' whenever he wishes!'" (Nyanzi, Nyanzi, Wolff and Whitworth, 2005, pg 20). Limited knowledge on sexuality and sexual health among women is the accepted norm among certain populations. In fact, knowing more than the conventionally-accepted minimum amount of knowledge is considered inappropriate, if not scandalous. Men are often deemed omniscient in this domain; women are expected to be their innocent, ignorant counterparts (Müller, 2005). In cultures where such ignorance or innocence is expected, women who acquire sexual education and then attempt to negotiate sexual practices face an extreme cultural challenge (Carovano, 1992 in Gupta, 2000). This knowledge is considered suspect by their partners and they may be accused of infidelity. HIV program designers must account for the reality that women cannot simply act on the safe sex education they receive. Both women and men appear to subscribe to the belief that women should fulfill the stereotypical role of being docile and passive, especially in sexual relationships (Kalichman et al., 2005). In fact, delegates from 14 African nations in attendance at the First International Workshop on Women and AIDS in Africa stated that:

> *Forces ranging from early childhood training to state laws governing marriage, divorce and property rights, prepare women to defer to their male partners, not to instruct or oppose them... especially in the context of marriage.* (Mahmoud, de Zolduondo, Zewdie, Williams, in Ulin, 1992, pg 62).

An article by Nyanzi, Nyanzi, Wolff and Whitworth (2005) describes the traditional role of paternal aunts, known as *ssengas*, who are responsible for instructing young women about gender role expectations from adolescence through marriage; namely, to obey their male partners, follow their husband's lead in the bedroom and never deny their husband's sexual demands. Recently, the influence of *ssengas* has come under fire from contemporary debates generated in response to HIV, but their philosophies of female subservience still resonate with societally-expected gender-specific behavior.

The power differential characterizes attempts at discussion of safe sex practices as well. Women's initiation of a discussion of safe sex may cause partners to question the women's

sexual history or fidelity (Kalichman et al., 2005). Some women were afraid that their partners might suspect that they learned about these practices from outside partners (Nyanzi, Nyanzi, Wolff and Whitworth, 2005). Fear of being perceived as promiscuous or untrustworthy by their partners are often immediate grounds for women to forego discussing condom use (Haram, 2005). Women who venture to discuss condom use may be beaten by their partners, who label them as whores (McGeary, 2001). Hence HIV education and awareness programs that advocate safe sex practices but target only women may jeopardize the social position and reputation of intervention participants.

African women are often educationally and economically disadvantaged compared to their male counterparts (http://www.fao.org/sd/EXdirect/EXan0016.htm). Transactional sex is practiced by young women who migrate to urban areas and are economically driven to be involved with older, financially stable and often married men. This practice is definitively different from prostitution. The older men are referred to as 'sugar daddies'; these relationships are perceived as necessary for young women in their pursuit of independence and economic freedom (Haram, 2005). The risks associated with this kind of relationship are manifold: older men tend to have had more partners and therefore exposed to greater risk of HIV and other STIs. These relationships often result in unwanted pregnancies, infant mortality and higher instances of adolescents getting married (Heise and Elias, 1995). This unbalanced relationship result in the women's inability to negotiate the terms of their exchange, and translate into a pronounced sexual power inequity that prohibits women from having control over their sexual practices, including negotiating condom use.

Further evidence that the power differential often results in greater prevalence of HIV is the fact that women who live in parts of West Africa, which to date experience lower incidence rates of HIV/AIDS, may act upon their rights as women: they may refuse sex in the context of marriage, they tend to be more economically independent, and also

continue their ties and support with their family when married (Müller, 2005). Historically, West Africa cultivated their pre-colonial urban districts with a market sector dominated largely by women (Nyanzi, Nyanzi, Wolff and Whitworth, 2005). Similarly, the Yoruba women of Nigeria who tend to be financially independent also experience greater success declining sexual activity without violent retaliation. Another key advantage these women have is their families, who welcome them back in the event of conflict or other such events (Heise and Elias, 1995).   These circumstances further support the hypothesis that such rights enable women to better control their sexual practices, and therefore protect themselves from HIV or violence from partners.

The limitations of condom promotion

In disseminating health education messages, health workers often assume that their audience share their same values and that the audience consequently will interpret their health messages as the messages are intended. This assumption results in inevitable, though not necessarily insurmountable, gaps in frameworks between the health professional and the target population. Interventions are often designed without recognition of the community's own value system. Introducing new concepts and practices may further deepen the gap since these innovations are foreign, potentially meet with resistance, and may symbolically conflict with the population's existing value system. An example of a new and foreign innovation is the condom, widely touted by the Western medical community as one of the foremost life-saving HIV prevention devices. However, Ulin (1992) discusses the fact that the condom is in direct conflict with many African families' values of fertility and reproduction: "… a woman's fertility means status, self-esteem, and having offspring who will survive beyond infancy" (pg 67). Therefore, she states, "the greatest deterrent to the use of condoms may be their contraceptive effect" (pg 68). She attributes the lukewarm success of family planning programs in sub-Saharan Africa to the overpowering social and cultural expectations of fertility. Women who want to

continue to bear children yet also want to protect themselves from HIV and other STIs face a harsh dilemma, referred to in the literature as the "condom dilemma" or the "fertility-conundrum" (Müller, 2005, pg 27). At risk of losing face or the respect and honor associated with womanhood amongst their family and communities, many women choose to continue to have children over facing the consequences of unprotected sex (Gupta, 2000).

Ultimately, across nearly all cultures, condoms symbolize a lack of intimacy, trust and fidelity, all of which threaten the sanctity and stability of a relationship. Condoms are even interpreted as a direct assault on a man's masculinity. A popular cultural norm found in many cultures equates manhood with high numbers of sexual conquests (Campbell, 1995). Condoms are also associated with illicit sex such as in relationships with women "'of the street, not the home,'" (Gupta and Weiss, 1993, pg 403) and therefore do not have a place in the home. The suggestion of condom use may be threatening in the initial phases of a relationship; sudden suggestion of condom use mid-marriage or in the midst of a "monogamous" relationship presents even more opportunity for confusion and controversy. This is further evidence that female-controlled barrier methods must be available and acceptable to women.

Given the dual dilemmas of the condom as a male-controlled barrier and as a contraceptive, education about and dissemination of female-controlled barriers to HIV infection are crucial. Current technological advances aim for vaginal microbicides that can prevent transmission of HIV and sexually-transmitted diseases; these microbicides also come in both spermicidal formulae and nonspermicidal, therefore circumventing the concern for fertility amongst African women (Minnis and Padian, 2005) .

HIV prevention may not be a priority

As stated earlier, many women will engage in 'transactional sex' in order to gain material goods, money, shelter and other resources. For some of these women, especially those who are mothers, a longer-term health concern such as HIV is secondary to survival needs such as providing meals for their children for the week. Preventative health is often seen as a luxury, and while those of us who can afford to engage in preventative health do so, immediate needs must be addressed first when survival is on the line. Essentially, perceptions of risk may be skewed for individuals for whom futures are bleak: individuals in depressed economic situations must conduct cost-benefit analyses on a regular basis to secure their shorter-term financial and material security (Fenton, 2004). Under certain circumstances, financial or material benefits, however short-term, outweighs the less tangible cost of contracting HIV. Preventative health interventions are thus introduced in the face of this conflict of interest.

As illustrated by this discussion of disempowering gender norms, a very clear differential exists between the male's domain of control and the female's. The combination of these norms and the power differential is a critical obstacle to HIV prevention efforts. HIV interventions must involve a multilateral effort through navigating around or "relaxing" these norms, and empowering women at the same time.

