HIV/AIDS & STI NEWS

From the DFID Knowledge Programme on HIV/AIDS & STI

MRC Medical Research Council

No. 1, March 2002

From the editorial board

Welcome to the first newsletter from the DFID Knowledge Programme on HIV/AIDS and STIs. The Programme is funded by the Department for International Development, UK, and based at the London School of Hygiene and Tropical Medicine (LSHTM) and the Medical Research Council (MRC), Social and Public Health Sciences Unit, University of Glasgow. It has five research themes: 1) Determinants of sexual behaviour; 2) Biomedical risk factors; 3) Use and effectiveness of HIV/AIDS/STI services; 4) Interventions for diagnosis, prevention and care; and 5) Prevention and care policies.

These newsletters will provide a forum for the exchange of research within the Programme and introduce other relevant research from Programme members. They will serve to exchange information such as updates on projects underway, conferences, new grants, etc. Initially, the selected papers will reflect contents of our bi-annual scientific meetings in London (or Glasgow). Contributions from Programme members are invited. Please email comments and suggestions to Tamsin.Kelk@lshtm.ac.uk. Please also see our website at: http://www.lshtm.ac.uk/research/dfid/aids/.

Philippe Mayaud, David Mabey, Graham Hart and Tamsin Kelk

In this issue

Newsletter editor: Tamsin Kelk, Health Policy Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London, WC1E 7HT, UK. Email: Tamsin.Kelk@lshtm.ac.uk

Sexual violence and HIV/AIDS

Introduction

This first newsletter focuses on sexual violence and its links with HIV/AIDS, falling within Theme 1 of the Programme. It looks particularly at sexual violence or coercion in Tanzania, childhood sexual abuse and potential subsequent HIV infection, and client violence against prostitutes in the UK.

Violence, including the fear of violence, is emerging as an important issue for women and HIV transmission. An increasing body of research illustrates how different forms of violence against women can both directly and indirectly affect women's susceptibility to HIV infection. Gender inequalities (power, social and economic) fuel violence against women and increase women's vulnerability to STIs including HIV. They also influence how HIV infection and AIDS impacts on women's lives.

Sexual violence, pressure and HIV: preliminary findings from the HALIRA project, Tanzania

The link between sexual violence and HIV is generally based on the non-use of condoms in violent sexual encounters, but this is a largely Western perspective. In sub-Saharan Africa only a small minority use condoms even in consensual sex, so non-use of condoms is unlikely to put women at greater risk of HIV in violent sex. However, there are probably other links between violent, or pressured, sex and HIV. One problem in exploring these links is getting accurate data on the prevalence of coercive or pressured sex.

Study methods

The HALIRA (Health And LIfestyles of Rural Adolescents) research project is the main social science component of the larger MEMA Kwa Vijana project in Mwanza. In order to obtain data on sexual violence and coercion, the research team used a range of methods:

- a ***self-complete questionnaire*** with primary school pupils, average age 15 (N=6077) – using a method which tried to combine the benefits of self-completion (privacy, perceived anonymity) with those of face-to-face questionnaires (clarification of questions, guidance);
- a ***face-to-face questionnaire*** with most of the above sample;
- ***in-depth interviews*** with primary school pupils, average age 16 (N=72);
- ***group discussions*** with same-sex groups in their late teens/early 20s; and
- ***participant observation*** in 7 villages, involving living in a village household, befriending, assisting and informally interviewing adolescents in their daily lives.

In order to analyse the data collected, three categories of coerced sex were distinguished:

- ***rape*** – generally limited to violent sexual assaults which become publicly known and subject to some quasi-judicial response, such as a fine or beating.
- ***other physically forced/violent sex*** – many cases of sexual violence do not become publicly defined as rape, though often just as severe. A victim may not disclose such events if: a) she might be thought to have contributed to the event, or b) an authority figure or trusted friend acted as an intermediary facilitating the sexual encounter.

- ***coerced but not violent sex*** – e.g. where there is no physical violence but sex occurs through pressure from relatives, the threat of being shamed because of accepting gifts, or the threat of violence.

