

Voices from the Frontlines: The Epidemics of HIV/AIDS and Violence among Women and Girls

ANNE M. TEITELMAN

*Center for Health Disparities Research, University of Pennsylvania School of Nursing,
Philadelphia, Pennsylvania, USA*

ESTHER S. SELOILWE

*Centre for the Study of HIV and AIDS, School of Nursing, University of Botswana,
Gaborone, Botswana*

JACQUELYN C. CAMPBELL

Johns Hopkins University School of Nursing, Baltimore, Maryland, USA

The papers in this special issue focus on the topic of violence against women. This group of scholarly works explores theoretical issues, context and health care interventions pertaining to violence in women's lives. In conjunction with this special issue, this editorial provides a synopsis of presentations and discussions about the topic of the intersections of gender-based violence, HIV and the girl child that took place in July 2008 as part of the 17th conference of International Council of Women's Health Issues (ICOWHI) held in Gaborone, Botswana, focusing on the Girl Child. ICOWHI, in conjunction with the University of Botswana, Centre for the Study of HIV and AIDS (CSHA) sponsored a one day preconference on "Gender-based violence and HIV Risk among Adolescent Girls." A diverse interdisciplinary group of scholars from around the world closely examined these interconnected epidemics in a rich day long discussion. The aim of the preconference as well as the articles in this special issue is to build scholarship and inform practice of cultural and contextual factors as they pertain to violence in the lives of women and girls in order to promote their health, safety and well-being globally.

Address correspondence to Anne M. Teitelman, Center for Health Disparities Research, University of Pennsylvania School of Nursing, Fagin Hall, 2L (Room 244), 418 Curie Blvd., Philadelphia, PA 19104. E-mail: teitelm@nursing.upenn.edu

Background and Significance of the Problem

An emerging body of research reveals important associations between gender-based violence by intimate partners and HIV infection among adolescent girls worldwide as was described in both Dr. Afaf Meleis' (Council General of ICOWHI) introduction to the preconference and Dr. Jacquelyn Campbell's overview of the state of the science in the overlap of the two epidemics (Campbell et al., 2008). Globally, women and girls make up the fastest growing group of persons newly infected with HIV, most often acquired through heterosexual transmission. In the US, adolescent girls (ages 13–19) accounted for the highest ratio of females of any age group, 36% of newly diagnosed HIV cases (CDC, 2007; NIH & NIAID, 2006). African American and Hispanic girls are disproportionately affected in the US (CDC, 2007; NIH & NIAID, 2006). In sub-Saharan Africa, young women aged 15–24 comprise 76% of all young people living with HIV/AIDS (UNAIDS, 2006). In Botswana, adolescent females have a higher prevalence rate of HIV infection than their male counterparts (National AIDS Coordinating Agency, 2005).

According to estimates from the World Health Organization (WHO), between 11 and 45% of women whose first sexual experience was before the age of 15 were forced into that first sexual encounter (Garcia-Moreno et al., 2005). Globally, women report high rates of forced sexual debut, ranging from 8–30% with up to 40% among those for whom sexual debut occurred at 15 years or younger (Garcia-Moreno et al., 2005). The definition of gender-based violence, adopted by WHO, is any behavior within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship and includes physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion and various controlling behaviors (Krug et al., 2002).

Within WHO, programs on gender and HIV/AIDS have priority for addressing this pandemic. Violence against women (VAW) is rooted in gender inequities that exacerbates HIV/AIDS risk for women and girls through: 1) forced sex with an infected partner; 2) violence as it interferes with negotiating safer sex and treatment access; 3) fear of violence that limits communication about safe sex or positive HIV status; and 4) greater likelihood that abusive partners engage in HIV risk behaviors (Champion & Shain, 1998; Garcia-Moreno et al., 2005; Teitelman, Dichter, Cederbaum, & Campbell, 2007; WHO, 2008; Wingood, DiClemente, McCree, Harrington, & Davies, 2001). Trauma history, particularly childhood sexual abuse is also an important factor (Wyatt et al., 2002). Gender norms and economic inequalities—resulting in cultural norms that allow men to have multiple partners and older men to have sex with much younger women or girls—contribute to the higher global rates of HIV infection among young women compared to young men (Seloilwe, 2005; Seloilwe et al., 2001;

Seloilwe & Ntseane, 2000; WHO, 2008). Even though the interface of HIV and intimate partner violence (IPV) is recognized by the United Nations, WHO and the Institute of Medicine, our understanding of these mechanisms as they apply to increased risk for adolescent girls globally is still very limited.