Relationship between HIV and Intimate Partner Violence (IPV)

IPV is manifestation of power differential

Intimate partner violence is discussed in this thesis because it is not only highly correlated with HIV, but it is also the ultimate manifestation of the gendered power differential. The high prevalence of IPV around the world "serves to maintain this unequal balance of power" between women and men (Watts and Zimmerman, 2002, pg 1232). Intimate partner

violence was recently recognized as an international health problem and a violation of human rights (Heise, 1996). General violence against women, also referred to as gender-based violence, recently emerged as a public health issue worldwide. It is described as a "serious violation of human rights" and a "risk factor for many physical and psychological health problems." (Watts and Zimmerman, 2002, pg 1232).   The World Health Organization defines domestic violence as ''the range of sexually, psychologically and physically coercive acts used against adults and adolescent women by current or former male intimate partners'' (WHO, 1997, p. I-3).   Instances of intimate partner violence have been charted by over 50 population-based surveys worldwide, documenting that between 10% and 50% of women who have ever had partners have experienced physical assault by an intimate male partner (Watts and Zimmerman, 2002). Surveys conducted by Neft and Levine (1997) in a report titled, "Where Women Stand: An International Report on the Status of Women in 140 Countries" reported the following on the percentage of women who have reported physical abuse by a male partner between 1986-1993: Tanzania: 60%; Uganda: 46%; Kenya: 42%; Zambia: 40%; and United States: 28% (Bowman, 2003, 476).

However, within the scope of this paper, it must be noted that the sociological context of the gendered power differential does not necessitate that intimate partner violence will ensue. That is to say, specific circumstances are at play that move the power differential along the continuum of aggression into actual acts of violence.

The causes of intimate partner violence are unclear and/or often disputed. Poverty, patriarchal societies, alcohol abuse, unemployment – these and other factors have been cited as possible causes of intimate partner violence for decades (Jewkes, Levin and Penn-Kekana, 2002). An ecological framework devised by Heise (Jewkes, Levin and Penn-Kekana, 2002) describes factors on personal, situational and socio-cultural levels of a social environment. Examples of factors on the individual level include: experiencing child abuse,

growing up with marital violence; family-level or relationship-level factors include alcohol consumption and family conflict inspired by male-dominated control of wealth and decision-making; factors occurring at the community level include poverty, unemployment, forced isolation of the woman from friends and family; societal level factors are patriarchal societies and ideals of masculinity associated with dominance and aggression (Jewkes, Levin and Penn-Kekana, 2002). In this paper, I will argue that poverty and the power differential between women and men play definitive roles in engendering intimate partner violence in sub-Saharan Africa. Poverty is a disempowering experience for all who are subjected. Some theories suggest that poverty is emasculating for men for whom "successful" manhood cannot be achieved (Jewkes, Levin and Penn-Kekana, 2002) – perhaps through the failure to gain material attainment, financial security or vocational achievement. A "crisis of male identity" thereby occurs; men may often resolve this crisis of their masculinity by exerting control over women, often through violence (Jewkes, Levin and Penn-Kekana, 2002, pg 1424).

The following diagram is a simplified adaptation of a chart developed by Jewkes< Levine and Penn-Kekana included in their 2002 article on risk factors for intimate partner violence in South Africa. The crisis of male identity, low social value of women and societal perceptions of women as targets of punishment are examples of the illustrations of ideologies of male superiority.
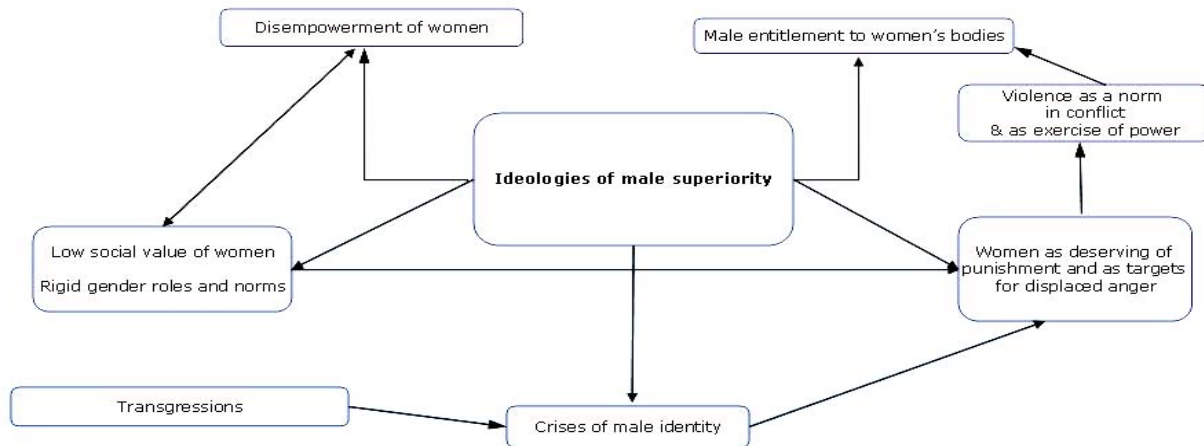
Figure 1: Causation of intimate partner violence. (Jewkes, Levin, Penn-Kekana, 2002)
Ideologies of male superiority are illustrated by the crisis of male identity, low social value of women and societal perceptions of women as targets of punishment.

Intimate partner violence is an extremely elusive problem, both as an area of research and with respect to designing interventions. Internationally, the task of identifying intimate partner violence is further complicated by different cultural norms and practices with varying beliefs of what constitutes violence and what is considered "acceptable" violence. In some cultures, violence is simply a fact of life, even an indicator of "spousal affection" (Human Rights Watch, 2003, pg 40) and is challenging for some women to tease apart the violence from other aspects of their marital life (Human Rights Watch, 2003). IPV is often under-reported by victims, if reported at all. In the United States, 50% of IPV victims at most report the violence to the police, whereas Human Rights Watch Africa report rates of reporting at 6% in South Africa (Bowman, 2003). Spousal rape and intimate partner violence have traditionally been perceived as a 'private' domestic issue between man and

wife, in which states should not meddle (Heise, 1996, pg 13). Further, as Fonck et al. (2005) state, "Cultural acceptance of gender based violence in general and partner violence in particular may be another factor of under-reporting" (pg 338): at best, reports by women who experience intimate partner violence are met with indifference from the rest of society (Human Rights Watch, 2003). Shame, protection of the perpetrator, fear of a backlash of violence, and the expectation of no action by law enforcement are only a few of the reasons why women may not report incidents of partner violence (Bowman, 2003). Further, Western ideas of protecting oneself when one's welfare is jeopardized by a spouse do not necessarily translate around the globe. Feminist values that strive for equality between women and men are often perceived as anti-male, anti-family and anti-tradition, especially in areas within Africa where "community and family are valued and recognized far above individual rights" (Heise, 1996, pg 24).

The notion of women as purchased property in many African marital traditions (bought for a "bride price") helps to illustrate the context of intimate partner violence. This transactional practice often leads the husband to feel as though he owns the wife and can do with her as he pleases, including beating her when he is displeased with her in some way. The practice not only makes it very difficult for woman to leave the marriage to escape the abuse of a spouse, but also difficult for families unwilling to welcome daughters home and therefore return the "bride price" to the husband (Bowman, 2003).

According to Dunkle et al. (2004), no single standard exists for measuring the severity of IPV. Because violence against women is somewhat the norm in many cultures throughout the world including sub-Saharan Africa, it is difficult on the part of study designers to define or describe "coercion" in a manner that will be understood by participants as intended. The nature of the relationship between the abuser and the abused further augments the complexity of this problem; for example, women who have been abused do not necessarily

want their partners to face imprisonment or court. Added complexity and ambiguity exist within the areas of emotional abuse and psychological abuse. Not only are concepts and definitions of sexual and psychological abuse inconsistent around the world, both types of abuse are often difficult to quantify, and prove.