Prevalence

A rape has occurred in all the participant observation villages within recent years. Physically forced/violent sex, which is largely unacknowledged publicly, seems to be much more prevalent, but this is difficult to estimate since it is rarely disclosed. The female researchers estimated that about a quarter of young women receive gifts and are then pressured into having sex against their will, and about half get pressured into having sex by intermediaries.

Data validity problems

Despite careful and protracted development of the questionnaire, there were ***major validity problems with the data*** collected, particularly in relation to sexual force. The main problems were:

- massive under-reporting of sexual activity by the girls;
- discrepancy between behaviour reported in the self-complete questionnaire and the face-to-face questionnaire;
- discrepancy between biological data and self-complete questionnaire data – 62 of the sample had some biological marker of sexual activity but 37 of them reported that they had not had sex.

There were two main issues around reporting experiences of coercion: the first is ***conceptual***, i.e. what did respondents understand by the term *'kulazimisha kufanya mapenzi'* (forced sex); the other is about ***willingness to report coerced or forced sex***.

The term 'forced sex' seemed to be a clear concept for young women who had experienced it, but the young men in all three discussion groups emphasised its ambiguity, pointing out that it is nearly always necessary to use some pressure before a young woman agrees to have sex - with the common practice of 'ritualised resistance' by women.

Link between violent/pressured sex and HIV

Any link between violent or pressured sex and HIV is likely to be through ***lack of vaginal lubrication***, since a dry vagina is more likely to lead to abrasions. This is more likely where there is no sexual foreplay or where the woman resists this – if not wanting vaginal sex, she will likely also resist foreplay. Even when the sex is non-violent presumably it often does not involve physical pleasure for the woman, because it is coercive or done purely for material gain. It could be that in the majority of such cases, the sex will be unlubricated.

Another possibility is that ***some of those sections of the population who have a higher prevalence of HIV are, to an extent, also more likely to experience sexual violence***. For example, can we assume that people in road-side settlements and/or men in travelling jobs (e.g. truck drivers, fishermen) and/or women who travel themselves or have multiple, travelling partners are most likely to have HIV? Are these people more likely to experience sexual violence? Other factors include the use of video shows and alcohol, which are, at least anecdotally, associated with publicly discussed acts of sexual violence.

Daniel Wight and Mary Plummer

A history of sexual abuse and early HIV infection

There is increasing evidence of an indirect way in which childhood sexual abuse is linked to HIV/AIDS transmission. An emerging link is the relationship between childhood sexual abuse and high-risk sexual and drug-using behaviour later in adult life. Several studies on sexual abuse in childhood and adolescence report a strong association between the experience of abuse during the formative years and indicators of low self-esteem, including feelings of vulnerability, unworthiness, shame and lack of trust.

There is also evidence that a key factor in adolescent and adult risk behaviour, including early and multiple partners, unprotected sex and excessive use of alcohol and drugs, may be a history of childhood sexual abuse. A relationship between childhood abuse and subsequent prostitution has also been found.

A prospective study of causes of HIV in the United States found that people who reported childhood rape were four times more likely to have worked as prostitutes during their lifetime than those who did not. Survivors of sexual abuse were 40% more likely to have sex with someone they did not know and were twice as likely to have multiple sexual partners.

A study in Barbados found that sexual abuse was the single most important determinant of reported high-risk sexual behaviour. A history of sexual abuse was strongly linked to the number of years sexually active before the age of 20, the number of partners in the past 5 years, a lack of condom use and a history of STIs.

These findings illustrate the importance of taking into account present and past history of abuse in STD and HIV control programmes.

Early sexual abuse and vulnerability to HIV infection

Forms of early sexual abuse
Childhood sexual abuse
Early coerced sex
(different levels of physical violence)

→ **Infection at time of forced sex**
Characteristics of perpetrators
Age of victim
Role of loss of virginity
Level of force used

→ **Subsequent risk**
Inability to set boundaries of acceptable behaviour
Low self esteem, poor ability to cope – use of drugs, alcohol, engage in sex-work

Research needs

New studies need to ***build on existing VAW research***, such as the WHO multi-country study on women's health and domestic violence against women; the global initiative on sexual violence – Global Forum; work in Mwanza, the UK etc. The VAW and HIV/AIDS debates have developed largely separately. It is important to ***improve collaboration between HIV and VAW groups***; to exchange experiences and expertise; and learn from existing initiatives.