Many aspects of adolescent development play a crucial role in understanding adolescent girls' increased risk for IPV and subsequent HIV infection. Biologically, women are more susceptible than men to acquiring HIV, and the developing cervix of adolescent girls is even more vulnerable to infection than that of their adult counterparts. This risk is further compounded by forced or physically traumatic sex with a partner infected with HIV or other sexually transmitted infections (STI's; Sommers et al., 2006). There are also important immune system sequelae of violence (through stress responses and depression) that increase chances of contracting HIV and may decrease the time from HIV positivity to AIDS (Maman, Campbell, Sweat, & Gielen, 2000; Woods et al., 2005). Girls are especially disadvantaged because of gender disparities in educational and economic opportunities globally (Phaladze & Tlou, 2006). Girls may have limited understanding of HIV transmission; prevention and safe sex negotiation and be inexperienced in navigating relationships and in sexual decision-making (Teitelman & Loveland-Cherry, 2004; Wolfe & Feiring, 2000). In many cultures, gender role socialization, which encourages girls to accommodate to their male partners' needs and wishes, can further exacerbate these risks (Berman & Jiwani, 2002). The developing girl comes to understand her capabilities and potential within the family and among social and cultural contexts in relation to sexual, gender, race/ethnicity and class distinctions, including an understanding about power, privilege and discrimination (Amaro & Raj, 2000; Berman & Jiwani, 2002; Im & Meleis, 2001; Lee, Spencer, & Narpalani, 2003; Phinney, 2000). A thorough understanding of these intersecting contexts as it pertains to the girl child is vital to building effective health promotion interventions (Jemmott & Jemmott, 2000; Murry et al., 2004)

Theoretical and Conceptual Issues

The first panel of the preconference focused on conceptual and theoretical foundations (Berman & Hussain, 2008; Dube, 2008; Seboni, 2008; Teitelman & Chilisa, 2008) with consensus on a post-colonial feminist approach recognizing the importance of understanding the experiences of girls from across the globe in light of intersecting structures of power and inequality (based on gender, race, class, ethnicity, age, sexual orientation, histories, colonial oppression etc.). These structures create background (social and material) inequalities that foster susceptibilities to conditions such as HIV/AIDS and violence. All the presenters on the first panel traced the social and material roots of violence and HIV risk for adolescent girls and emphasized the

importance of working toward change at the structural level as well as at the individual level (Berman & Hussain, 2008; Dube, 2008; Seboni, 2008; Teitelman & Chilisa, 2008). Gender inequality was identified as a root cause for both gender-based violence (GBV) and HIV/AIDS; however, the distinct ways in which this manifests among adolescent girls need to be carefully explored and addressed.

Teitelman & Chilisa (2008) discussed theoretically-based specific pathways connecting structural and individual factors. Guided by an integration of gender and behavior theory, (Ajzen, Albaraccin, & Hornik., 2007; Wingood & DiClemente, 2000) Teitelman described analyzing focus group discussions to identify how gendered power dynamics, as manifest within relationships, influences violence and increases urban US adolescent girls' vulnerability to HIV. Chilisa (2008) explored how social beliefs about sex influence adolescent sexual behaviors in Botswana. She identified multiple conceptions of sex in Botswana society: sex as procreation, exchange, social interaction, religion or spirituality, healing, family property and control and oppression. Chilisa argued that these conceptions of sex promote gender violence by controlling the girl child's body, sexuality and involvement in procreation and child bearing. Both Teitelman and Chilisa (2008) saw tracing these pathways as vitally important to inform prevention interventions.

Dube (2008) highlighted the importance of pre-colonial, colonial and post-colonial influences on gender relations in order to forge liberating perspectives while emphasizing the great diversity of feminist perspectives within the continent of Africa. Various recommendations from these diverse perspectives include: advocating for women and men to have equal access to national structures (politics) and resources/opportunities (economy, health, education); removing gender oppressive practices (laws, cultures, etc.); and collaborating with international organizations and development agencies and advocate for gender justice nationally and internationally (Dube, 2008).

Seboni (2008) emphasized the importance of understanding both GBV and sexual risk among adolescent girls from a human rights perspective. She argued for the imperative of viewing sexual rights as human rights, that "everyone's right to health includes entitlements to sexual health, sexual freedom and sex education and information." In a similar theme, Berman & Hussain (2008) identified a gap between what is articulated in international human rights doctrines and actual condition of the girl child. They added that issues pertaining to the girl child are often invisible within these documents and that there is no doctrine specific to the human rights of the girl child. They stressed the importance of listening to girls' to identify links between HIV/AIDS and factors such as colonization, poverty, gender relations, violence, access to education, and sexual decision-making as well as getting girls input in intervention development. Seboni as well as Berman & Hussain suggested raising awareness of gender-based—violence and developing policies and laws so girls can fully realize their potential.