Interaction of IPV and HIV

The co-occurrence of IPV and HIV infection is a comparatively new area of research that has been investigated in the United States and throughout the world. Relatively few data exist on this interaction in countries exclusively in Africa. For purposes of developing this section, I will draw on studies from both the US and Africa.

Studies suggest that violence and IPV in particular, are determinants of women's HIV risk. A study by Dunkle et al. (2004) of South African women concluded that intimate partner violence was associated with "increased likelihood of HIV risk behavior, including having multiple partners, having non-primary partners, engaging in transactional sex, and having problems with substance use" (pg 1419). This increased likelihood of high-risk behavior results in part from the theory that abusive men are more likely to be seropositive and often impose risky sexual behaviors on their partners (Dunkle et al., 2004).

Studies that were collected and reviewed by Maman, Campbell, Sweat and Gielen (2000) on women in both the United States and in South Africa investigated the correlation between HIV and IPV. Their review also described the three mechanisms by which intimate partner violence leads to increased risk for HIV: (1) forced or coerced sexual intercourse with a partner who is HIV-positive; (2) affecting women's ability to negotiate safe sex using condoms or other means; and as aforementioned, (3) the evolution of a pattern of sexual risk-taking behavior among women who experienced childhood or adolescent sexual abuse. Their study makes reference to Wingood and DiClemente (1997), who conducted research

in an African-American community in San Francisco in which women with abusive partners received threats of abandonment and physical abuse when they suggested condom use with their partners.

Research conducted by Koenig et al. (2004) with women in rural Uganda further support this correlation between IPV and elevated risk for HIV with this finding on risk perception: "women who perceived their partner to be somewhat or very likely to be at risk of HIV were significantly more likely to report sexual coercion, relative to the reference category of not at all/ unlikely (OR=2.32 and 2.89, respectively)" (pg 792). Therefore, an additional risk factor for IPV is *perception* of risk associated with a partner's serostatus: there is evidence that women who perceive a high risk of HIV in their partners refuse to have sex with them, and therefore report more instances of coercive sex after refusal (Koenig et al., 2004). They also referred to a study in Sierra Leone, where the perception by the female partner's perception of likely risk of AIDS through exposure with her partner was highly related to reports of coerced sex (Coker & Richter, 1998).

Although the hypothesis that intimate partner violence is a risk factor for HIV/AIDS has not been universally supported by studies, research does support the inference that IPV jeopardizes the ability in women to negotiate condom use, and that therefore, IPV is an indirect risk factor for HIV. In their study with South African women in Cape Town, Kalichman et al. (2005) observed that women who had been sexually assaulted are less likely to suggest the use of condoms with their sex partners.

However, other studies provide conclusions that conflict with the theory that women who have experienced abuse are less likely to negotiate condom use: work conducted in South Africa by Jewkes et al. (2003) suggested that women with histories of abuse are 1.5 times more likely than women who have not experienced abuse to insist upon condom use. A possible explanation of why abused women are more likely to suggest using condoms is that

women "who have experienced physical violence in the past may find it harder to trust men and more difficult to be terribly intimate again" (Jewkes et al., 2003, pg 131).   They conclude this section by suggesting that the argument of the gendered power differential as an obstacle for women to protect themselves against HIV is over-reductionist; there are many factors at play in the relationship between IPV and HIV.

The study conducted by Kalichman et al. (2005) among women and men in Cape Town determined that characteristics in the male partner are predictive of a female partner's increased risk for STIs or HIV. These particular characteristics include gender attitudes and "rape myth acceptance," which is described as "attitudes that may promote sexual violence" (Kalichman et al., 2005, pg 300). Their findings urgently demonstrate the need to develop HIV interventions that target men in order to modify their sexual attitudes, beliefs and behaviors.

The association between HIV and IPV has been documented in the "other direction," as well: women who are seropositive are at greater risk for IPV. A study in Rwanda indicated that the positive HIV serostatus of the woman, but not the positive status of the male partner, was "associated with a significantly increased likelihood of sexual coercion" (van der Straten et al., 1998). Disclosure of positive HIV serostatus by a woman to her male partner may lead to increased frequency of IPV. According to a study conducted in Baltimore by Gielen, McDonnell, Burke and O'Campo (2000), both women who experienced abuse before disclosure of their serostatus, as well as women who had not, experienced intimate partner violence upon sharing this information with their partner. Receiving news of one's positive serostatus is traumatizing on its own; the anxiety of disclosing this to family and lovers augments the trauma. Hence, any abuse or violence that ensues after such disclosure is deplorable. This is reason for further research into providing support to HIV-positive individuals and their loved ones during the process of disclosure.

As is evident by the research presented above, an actual direction of causality between HIV and IPV has not been universally established. The argument of linear causality between the gendered power differential and increased risk for HIV may also be too reductionist an approach. Despite the ambiguity of direction in causality and contradictory findings, research on the intersection of these two events suggests that IPV and increased risk for HIV are strongly associated.   These are definite grounds for additional research.

Raising societies' awareness of IPV

Efforts to enact domestic violence codes have been successful in the legislatures of at least South Africa and Mauritius (Bowman, 2003). However, enforcement of such laws is challenging. The depressed economy of many sub-Saharan countries do not compensate law enforcement well, nor are law enforcement officers provided with sufficient training on domestic violence issues. Further, the predominantly chauvinistic culture of law enforcement does not advocate on behalf of the woman abused; an example of this is of officers being paid off by the abuser to drop a case (Bowman, 2003). Finally, the enactment of legal measures to protect women who experience domestic violence does not necessarily change deeply-embedded cultural notions of gender relations. "Disciplining" of a wife is the norm accepted by *both* women and men in some African communities. A women's survey conducted in Ghana by the International Federation of Women Lawyers revealed that although in theory, a culture or tribe does not tolerate that a man beat his wife, a husband's behavior is only considered to have violated the norm if his beating his wife resulted in a scar or serious injury (Bowman, 2003). Hence, intimate partner violence is often considered normative behavior and not perceived as criminal unless serious injury ensues.

Intimate partner violence is not considered criminal on many levels of society. There is a lack of infrastructure through which dialogues or reports of IPV may be brought forward by women. Dipak Naker, co-director of Raising Voices, a non-governmental organization in Uganda which works to prevent violence against women and children, states: "'We need to develop an opinion structure. Right now women are isolated. They need an infrastructure that condemns the violence'" (Human Rights Watch, 2003).

Non-governmental organizations such as Raising Voices, human rights groups and legal organizations throughout Africa have been mobilizing to bring intimate partner violence to the attention of the government and to the public. In addition to advocacy, these organizations also provide women with resources such as counseling and legal assistance. The mission of the Musasa Project, an organization in Zimbabwe, is empowerment of women through education and counseling, as well as collaborating with other agencies working on violence issues (Bowman, 2003, pg 484). Musasa has done seminal work developing a unique program of working closely with the legal system and training law enforcement officials and prosecutors on domestic violence issues (Stewart, eds. Zeidenstein and Moore, 1996). Their training sessions have encouraged open discussion among male and female officials on issues of rape and intimate partner violence, which often evolved into sessions in self-evaluation and self-criticism - coinciding with one of Musasa's core objectives of catalyzing change in behavior and attitudes from within. EngenderHealth, a US-based international non-profit organization, started the Men as Partners (MAP) program in South Africa in 1998. MAP recognizes that men, whom the power differential often favors, should be involved more actively in risk reduction or violence prevention interventions. MAP engages men in interventions to teach fellow men behaviors in HIV risk reduction and to recognize and stand up against intimate partner violence (http://www.engenderhealth.org/ia/wwm/wwmds.html).