Future research needs to:

- Explore the implications of VAW for HIV
- Broaden the concept of risk – moving from viewing sex as mutually desired
- Better estimate the magnitude of sexual violence
- Explore factors influencing women's vulnerability to both HIV and violence
- Understand strategies used by women and girls to protect themselves from violence
- Consider ethical and safety implications when conducting such research.

Education and counselling is needed for women/girls, and for men, to address their particular needs.

For women and girls it should include:

- Broader HIV/AIDS discussions, to cover:
  – Gender and HIV
  – Roles and expectations in relationships
  – Risks of physical and sexual violence.
- Discussion of skills to enable girls and women to recognise and avoid risk situations.

For men it should:

- Ensure prevention messages do not appear to condone abusive sex.
- Use a range of HIV prevention activities focused on men to:
  – Discuss power, roles and expectations in relationships
  – Promote increased communication, male responsibility
  – Challenge expectations around sex, decision-making
  – Discuss non-violent means of resolving conflict.

Charlotte Watts

Reference

Garcia-Moreno C and Watts C (2000) Violence against women: its links with HIV/AIDS prevention. AIDS 14 (Suppl 3): S253-266.

Client violence against prostitutes working from street and off-street locations: comparing Leeds, Glasgow and Edinburgh in the UK

The findings from this UK study could be transferable to developing country situations, e.g. South African mines, and hence are presented here. Past research on the health issues of sex workers has tended to overlook the prevalence of client violence against prostitutes, and the lack of systematic data has perpetuated its invisibility, yet it is a major health issue. This study aims to: establish the prevalence, nature and patterns of violence against women selling sex in Glasgow, Edinburgh and Leeds; identify why and how the tension and conflict between prostitute and client arises; describe the responses of the women, individually and collectively, to violence; and explore how the vulnerability of prostitutes might be reduced. Data collection has involved use of structured questionnaires, in-depth interviews and field observation.

Results

Violence experienced: 63% of the prostitutes had experienced client violence at some point, 37% in the last 6 months – violence included being slapped, punched or kicked, robbery and attempted rape. Street workers tended to experience longer attacks, receive less outside help and were more likely to sustain injury and experience combined physical, sexual and economic assault than indoor workers. Glasgow street workers were 6 times more likely to have experienced client violence than Edinburgh indoor workers.

Factors associated with client violence included: disagreements over payment, over sexual services provided and the duration of services.

Protective factors for indoor workers are: they work in a familiar environment, with other women; a receptionist or manager serves as gatekeeper/first line of defence; they are able to sound the alarm if necessary. By contrast, ***street workers*** work alone, must negotiate business quickly, have little time to assess possible risk and have limited opportunities for escape/evasive action.

Policy implications

- Services for sex workers should address other (non-STI) health issues such as violence and drug dependency.
- Sex workers should be encouraged to report violent clients to the police.
- Indoor workers are safer, less vulnerable to violence, than street workers. Policies should reflect this.

Measures to improve safety

Unionisation of the work – this exists to some extent, with workers 'looking out' for each other's safety. However, there is also some competition between the women for work.

Policing policies have implications for safety – e.g. in order to reduce the public presence of the work, a move to indoor working rather than street working can also promote safety.

Council policy can impact greatly on safety – e.g. in Edinburgh, the Council had issued licences for indoor working. This strategy contrasted with other cities where measures to reduce streetworking in one area could result in women working in other areas. Factors influencing Council policy include a powerful religious lobby in Glasgow.

Local media raised public awareness of the level of violence – e.g. one street worker per year is killed in Glasgow, and there are many serious violent attacks.