Females in most societies are marginalized and excluded from critical and powerful decision making in most communities. Persons who are marginalized also feel powerless. The article in this issue by Thomas & Gonzalez-Prendes describes a conceptual model that outlines a pathway between the historical and cultural experiences of racism and sexism for African-American women and health consequences. Powerlessness, defined as an inability to access valued resources such as income, education and employment, is an important intermediary. The belief, that one has little or no control over the causes and solutions to one's problems, is a reflection of powerlessness. This conceptual model can help explain why African-American adolescent girls are disproportionately affected by HIV/AIDS and other sexually transmitted infections (STIs), as does the article in this issue by Koci & Strickland exploring the association between marginality and abuse. Poor, young, minority women are among those most marginalized and are exposed to greater health risks, such as abuse. These complementary frameworks imply understanding health risk behavior as a consequence of intersecting social locations that convey disadvantage, a perspective echoed in the conference presentations on Gender-based violence, HIV and the girl child. Early detection of IPV and access to needed resources are critical to halting the negative health consequences and further marginality that are more likely to follow from these exposures.

Risk and Resiliency on Context

The impact of GBV, especially sexual violence, for girls was the focus of the second preconference panel. The World Report on Violence and Health (Garcia-Moreno et al., 2005) describes sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim in any form including but not limited to home and work." A fundamental premise of violence is coercion. Coercion can cover a whole spectrum of degrees of force. It may involve psychological intimidation, blackmail, or other threats such as physical harm or enticement with material goods as well as physical force. It can also occur when the aggressed person can not give consent. Factors such as poverty, unemployment, power dynamics, and age differentials have been known to promote sexual abuse and violence. The acts of violence inevitably accentuate the spread of HIV and AIDS.

In the ICOWHI preconference, Seloilwe and Tshweneagae (2008) explored sexual violence and the psychological impact on adolescent girls living with HIV and AIDS in Botswana. Situation Analyses was used to identify that young girls and boys were coerced into sexual relations for material

gain (Fidzani, 2000; Molebatsi & Mogobe, 2000; Ntseane & Ncube, 2000; Seloilwe & Ntseane, 2000). Findings from these studies indicated that youth were enticed with material goods to engage in sexual relations with significantly older partners. This phenomenon was labeled the “sugar daddy and sugar mummy syndrome” because older men and women exchanged sex with younger persons by giving them rides in their expensive cars, buying them cell phones, clothes or actually giving them cash. This is also referred to as the “four C” syndrome of young girls and boys lured with cell phones, clothes, cash and cars for exchange of sexual relations.

Sexual violence has a profound impact on the physical and mental health of girls. In addition to causing physical injury, it is associated with increased risk of sexual and reproductive health problems including HIV/AIDS. Psychological consequences such as guilt, anger, anxiety, depression, post traumatic stress disorder, sexual dysfunction, somatic complaints, sleep disturbances, withdrawal from relationships, stigmatization by family and community, and attempted suicide have been observed as a result.

Sommers (2008) discussed the physiologic impact of sexual violence on girls the role that skin color plays in accurate identification of injury from sexual violence. Her program of research has begun to identify the pattern and severity of physical injuries that girls develop as compared to women after a sexual assault. Several important issues are being addressed including: 1) the role of skin color in forensic examinations; 2) technology in sexual assault exams, including the costs of technology for resource poor countries; 3) investments needed by developed and developing nations in technology and training of sexual assault examiners and; 4) variations in training needed based on age and developmental status of girls and women and the culture(s) of the population.

Jemmott (2008) described strategies for designing and evaluating effective contextually appropriate, culturally sensitive, and gender specific behavioral interventions to reduce the risk of sexually transmitted HIV infection among female adolescents. She emphasized the importance of collecting indigenous knowledge based on local expertise and experience of members of the community or country that reflects the cultural beliefs and attitudes that may facilitate or inhibit sexual risk behavior and using this information to design effective HIV prevention interventions. Jemmott discussed how these effective interventions have been used in various community settings and disseminated globally, and considered how IPV interfered with the effectiveness of interventions. Questions raised were: Can adolescent girls’ HIV risk—associated behaviors change in the context of partner violence?; What strategies are needed for HIV and IPV prevention?; Who should we target in our interventions, females only, males only, or both?; What about the role of alcohol and drugs?; What about the role of parents?; What resources are needed? She concluded by suggesting we build new global partnerships, listen to girls voices and design culturally competent, collaborative,

compassionate strategies to reduce HIV risk behaviors, especially in the context of IPV.