In acknowledgement of the profoundly community-oriented nature of African society, the capacities of these communities must be involved in IPV interventions. In many rural areas of sub-Saharan Africa, the influence of government law is limited. These areas are essentially governed by tribal and village leaders whose counsel bears far more weight and influence on local communities' lives. Interventions must value the authority of these leaders, possibly including them as mediators in domestic conflicts and disseminators of messages against intimate partner violence (Bowman, 2003).

Recommendations

Empowerment is key in HIV and IPV interventions

> In the light of the continuously changing biological and social context of HIV/AIDS we need to work towards an approach which gives women the tools they need, and enrolls them as strategists. (Susser, 2002, pg 48)

Ultimately, empowerment must be introduced as an underlying focus in all health interventions directed towards women (Amaro, 1995). Nearly all studies on women and HIV/AIDS prevention have stressed that empowerment of women must be at the heart of interventions and not remain at the sidelines. The trying circumstances of poverty already have disempowering and defeating effects upon women (St. Lawrence et al., 1998): women who are disempowered in other facets of life may maintain abusive relationships, which only further perpetuates the cycle of disempowerment. The utility of and urgency for empowerment transcends far beyond the realms of HIV protection and prevention. According to the literature, common "proxy indicators" of women's empowerment include: a woman's level of education, employment status/history, a woman's age at marriage, and the age difference between the woman and her spouse (Schuler, Hashemi and Riley, 1997, pg 564). Schuler, Hashemi and Riley (1997) recommend using other indicators for

women's empowerment, which encompass empowerment on many levels of a woman's status: "freedom of mobility, economic security, ability to make small and large independent purchases, participation in important family decisions, relative freedom from domination by the family, political and legal awareness, and participation in political campaigns and public protests" (pg 564).

The introduction of devices such as the female condom and substances such as microbicides has great potential for empowering women to protect themselves without dependence on the compliance of men (Minnis and Padian, 2005). With proper awareness and dissemination of these life-saving measures, women will be better armed to protect themselves. Microbicides that are nonspermicidal, as discussed earlier, have great potential as life-saving devices that will not interfere with a woman's ability to bear children. These interventions, however, must be accompanied by behavioral modification interventions directed towards men to help modify their sexual practices and attitudes. Otherwise, female-controlled protective methods introduce the concern that men are freed of their responsibility to their partners (Campbell, 1995).

The intent of this paper is not to paint a picture of African women as disempowered, victimized individuals. Rather, it is to discover and demonstrate their capacities, as well as their potential for promoting themselves and protecting themselves. However much women may be socially and economically disenfranchised in many African societies, particularly by Western standards, their existence and capacities must not be discounted. One such capacity comes from the informal groups of women, particularly amongst rural populations in Sub-Saharan Africa. As noted by Ulin (1992), women in these groups provide support and solidarity for one another. These networks have the potential to quickly disseminate messages around health and the like. For example, sexual health education may be encouraged in environments such as these, which may be safe,

supportive and empowering. Just as gay communities in the 1980s rallied together to educate their own and thereby alter sexual norms, the shaping of norms may start from within these informal enclaves, and through a ripple effect trickle outwards through all levels of society.

Capacity-building efforts of individuals are integral to the forward movement of preventing HIV and eradicating IPV. As stated by Heise and Elias (1995), "until women become part of the dialogue that establishes policy and distributes resources [to promote gender equity], women's issues will remain vastly underattended" (pg 939).

Initiatives for economic enhancement

Many women are forced to remain in abusive relationships due to financial dependence on male partners. Women are also often forced into transactional sex, exchanging sexual favors for financial support or employment. Opportunities to enhance the economic situations of women are therefore critical, not only to break the cycle of intimate partner violence but also the cycle of engaging in high risk sexual behavior out of necessity. One such genre of projects in economic enhancement is microfinance. Microfinance is described as "the provision of financial services (savings and credit services) to low-income people" (HIV/AIDS and Microfinance, Interagency Coalition on AIDS and Development, pg 1). In the past decade and a half microfinance services have grown popular as initiatives to help people in developing countries to help themselves. Many microlending banks have established micro-credit lending practices to women, not only because women are purportedly more trustworthy in their loan repayment, but also as part of an effort to empower women (Hashemi, Schuler, Riley, 1996). These loans are intended to support clients in income-generating activities in the informal sector: street vending, artisanal work and small farming ventures.

Studies on microfinance institutions (MFIs) and their impact on women have generally shown very favorable results. The Grameen Bank and Bangladesh Rural Advancement Committee (BRAC), both in Bangladesh, are two notable examples of MFIs that have empowered women on many levels. Participants have been drawn out of their homes to attend meetings, thereby cultivating an identity outside of the home; their economic roles have been strengthened; they are better able to contribute to their families' welfare; and they are more involved in the household decision-making process (Hashemi, Schuler, Riley, 1996). Further studies suggest that involvement in these programs also decrease women's vulnerability to intimate partner violence (Hashemi, Schuler and Riley, 1996). Presence of a micro-credit program and the progressive empowerment opportunities it affords results in positive effects on the village through "diffusion": research by Schuler, Hashemi and Riley (1997) suggests that a micro-credit program's existence in a village affects certain family planning behaviors and norms throughout the village amongst credit members and non-members alike. Ultimately, as more women adopt family planning practices, psychosocial and cultural opposition to these practices may fade gradually. These studies give hope to the prospect of initiatives like MFIs impacting gender norms and sexual practices in villages throughout sub-Saharan Africa.

The structure of many microfinance institutions lend themselves to being ideal hosts for disseminating prevention information for HIV/AIDS. Microlending practices such as the Grameen Bank and BRAC require that women organize themselves into groups; the group as a whole is responsible for each group member's loan repayment (Hashemi, Schuler, Riley, 1996). By creating partnerships with local HIV/AIDS specialists and arranging for them to meet with MFI clients, this group setting is ideal for holding prevention education programs (Parker, 2000). In Uganda, the Foundation for International Community Assistance (FINCA) partnered with the Church of Uganda Doctors to teach sessions on HIV/AIDS awareness throughout the village banks. Other MFIs integrate both business

and health education essentially under the same roof. The Foundation for Credit and Community Assistance (FOCCAS) is one such organization in Uganda that applies a Freedom from Hunger-supported strategy called "credit with education." Weekly village bank meetings hence cover topics in better business and health.   A program started in South Africa called IMAGE, or Intervention with Micro-finance for AIDS and Gender Equity, targets women exclusively in high poverty areas (Pettifor, Measham, Rees and Padian, 2001, pg 2002). IMAGE combines a microfinance program with a participatory learning program called Sisters for Life (http://www.comminit.com/experiences/ pdskdv82003/experiences-1589.html). The region's poorest women are identified and invited to participate in this program. Through these programs IMAGE hopes to impact the environment not only social norms and community-level responses to poverty, but to HIV and gender-based violence, as well (http://www.sarpn.org.za/mitigation_of_HIV_AIDS/m0025/index.php).

The JEWEL Project conducted in Baltimore by researchers at Johns Hopkins was built around an income-generating project for its participants in combination with HIV education (Sherman et al., 2006). This project, targeted at a drug-using female population, aimed to increase self-efficacy in legal employment as well as self-efficacy in risk reduction. Its success with reduced rates of illicit employment and reduced high-risk sexual and drug-related behaviors, demonstrates the empowering and educational potential of small-scale, income-generating ventures.