Structural features and social organisation of sex work have a major impact on exposure to violence. Sex work needs to be treated as a public health issue, which can be generalised into sexual violence in general – e.g. improved health, with less violence, increased co-operation between women, women controlled co-operatives, use of money for community research.

Graham Hart

Reference

Church S, Henderson M, Barnard M, Hart G (2001) Violence by clients towards female prostitutes in different work settings: questionnaire survey. British Medical Journal **322**: 524-5.

Some useful websites on gender and violence

Institute of Development Studies, University of Sussex, UK:
http://www.ids.ac.uk/bridge/
International Center for Research on Women, Washington DC:
http://www.icrw.org
National Council of Women of Kenya:
http://www.ncwk.org/violence.htm
UNAIDS:
http://www.unaids.org/fact_sheets/files/GenderFS_en.pdf
UNICEF: http://www.unicef.org/vaw/
United Nations: http://www.unifem.undp.org
University of Toronto, Women's Human Rights Resources:
http://www.law-lib.utoronto.ca/diana/mainpage.htm

Conference Report

XIIth International Conference on AIDS and STDs, Ouagadougou, Burkina Faso, 9-13 December 2001

This is an impressionistic report on some of the social science presentations at the above conference. Outside the bio-medical streams many presentations concerned service delivery and support organisations. The conference was probably of most value to NGOs, service providers and activists in facilitating networking and boosting morale, rather than to researchers.

Daniel Wight

Social factors underlying the epidemic

Vulnerability of women: Petudzayi (11BT7-1) reported that in Zimbabwe, women expect their husbands to hit them and do not realise when they are being abused. In Burkina Faso young women are particularly vulnerable to sex work if they have no father or are betrayed into sex work by their male

partners or elder sisters, and the age of sex workers has fallen. Huygens (11DT2-2) recommends enforcing existing laws against pimping, initiating debates about gender at a community level, and making young people more realistic about job opportunities in cities. A review of why young women are infected earlier than men (Michel, 10PT5-359), drawing on the Four City Study, concluded that biological factors might be more important than sex with older men.

***Young people's sexual behaviour*:** On the Tanzanian coast traditional sexual socialisation for young women could encourage sexual activity (Kasili, 11PT2-101). A study in Kigali, Rwanda, found the experiences of street children put them at risk of HIV: 93% knew a girl who had been raped, 63% of boys reported forcing girls to have sex, condom use was low and drug use high (Awasun, 11DT2-1).

***Unprotected sex between men*:** In Dakar, Senegal, a study of men who have sex with men (MSM) (Niang, 12PT5-407, 12PT2-138) found that only 14% used condoms at last intercourse, about half rely on self-medication for anal illnesses and most also have sex with women.

A useful ***methodological*** presentation from South Africa found that using indigenous categories for different kinds of partnerships, and asking about each separately, will provide more valid data on sexual partners (Nduna, 12PT6-541).

Consequences of the epidemic

In an analysis of ***street children*** in Zimbabwe, Mawoneke (11BT7-3) found many reasons why they were on the streets (about a third had parents who might have died of AIDS) and concluded that no single intervention would be of much help. Some children were not motivated to leave the streets.

In South Africa researchers are trying to calculate the best use of scarce ***teacher training resources***, given the likely impact of the epidemic on teachers. ***Staggered training*** is being considered, to avoid investing heavily in students who are likely to die within a few years.

Social interventions

Preventative interventions discussed were usually fairly broad, e.g. ***community mobilisation*** (Vera, 11PT1-36), the mobilisation of young people through ***open space galas*** (Chigariro, 12PT6-533) or musical ***concerts*** and competitions (Kapakala Mwewa, 13PT6-578), and general ***consciousness raising*** (Mukakibibi, 11PT1-37). But few interventions had been rigorously evaluated. One exception was the Ugandan Masaka trial (Whitworth, 11PT2-108), but this was given only a poster presentation.

In a five year DFID funded project in Kenya (Rakama, 11PT1-29) the ***peer education*** component suffered from attrition and, given the limited resources, replenishment was questioned. In contrast, a study of Indian post-graduates (Hassan, 12PT2-131) showed marked improvements in HIV knowledge and attitudes through peer education, but behavioural measures were not mentioned.