Several of the articles in issue 30(1–2) illustrate the value of understanding indigenous perspectives to illuminate the context of risk and resilience in relation to GBV. Using qualitative interviews, Johnsdotter, Moussa, Carlbom, Aregai & Essén found Ethiopian and Eritrean parents who migrated to Sweden rejected the custom of female genital cutting (FGC) indicating the girl children were at low risk for this type of GBV. Riddell, Ford-Gilboe, & Leipert explored the social and physical strictures imposed upon women living in rural areas of Canada as they carried out strategies to ameliorate their exposure to IPV. They found several forms of social control, more prominent in rural settings, limited women's access to safety resources. However, rural women preferred more private strategies and were able maintain a resilient spirit that aided them in gaining greater control in their lives. Hawkins and colleagues contend that women's own appraisal of the severity and dangerousness of IPV are generally concordant with actual outcomes. Their study presents findings on a measurement tool to assess women's perceptions of severity, dangerousness, and controllability of violence so that interventions can be tailored accordingly.

Interventions

The third panel of papers at the preconference workshop addressed interventions for gender based violence and/or HIV/AIDS. Two of the papers presented work being conducted in Sub Saharan Africa (Abrahams, 2008; Davhana-Maselesele, 2008) one in Canada (Jackson, 2008) and two in the US (Glass, 2008; Sharps, 2008). All emphasized the need to address HIV risk, IPV and other reproductive health issues for adolescents together within a culturally appropriate context. Abrahams' (2008) intervention for girls in South Africa addresses the realities of school restrooms and "the long walk" to school as places where girls are frequently sexually abused. The intervention described is aimed at the school and community policies and environment, and teacher, administrator and community training as well as the individual knowledge and behaviors of young girls and boys. Davhana-Maselesele (2008) highlighted the high rate of sexual and GBV in South Africa, aimed primarily at young women and girls, which is exacerbated by the myth that if an HIV infected person has sexual intercourse with a virgin, then the disease gets cured. She described significant advancements as well as challenges in establishing comprehensive sexual abuse services in a poor, rural area of Limpopo Province in South Africa. The Glass presentation outlined the need for interventions that address the context of violence with providing safe and affordable housing for abused women and their children in the US and economic resources for women and girls who have been raped to

rebuild their lives in the Democratic Republic of the Congo as well as changing the community norms so that tolerance for violence is decreased and support for victims enhanced (Glass, 2008). Continuing the themes of intersectionality, Jackson (2008) presented an intervention that addresses racism and acknowledges the realities of poverty for aboriginal Canadian young women that builds on Berman's violence prevention intervention for girls from many different ethnic groups. Such interventions also need to address sexual health, including HIV prevention that acknowledges and expressly addresses the reality of violence in many girls' lives. Finally, Sharps (2008) presented on a nurse home visitation program in the US that addresses the IPV that often is part of the challenges facing pregnant adolescents. Their reproductive health can be severely compromised, and nursing interventions that address abuse as well as other health issues of pregnancy are needed.

Interventions that address HIV/AIDS as well as gender-based violence are critical to effectively address these interconnected epidemics. However, in the health care setting there are specific challenges that would need to be addressed, as identified in some of the papers in this special issue. Chung, Oswald and Hardesty (30(1-2)) identify level of enculturation as an important factor for IPV screening in the clinic setting among Korean-American physicians and may play a role with other immigrant groups as well. Laisser and colleagues describe the impact upon health care workers' (HCWs) of interacting with women who have experienced IPV in Tanzania. Within a context of limited resources, HCWs responses varied and in some cases limited their ability to effectively support their clients. McGregor and colleagues examined the literature on acute care for sexual assault survivors and found several gaps in terms of providing women-centered care. Findings from the study by Romito et al. indicate effective interventions for post-partum depression need to include family violence screening and, if needed, treatment as well.

In summary, both the ICOWHI preconference and the articles published in the special issue, 30(1-2), present the realities of both the context and consequences of violence in the lives of women and girls and the need for culturally appropriate interventions that reflect the voices of those affected. As Nelson Mandela said in 2002, "Less visible but even more widespread, is the legacy of day to day individual suffering. It is the pain of children who are abused by people who should protect them, women injured or humiliated by violent partners, elderly persons maltreated by their caregivers, youths who are bullied by other youths, and people of all ages who inflict violence on themselves."

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