Economic empowerment initiatives cannot be used indiscriminately as a panacea for women, however. Economic inequality between a couple when the woman, and not her male partner is the wage earner, may inspire resentment in the male partner, which may result in her increased risk for intimate partner violence (Jewkes, Levin and Penn-Kekana, 2002). Koenig et al. referenced a Zimbabwean study which found that "women who were

married and women who had their own income were both at increased risk of sexual coercion" (Watts et al., 1998).

Studies on initiatives for women's economic independence claim that social empowerment ensues as a direct result; however, other studies stress that economic empowerment does *not* translate into an ability to overcome barriers to sexual equality. The study conducted by Nyanzi, Nyanzi, Wolff and Whitworth (2005) on marketplace-working women in Southwestern Uganda demonstrates that economically empowered women not only have their own share of problems in relationships, but also face the same barriers in the bedroom as non-working women. Most notably, these market women attract many more men than non-working women because men are not financial obligated to their working partner. Additionally, men who formerly contributed to the household withdraw their contributions once women begin to earn an income; women also cited instances where their male partners would grow completely financially dependent upon the woman's income. Ultimately, through working these market women do exhibit greater assertiveness in the public domain, experience increased mobility, become involved in the exchange of information, and have increased bargaining power in the marketplace. They are called *kiyagi*, a term which is traditionally used to describe masculine qualities: to be independent, self-reliant, even insubordinate (Nyanzi, Nyanzi, Wolff and Whitworth, 2005). This term embodies a combination of both derision and begrudging admiration for the drive of these women. In a similar vein of labeling, economically independent women were referred to as *nakyeyombekedde*, which translates into "I built my own house" – which not only implies the same masculine qualities as *kiyagi*, but also bears the connotation that the woman's purported vocation in prostitution enabled the construction of this house (Nyanzi, Nyanzi, Wolff and Whitworth, 2005). This study suggests that empowerment initiatives for women should focus on community-level social advancement of women in addition to economic enhancement.

Ultimately, economic empowerment offers women options for leverage and self-protection, and greater potential for an exit strategy. In addition, greater social empowerment may result for women who gain economic independence. This form of empowerment is gained through "social networks, self-confidence and an ability to utilize sources of information and resources available in society." (Jewkes, Levin, Penn-Kekana, 2002, pg 1612). Additionally, these micro-financing initiatives have the potential to raise the income level of an entire community, gradually offsetting its original impoverished status.

Integration of HIV prevention and screening for IPV

According to a male peer educator of the group Men as Partners in South Africa "'it is impossible to talk about HIV/AIDS without talking about domestic and sexual violence,'" (WHO, 2004, pg 1). As was described in the proceeding sections, risk of HIV and risk of IPV often co-exist in many women of sub-Saharan Africa: the prevalence of one condition often results in the emergence of the other. HIV prevention and screening for IPV should therefore be considered in the same breath. Maman, Campbell, Sweat and Gielen (2000) suggest that private, one-on-one VCT sessions are a good opportunities for individuals to be screened for childhood or current instances of violence. The results of this combination of services are two-fold: (1) women who are currently experiencing violence in their relationships may be referred to services that deal with IPV; (2) women who experience history of abuse may be identified as being at higher risk for HIV. Screening for IPV during a VCT session is particularly relevant for women whose disclosure of their positive serostatus might incite further violence: upon being screened for violence these women may even be counseled against HIV serostatus disclosure.

Work by Gielen, McDonnell and O'Campo (2002) supports the concept that risk reduction interventions should be coupled with an assessment of the woman's risk for IPV. This concern is especially relevant to the population of interest, given the potential for violence

associated with participation in HIV education such as knowing more about safe sex and HIV than a woman "should." Amaro (1990) suggests that interventions should consider not only the women's history of violence in their current relationship, but also in relationships over the course of their lifetime.

A study by O'Campo, McDonnell, Gielen, Burke and Chen (2002) revealed that health care workers do not play enough of a role in assisting women in situations of intimate partner violence, and therefore should play a greater one upon receiving training to screen effectively. Another study conducted by Glass, Dearwater and Campbell (2001) concluded that general screening for intimate partner violence of all patients in a healthcare setting does not offend women who have not been abused – which had been, and in some areas may continue to be, an ethical concern. Hence it is recommended that health centers screen all women for IPV during their visit, preferably when the patient is alone and not with family or possibly the abusing partner.

Health communication may influence socio-cultural norms

However much norms are embedded in the identity of different cultures, those norms that antagonize, ostracize and oppress women are leading to their increased risk for HIV, and therefore, their general peril. Education must continue to play a vital role in dispelling myths and mis-information about HIV, its transmission and its victims.

Gender-specific health education campaigns should continue to target women, but educational interventions targeting men and adolescents (both girls and boys) are equally, if not more, important. Initiatives that target couples should promote not only communication between partners, but also the responsibility parents or spouses have to their family (Gupta and Weiss, 1993). Another crucial type of message must target families whose daughters become, or are, married. A widespread cultural practice in many developing countries is the rejection by families of women who have been raped or whose

serostatus has been determined positive (Heise and Elias, 1995). Abandonment and severing of ties with family especially in times of marital crisis are traumatizing: according to Mooney's study as described by Kelly (1996), women often turn to their family first for support when abused. Rejection by family often forces women into prostitution as a survival strategy. An organization in India called Jagori urges family members to modify their behaviors and be supportive of their daughters in instances of intimate partner violence which traditionally bring shame upon the family. There is a clear need for developing the social support networks of women, both single and married, who experience intimate partner violence. The support of a broader-base of people may not only better solace for the individual woman but also helps create an environment that does not tolerate violence (Heise, 1996).

Local health professionals are in influential positions for cultivating healthier attitudes towards HIV and sexually transmitted infections. Research conducted by Muturi (2005) refers to feelings of intimidation and stigma experienced by individuals who get tested for HIV or sexually transmitted infections: "They treat everyone who comes to the clinic with a VD [venereal disease] as if she is a prostitute. I don't want them to think I am a prostitute because I am not. I don't think I can go back there." Participatory communication is encouraged, in which communities and health professionals together are engaged in the development of HIV/AIDS interventions. Another key segment of the community are traditional healers, whose counsel and service continue to be in great demand in many communities; given their position of influence and cultural significance to the community, their services may be integrated into the development of community-wide HIV preventions (Mtshali, 1995). Strategies in participatory communication have been applied in development programs (UNDP, 1993 in Muturi, 2005).

Voluntary counseling and testing (VCT) has and should continue to be encouraged for women and men alike. However, counseling and support for individuals who test positive

must be greater emphasized during VCT. HIV positive individuals who commit this service to themselves and to their communities often face overwhelming stigma, discrimination and violence from their families upon disclosure of their status (Gupta, 2000). These repercussions are conceivably enough of a reason not to get tested.

Local non-profit organizations advocating against family violence and for HIV prevention can be found throughout sub-Saharan Africa. The capacities of these organizations must be built continually, as should coalitions with health agencies and law enforcement. The Ugandan organization Raising Voices published a program tool called *Mobilising Communities to Prevent Domestic Violence: A Resource Guide for Organisations in East and Southern Africa*, which is available free on the internet may be used as a resource (http://www.raisingvoices.org/
publications.php). Projects such as the aforementioned MAP program and Musasa Project must also be recognized as model programs, and considered as templates for other programs throughout Africa.

Finally, although legal reform on the governmental level is crucial, it does not transfer into rural areas of Africa where the law of tribal leaders prevails: "Almost invariably men, tribal leaders are rural Africa's cultural arbiters" (LaFraniere and du Venage, 2005). Hence, involvement of community and village leaders is crucial, not only in mediating domestic conflict, but also in the development of HIV interventions, particularly when introducing normative behavior (e.g., staying monogamous) that may go against the traditional grain.