In Zambia, a ***theatre for development*** initiative by the Catholic Church was considered highly effective in improving young people's HIV knowledge (Bukanga, 10PT5-364).

Microbicides

Faleyimu (12PT2-134) reported results regarding the reported acceptability of different prophylactics by commercial sex workers in Nigeria: while 35% were ready to negotiate the use of female condoms and 66% male condoms; 92% would be ready to use a cheap, effective and 'invisible' microbicide.

In a satellite meeting organised by International Family Health, several speakers stressed the importance of female-controlled preventative methods, claiming very positive take-up of female condoms in developing countries and advocating their wider promotion. They implied that no governments or large donors are supporting microbicide research and called for them to be put under pressure to do so. There was no reference to concerns about the safety of potential microbicides or of DFID's multi-site feasibility study in preparation for Phase III trials.

Preventing mother-to-child transmission (MTCT)

Several programmes to prevent MTCT through anti-retroviral therapy were severely hampered by difficulties in recruiting mothers and attrition of those recruited (Kassamba Diaby, 10BT2-1; Painter, 10BT2-2, 10BT2-6). Although take-up varied considerably from one project to another, the main barriers to participation were generally relationships with clinic staff, disbelief of HIV status, stigma of identification as HIV+ and opposition from partners.

Future priorities

In a plenary presentation (11A2), Michel Carael (UNAIDS) identified the main priorities for the future. He attached greatest importance to the ***development of a vaccine against HSV2***. Beyond this he emphasised (previously established) findings on: the protective effect of circumcision; the danger of early sexual activity; transmission from older men to young women; and four main lessons about the most appropriate sex education, i.e. the importance of community support, complementing education with services, greater emphasis on inter-personal issues rather than reproduction and, apparently, peer education.

Dialogue between researchers and researched

Pierre Huygens' plenary (11A1) reviewed social scientists' response to the epidemic over the last two decades and set out a model of how researchers should engage with communities in the ***long-term***. He argued that there should be a dialogue between the researchers and the researched at every stage (local empowerment is not enough) and further, that the researcher's role does not end once the effectiveness of an intervention has been demonstrated. The requirements for an intervention to be sustained institutionally should be clarified, including sensitive issues such as corruption. This institutional analysis has to be neutral, preferably conducted by someone from outside the country. Apart from this last point these recommendations are in keeping with the Global AIDS Programme/CDC project to develop countries' capacity to monitor and evaluate their own AIDS programmes (Peersman, 11PT2-109).

Selected New Publications

Buvé A, Changalucha J, Mayaud P et al. (2001) How many patients with a sexually transmitted infection are cured by health services? A study from Mwanza region, Tanzania. Trop Med Int Health 6: 971-79. *(Theme 3)*

Caraël M, Holmes K, editors (2001) The multicentre study of factors determining prevalences of HIV in sub-Saharan Africa. AIDS **15,** Supplement 4, December. Papers by A Buve et al, JR Glynn et al, L Morison et al, E Lagarde et al and HA Weiss et al. *(Themes 1 & 2)*

Grant AD, Kaplan JE, De Cock KM (2001) Preventing opportunistic infections among human immunodeficiency virus-infected adults in African countries. Am J Trop Med Hyg **65**: 810-21. *(Theme 3)*

Mayaud P, West B, Lloyd-Evans N, Seck K (2002) GASP-WAR: West African network to tackle gonorrhoea. Lancet **359**: 173. *(Theme 4)*

Miles K, Shaw M, Paine K, Hart GJ, Ceesay S (2001) Sexual health seeking behaviours of young people in The Gambia. Journal of Adolescence 24: 753-64. *(Theme 1)*

Patel V, Andrew G (2001) Gender, sexual abuse and risk behaviours in adolescents: a cross-sectional survey in schools in Goa. Natl Med J India **14**: 263-7. *(Theme 1)*

Details of Programme research themes are given on page 1.

A more extensive list of publications can be seen on our website.