This is further evidence that HIV and IPV interventions must take a multi-pronged approach: intervening on the individual level as well as at the level of the community. Fortunately, increasing recognition by the global community of the need for community-based participation is apparent in both research and in the structure of interventions.

Expansion of male-oriented and partner-based interventions

The orchestration of partner-based interventions is challenging because willingness to participate is necessary of both parties. Partner-based interventions may encounter the challenge of open communication between both partners, which may be hampered by the fact that certain behaviors of one partner are clandestine and kept secret from the other. Men often engage in clandestine drug use, an activity that is often reserved for sharing with other males unbeknownst to their female partners (Campbell, 1995). For obvious reasons, this activity and involvement in extramarital affairs are not always behaviors shared readily between partners.

Although this paper has focused on the influence of gender norms upon women, these norms also have detrimental effects on men's health and impact their quality of life as well. Norms that encourage men to be all-knowing and self-reliant prohibit men from seeking more education. Gender norms that encourage, if not assume, promiscuity of men put them in further danger (Müller, 2005). Hence, there is a great need for interventions, targeted either at communities or at male populations or both, to recognize these norms as well.

In discussions of HIV risk, research on the gendered power differential merits exploration of men's perceptions of power and how this differential interacts with disempowering circumstances of unemployment, poverty or little education. An additional compelling question to be asked is, "Which men in which circumstances use their gender power advantage to reduce their risk of HIV?" (Jewkes et al., 2003, pg 132).

Macro-level changes in policy

Advocacy for property rights for women is an age-old battle. Property rights vary from region to region throughout sub-Saharan Africa: women were recently awarded property rights in Zimbabwe in 2005, as were women in Swaziland (LaFraniere and du Venage,

2005), but in many areas women continue to live without any property or inheritance rights. This situation oppresses women on multiple levels, in a variety of circumstances. Without property rights women cannot claim their own land, even the land they may have dedicated their lives to cultivating, and thus are dependent upon their husband's ownership of land. Many women are compelled to tolerate abusive relationships in order to avoid being kicked out of their husband's home. For some women, the fear of eviction from their homes is greater than their fear of violence. Although they suspect that their husband is HIV positive, women may not get HIV testing for fear of eviction; this fear is exacerbated by the threat of the husband accusing her of bringing HIV to the home and to him (Human Rights Watch, 2003). Low social status and limited decision-making ability make the actualization of property and land rights virtually impossible for women.

In areas of economic depression women tend to be less educated than men. Policy changes that create high standards for education of its people are necessary, and should enable women to receive as much education as men. Growne, Gupta and Pande (2005) suggest modifying education for school-aged girls: making school fees more affordable, building schools closer to where girls live, and developing school curricula that transform the sociocultural norms that favor one gender over another. Currently, literacy rates in sub-Saharan Africa hover at 47% for females (http://www.fao.org/sd/EXdirect/EXan0016.htm). Initiatives for literacy are crucial for raising the education levels of African women and thereby increasing their potential for gaining employment. Although equity in salaries between women and men is a separate issue from this paper, the cultivation of employable skills acquired through education would help achieve this. Secondary education is associated with lower fertility and mortality, better prenatal and maternal care, and lower risk of HIV/AIDS (Grown, Gupta, Pande, 2005). Although the relationship between the woman's level of education and her risk of intimate partner violence is not always proportional, women who have had more

years of education tend to experience less intimate partner violence as a whole (Jewkes et al., 2003).

Proposal for an intervention

The proposed intervention would be a multi-tiered effort targeting (1) the community at-large on intimate partner violence and (2) targeting smaller groups of women on HIV education, IPV safety enhancement, and raising literacy levels. The multi-tiered design is inspired by the structural-environmental intervention design, and selected to maximize the effectiveness of influencing social and cultural norms. Social norms, it has been stated, are "most likely to change at the environmental and structural levels, and with a change in the social norms comes a change in associated behavior" (Sweat and Denison, 1995, pg S253). Safer sex interventions experience greater success when applying structural level changes (Maman, Campbell, Sweat and Gielen, 2000). Primary prevention efforts in IPV also would have the greatest impact if implemented on a community-wide scale, given the need to educate parties in power such as men, tribal and community leaders and families.

The goal of the group-level intervention, called Empowerment and Literacy in the Fight Against Violence and AIDS (ELFAVA), is to educate the population about HIV/AIDS, inspire modification in the behaviors of women through activities that may lead to HIV risk reduction and expand their risk-reduction and possibly vocational skill set with an economic enhancing initiative. This component of the proposed intervention is closely modeled after the JEWEL project (Jewellery Education for Women Empowering their Lives), conducted in 2005 in Baltimore, Maryland, by researchers at the Bloomberg School of Public Health at Johns Hopkins (Sherman, German, Cheng, Marks, Bailey-Kloche, 2006). The target population of the JEWEL project was illicit drug-using women involved in prostitution. Based on the social cognitive theory, the project endeavored to increase their HIV awareness; elevate their efficacy in sexual and drug-related risk-reduction behaviors; expand their risk-

reduction and critical thinking skills; and increase their employment self-efficacy through

learning licit income-generating activities.

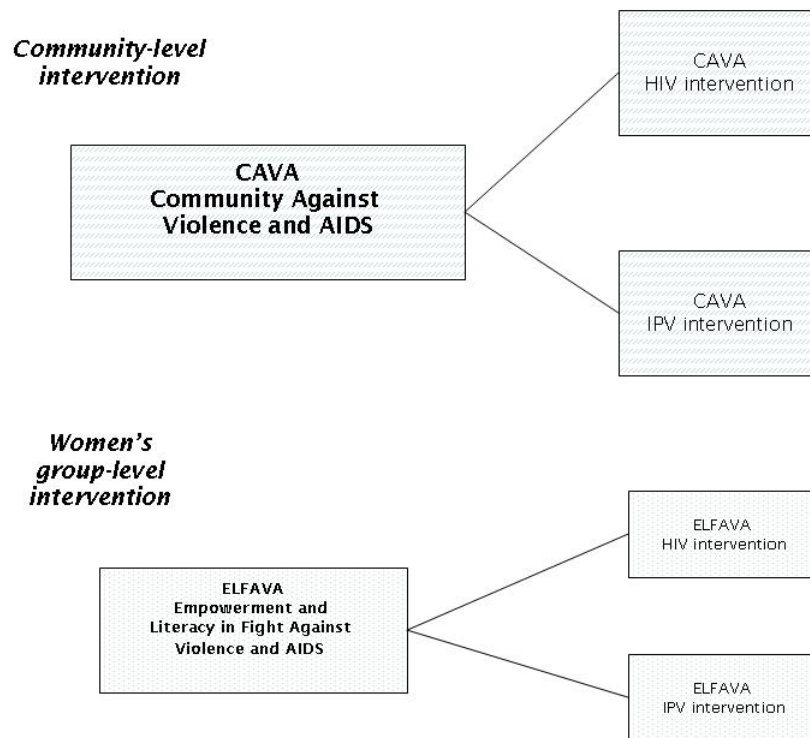The two tiers of interventions are illustrated in the diagram below:

Figure 2: The multi-tiered CAVA and ELFAVA intervention

The ELFAVA intervention is grounded in the ideology that empowerment in addition to

education are vital to an HIV intervention. The intervention will not only empower women

financially and with health information, but also increase their literacy rates and increase

their self-efficacy with general employment skills. Women who are illiterate will be taught

how to read and write, with those literate women assisting or tutoring the less literate of

their peers. Ultimately, they will be involved in a potentially income-generating activity in

which they will write fictional or personal stories about their lives, where they may reflect on

their experiences of family violence, risk of HIV, or poverty. These stories would eventually be collected and made into an anthology of personal stories and marketed to a global audience.

The Intervention focused on HIV: ELFAVA

The theoretical framework of the HIV intervention portion of ELFAVA will be loosely built on the social cognitive theory, which proposes that human behaviors are largely attributed to the environment (Glanz, Rimer, and Lewis , 2002). Given the challenges of their environment, this intervention recognizes that some of the behaviors of this target population reflect a lack of certitude or self-efficacy, and therefore aims to bolster self-efficacy. ELFAVA will modify their environment socially by creating a safe place for women to learn, both from interventionists as well as each other, to practice their skills, discuss new information, and perhaps create social bonds. This intervention may serve to strengthen already-existing social networks amongst the women in the community. Finally, over the course of the intervention, participants may gain competence in impacting the environment within their relationships, and their broader environment with their newly-developed literacy skills.

This intervention will assume that the target population has limited to no knowledge of how HIV is spread; therefore the initial phases of this intervention will be devoted to applying culturally-competent education. Cultural competence will include tailoring the intervention to the literacy level of the population, use of traditional means of dissemination of information such as dance and song, as well as sensitivity to the potential conflict that may arise between the values of the indigenous culture and the information that is presented.

Community health workers (CHWs) will play a crucial role in this intervention as emissaries of the community to the intervention team, as well as the voice and message-bearers of the intervention to the community. Their involvement will not only help pave the way between the foreign intervention team and the community, but also contribute to the sustainability of the project within the community. CHWs will be recruited from the more literate members of the community and trained extensively on HIV methods of transmission and prevention. CHWs will help inform the methods of the intervention and design the language of the messages that they will present to the rest of their community.

Discussion about sex is taboo in many cultures; consequently, discussion of HIV/AIDS is taboo. Both of these phenomena fuel beliefs in myths and perpetuate the stigma associated with HIV and people who are living with HIV/AIDS (PLWHA). These stigma obstruct an intervention's ability to help modify the behavior of participants (Bos, Schaalma, and Mbwambo, 2004). Hence, this proposed intervention will begin with small-group discussions amongst community members facilitated by CHWs on sexual practices, attitudes and beliefs, as well as their knowledge about HIV/AIDS.

Visual aids will be used extensively to educate the population which may have varying levels of literacy and education. Picture cards will be developed by the intervention with the help of CHWs to illustrate heterosexual contraction and transmission of HIV. The depiction of a hypothetical, basic path of transmission enlightens the audience in terms of increasing their perceived susceptibility to HIV as well as the effortlessness with which transmission can occur. Picture card presentations such as this should also serve to shatter certain myths about HIV. Such myths include ridding oneself of HIV (as a man) by sleeping with a virgin, or the myth that the woman is responsible for bringing HIV to the home, not the man. By describing the physical transmission of the virus, these presentations also aim to reduce the stigmatization of HIV/AIDS and people who live with HIV/AIDS (PLWHA). Additional means

of communicating HIV prevention messages are through culturally-appropriate methods such as skits, poetry, songs and dance.

The next phase in the education will introduce HIV preventative methods. Demonstration of physical barriers to transmission is vital to substantiate the fact that HIV is spread through physical, sexual contact and not through other traditionally-held beliefs such as spirits or curses or witchcraft. As was discussed earlier in this paper, use of male condoms relies heavily on the man's acquiescence and cooperation, and suggestion of condom use by the woman often incites negative, and sometimes violent, repercussions. Therefore, the crux of this intervention will focus on developing women's sense of their internal locus of control and learning to protect themselves using microbicides. The availability of spermicidal and non-spermicidal microbicides is particularly beneficial to women for whom child-bearing is an interest or priority. African women's culturally-embedded desires to bear children conflict with messages advocating condom use, and often supersede women's willfulness to protect themselves from HIV (Gupta, 2005).

Knowledge alone does not necessarily translate into adoption of health behaviors. As supported by the SCT, the women's education will be supplemented by the learning of negotiation skills and modeling. Although condom use is not the ultimate goal of this intervention, negotiation of safer sex practices is included to help increase women's self-efficacy with her partner. The activities in negotiation skill-building will be demonstrated by the CHWs. During the initial weeks of the intervention, demonstrations of negotiation skills will be performed by CHWs to the women. As the sessions progress, the demonstrations will model skills in incrementally more challenging situations, i.e., when the partner is under the influence of alcohol. A discussion on what was observed during these demonstrations will follow each session.

To cultivate behavioral capability, another construct in the social cognitive theory, intervention practitioners will facilitate role-playing exercises in which participants pair off and practice the negotiation activities that were observed. This interaction will serve to aid in their retention of the modeled behaviors. Afterwards, the group would re-assemble to discuss what was learned from the role-playing exercises. In a positive feedback loop, these group discussions will inform material for future sessions. A desired expectation is that with ongoing sessions, participants will feel increasingly comfortable about leading the sessions on their own, whereby facilitators will lead less and merely facilitate. Every session will end with a demonstration session on various ways of condom application as well as a demonstration of use of female-controlled contraceptives. These activities are designed to ultimately increase self-efficacy in the negotiation of condom use in the participants.

The Intervention focused on HIV: CAVA

This portion of the intervention is inspired by the "environmental-structural" intervention focusing on reduction of HIV and STI risk in the Dominican Republic in the mid-1990s among sex workers. The design of these interventions sought to alter the "physical and social environments" within which individuals behave (Kerrigan et al., 2006, pg 120). The intervention in the Dominican Republic combined the strengths of "community solidarity" and governmental policy to effectuate change in condom use levels. In conducting a community-wide intervention, it is crucial to establish dialogue with the gatekeepers of the community. These individuals may include tribal leaders, traditional healers, law enforcers and other individuals with informal but influential authority. Rarely can a community-wide intervention be effective without their support. Once engaging their support, the CAVA intervention aims to increase the community's awareness of HIV transmission, increase their knowledge of safe sex practices, develop social support networks for people living with HIV and furthermore, reduce stigmatization of HIV.

The Intervention focused on Intimate Partner Violence: ELFAVA

Women participating in this intervention will be screened for the various risk factors for intimate partner violence described in the literature overview. These include histories of sexual and physical assault throughout their childhood, abuse at the hand of their male partner or husband in the recent past, and/or experience of forced or coercive sex (Maman, Campbell, Sweat and Gielen, 2000). IPV screening is crucial to evaluate participants' degree of risk and how their situations of abuse and/or violence will pose as barriers to HIV risk reduction.

The Transtheoretical Model (TM) (Glanz, Rimer and Lewis, 2002) has been researched as an effective framework of responding to individuals who experience IPV at each of their stages of readiness to change. The TM is particularly applicable to women who have experienced intimate partner violence because it illustrates that leaving a situation of abuse is a gradual, and sometimes protracted process (Burke et al., 2004). Women who attempted to leave their situations experience a process that can be captured in the five principal phases of the TM model: *pre-contemplation* (non-recognition of a problem); *contemplation* (assessment of the situation leading to acknowledgement of a problem and an interest in change); *preparation* (developing plans of effectuating change, perhaps by removing oneself from the situation); *action* (acting upon those plans of change); and *maintenance* (perpetuating that action of change on a sustainable level) (Burke et al., 2004).

In the initial stage of pre-contemplation, abusive behavior is not recognized as a problem by the woman and therefore, she is not interested in change. Consciousness-raising will be the objective of this phase of the IPV intervention. Given that degrees of intimate partner violence are normative male behavior throughout communities in Africa, the challenge of

helping women recognize that they are being abused and that this type of behavior is criminal is formidable.

The second stage of change is contemplation, in which abusive behavior is identified as a problem and the woman becomes interested in changing her situation. During this stage women will be encouraged to discuss the ideal resolution to their current situations and what strategies may be implemented to arrive at these resolutions.

Preparation, the third stage, is a crucial phase when women begin to actually plan their transition to safety. The intervention will teach women in this stage to learn about safety enhancement measures. Leaving the abusive relationship is not always a realistic, or even ideal goal for all women, since this may exacerbate their situation in some ways – by becoming homeless, straining relations with their family, compromising the safety and security of the children, and the like. Instead, ending abuse in the relationship is the goal. Safety enhancement measures may include learning to recognize the triggers that incite violent behavior by the male; learning to avoid setting off these triggers; avoiding the partner when he is angry or has been drinking; informing family members and friends about the problem and requesting refuge for herself and her children at their homes if necessary.

During the stage of action, women begin to act out these pre-meditated plans to try to end their situation of abuse. These actions may be facilitated by the support and intervention of family members and friends, law enforcers, or by the women on their own. However, encouragement and support of women are crucial during this stage of transitioning to safety.

The maintenance stage of the TM is perhaps most rewarding, where women have removed themselves from the situation of abuse or the abuse has ended. Relapse prevention is the

primary goal. The maintenance stage can also be sustained by the processes of building *self-efficacy*; *self-liberation*, "when an individual chooses and commits to changing the problem behavior" (Burke et al., 2004, pg 128); and *stimulus control*, described as "controlling of situations and other causes that trigger the problem behavior" (Burke et al., 2004, pg 129).

The Transtheoretical Model can serve two purposes: that of ascertaining the stage of change of participants, and then determining which processes of change may be of greatest influence to promote movement through the stages (Burke et al., 2004).

The Intervention focused on Intimate Partner Violence: CAVA

Successful primary prevention efforts in IPV may be more effective if designed to target the community as a whole (Gundersen, 2002). This intervention will concentrate on developing a "zero-tolerance policy" (Gundersen, 2002) of intimate partner violence and a community-wide educational component, including an assessment of the cultural ideologies of male superiority, discussed earlier in this paper. Discussions on this topic may also inform skill-building exercises on peaceful conflict resolution and basic stress/anger management skills. The community will be further engaged in a dialogue about the compromised rights of women, especially vis-à-vis the rights of men. The intervention will also increase acknowledgement of women's integral role in the sanctified unit of the family and in the community at large; the community will be encouraged to see women as equal contributors to society as men, and therefore, equal to men. The community will learn how to recognize signs of intimate partner violence such as alienation by a husband of his wife from her family and be attentive to at-risk populations, such as couples with a marital history of dispute or children who experience child abuse. Ultimately, the community may demonstrate its commitment against intimate partner violence by raising the "social cost of

violence" (Heise, 1996, pg 29) and creating an environment whereby sanctions are enforced against men who are violent towards their spouses (Maman, Campbell, Sweat and Gielen, 2000). The intervention therefore aims to increase knowledge of intimate partner violence, and change attitudes and beliefs on the power differential and on intimate partner violence. The theory that will loosely guide this level of intervention is the Health Belief Model, which endeavors to modify health behavior through the modification of attitudes and beliefs (Glanz, Rimer, and Lewis, 2002).

Limitations

Based on the review of the literature, many generalizations have been made throughout this paper on women and men in sub-Saharan Africa. These practices and norms certainly cannot be attributed to every individual, or even to every community. For example, promiscuity of young women is generally frowned upon, but as observed in parts of Kinshasa, young men *and* women alike aspire to gain a higher social status associated with having many lovers (Müller, 2005). Generalizations such as this were made to help create a compelling, and overall accurate depiction of the normative behaviors that engender the gendered power differential. In addition, I do not attempt to construct a reductionist argument for what gives rise to HIV, IPV and the intersection of the two. However, the power differential does fuel the intersection of violence and the HIV epidemic in this part of the world, both of which are very real international health concerns.

The review of the literature was limited to research on female study participants' perceptions of intimate partner violence regarding condom usage and female researchers' perceptions of the power differential between men and women. This "bias" is due in part to the fact that overwhelmingly, women researchers are interested in this topic more than men. Further research of this complex issue should continue to include investigation of

men's perceptions not only of intimate partner violence and their risk for HIV, but also their perceptions of the social norms that perpetuate the gendered power differential. Ideally, a constructive dialogue incorporates the points of view of both parties. Their points of view may further illuminate this area of public health.

Although I attempted to focus the literature overview on women's health issues in sub-Saharan Africa exclusively, I found that valuable research, on the intersection of HIV and IPV in particular, was conducted among groups of women in the United States. Clearly the two populations are incomparable on most levels, but relevant research yielded data that may be transferable to all women who experience intimate partner violence and risk of HIV. For example, the findings from research conducted with Project WAVE in Baltimore, Maryland (Sherman, German, Cheng, Marks and Bailey-Kloche, 2006), are innovative and valuable, and may inform culturally-appropriate interventions for women in sub-Saharan Africa, if not the world.

Finally, although I attempted to conduct an extensive literature overview, it was by no means exhaustive. A great deal of interesting, innovative research abounds. Many research teams around the world have been working diligently to demystify this epidemic to inform the construction of effective interventions for HIV, IPV and both HIV and IPV. My literature overview only scratched the surface of the work being done, and I am deeply grateful to have reviewed this work. It is also profoundly encouraging to read that community-oriented approaches to research and interventions are growing in popularity and in number. Resolution of these health issues truly lies in the ability of communities to work not only with health professionals, but with each other, to move in the direction of sustainable progress.

Conclusion

The issue of HIV/AIDS is not one of public health alone. It is a crisis with systemic implications that threaten the integrity of entire peoples, countries and futures. HIV/AIDS education and awareness initiatives continue to be crucial. The need for prevention efforts to recognize norms surrounding sexual practices is urgent, particularly those norms that compromise women's and men's abilities to exercise self-protection. The power differential between men and women is deeply embedded within societies throughout much of the world: often so embedded that women and men subscribe to the differential without questioning its justification. This differential has prevented women from gaining access to sexual education, negotiating safe sexual practices with their partners and leaving abusive relationships, all of which are factors that have fueled the fury of the HIV pandemic.

Intimate partner violence is discussed in this paper as the ultimate manifestation of the power differential between women and men. The interplay of HIV and intimate partner violence has furthered HIV's devastation. Intimate partner violence may increase a woman's risk of HIV by compromising her ability to negotiate condom use or by increasing her engagement in high-risk sexual practices; similarly, positive HIV serostatus may increase a woman's risk of intimate partner violence. Spousal abuse is often practiced, if not tolerated, in many parts of sub-Saharan Africa. As I mentioned in this paper, one public health issue cannot be addressed without recognition of the other.

HIV and its hold on impoverished populations around the world must also be combated through a combination of broad-based systemic changes that encourage equality between women and men, including the granting of property and inheritance rights to women, access to education for both boys and girls, and microfinance initiatives that enhance women's income-generating skills. Public health interventions must also expand their scope to target

both women as well as their communities. As described in my proposed ELFAVA and CAVA interventions, structural-environmental models that target multiple tiers of a community maximize the ability to influence social and cultural norms. Community participation is integral to address HIV and IPV, not only to ensure education of the entire community, but also to ensure the sustainability of new attitudes, beliefs, and practices. It remains to be our work as public health professionals to help empower communities through creative educational initiatives, and rally international support against this worldwide crisis.

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