

# DOMESTIC VIOLENCE AND HIV/AIDS

## AN AREA FOR URGENT INTERVENTION

Written for the Consortium on Violence Against Women by

**Tanya Jacobs<sup>1</sup>**

Edited by

Kelley Moulton and Dee Smythe

---

*'One of the most powerful HIV vaccines today is women's empowerment ... it is the key to reversing the epidemic.'*

-UNIFEM (2001)

### INTRODUCTION

HIV/AIDS is most prevalent in parts of the world where poverty and economic inequality is extensive, where gender inequality is pervasive, and where access to public services is unequal (Collins & Rau, 2000). It is therefore hardly surprising that the two major public health issues facing women today are violence and HIV/AIDS.

That these issues are inextricably linked has been recognised recently by a number of researchers and activists who have begun to illustrate the burden that women bear being at the nexus of gender inequality, discrimination, poverty and HIV/AIDS. They are the fastest-growing group of people living with HIV/AIDS (UNAIDS 2001a), with Human Rights Watch estimating that in certain areas of Eastern and Southern Africa the rate of infection among girls aged fifteen to seventeen is between four and seven times higher than that of boys in the same age group (Human Rights Watch, 2002).

This paper highlights the link between gender inequality, HIV/AIDS and domestic violence. It emphasises the need to create programmatic interventions that recognise and accommodate this relationship. It identifies gender inequality as one of the greatest barriers to the prevention, treatment and management of HIV/AIDS, affecting the whole prevention-care continuum - from the possibility of prevention and access to information and resources to the quality of care received and survival (Tallis, 2000).

UNIFEM (2001) confirms that:

*'This is not simply a matter of social justice. Gender inequality is fatal.'*

Violence against women is both a cause and consequence of HIV/AIDS infection. Yet the two issues are rarely placed on the same political, health or legal agendas. Recognising and incorporating overlaps could undoubtedly strengthen both domestic violence and HIV/AIDS strategies.

---

<sup>1</sup> Tanya Jacobs is an independent health consultant to the Consortium on Violence Against Women. Other members of the Consortium are the Gender, Law & Development Project (UCT), the Gender Project of the Community Law Centre (UWC), Rape Crisis (Cape Town) and the Women on Farms Project. This document was initially developed to inform Consortium discussions on the relationship between domestic violence and HIV/AIDS.



## DOMESTIC VIOLENCE & HIV/AIDS

Violence against women is deeply rooted in patriarchal stereotypes and gender roles that often result in the abuse of women being 'normalised' or legitimised within domestic relationships. Physical violence, the threat of violence, the fear of abandonment and other forms of domestic violence are powerful factors that prevent women from talking about fidelity, sex and condom use, or leaving relationships that might put them at risk of HIV infection (Weiss & Rao Gupta, 1998).

Maman et al (2000) recognise that HIV/AIDS and violence against women overlap in the following ways:

- increased risk of HIV infection as a result of coerced sexual intercourse<sup>1</sup>;
- limits to women's ability to negotiate HIV preventative behaviour; and
- increased risk of violence as a result of disclosure of their HIV status to partners.

In studies conducted worldwide, anywhere from 10 - 50% of women report physical assault by an intimate partner, with one-third to one-half of physically abused women also reporting sexual coercion (Heise et al, 1999). In a study conducted in Zimbabwe, 26% of married women reported being forced into sexual intercourse (Watts et al, 1997). In this study responses to questions around the nature of this coercion included:

- 23% reported the use of physical force;
- 20% reported verbal abuse;
- 12% reported being forced while asleep;
- 6% reported their partner using threats of violence or leaving them; and
- 38% reported that their partner told them that it was their duty to have sexual intercourse with them.

Forced domestic sexual compliance is a major barrier to women being able to decide if, when and how sexual intercourse takes place. It infringes their right to sexual autonomy and makes them extremely vulnerable to HIV infection.

Gender inequalities also exist in terms of bearing the burden of care for others infected with HIV/AIDS. As noted by Cindy Berman from the

International Labour Organisation: 'The effects of unequal gender divisions of labour in the household have given rise to an unsustainable and untenable burden of care - primarily for women - wives, daughters, mothers, sisters, grandmothers - in the context of HIV/AIDS. This care burden is also having catastrophic effects on the world of work - whether paid or unpaid, and in both the formal sector and the informal economy.' The burden of caring for sick relatives, partners and children rests largely on women and young girls, many of whom themselves might be living with HIV/AIDS. This personal, social and economic burden placed largely on women is often referred to as the 'care economy' and needs to be acknowledged.

Gender inequality often overlaps with other forms of inequality. A woman's vulnerability is shaped by factors such as race, class, age, ethnicity, urban/rural location, sexual orientation, religion and culture. More specific factors that compound women's vulnerability to HIV infection are:

- **BIOLOGICAL FACTORS:** Women's physiology increases their risk of HIV infection in that they have, for example, a larger mucosal surface, which can be exposed to abrasions. They also have a higher rate of sexually transmitted infections than men, and this allows for easier transmission of the HI Virus (UNAIDS, 2000b).
- **SOCIAL FACTORS:** Their relatively low status manifests itself throughout women's lives in poor access to education, housing, health and social welfare services. Further, low rates of employment result in economic inequalities in terms of access to resources, information and money. Many women consequently find themselves at special risk of HIV/AIDS because they lack information on preventive measures, and access to treatment and care.
- **POLITICAL FACTORS:** The power differentials within domestic relationships often render women subordinate to their male partners. This is manifested in numerous forms of domestic violence, including rape and sexual abuse within relationships (Watts & Garcia-Moreno, 2000). Factors such as sexual and cultural norms (supported by both men and women) and double standards that encourage men to have multiple sexual partners contribute both directly and indirectly to especially young women's

vulnerability to HIV/AIDS (LeClerq-Madlala, 2000). Increasingly, girls and young women are being put at risk of becoming infected with HIV/AIDS by what is euphemistically known as "age-mixing" - girls and young women being coerced, raped, or enticed into sexual intercourse by men older, stronger, and/or richer than themselves.

- **ECONOMIC FACTORS:** Poverty increases women's vulnerability to HIV/AIDS. Poverty inevitably results in poor nutrition, inadequate sanitation and susceptibility to opportunistic diseases and infections. In addition, unequal gender relations and access to economic resources result in women having greater exposure to high-risk survival practices, which may include the exchange of sex for food, shelter, money and other resources.

Conversely, domestic violence may arise as a consequence of HIV infection. On disclosure of an HIV positive status many women face abandonment (McGeary, 2001), greater risk of abuse from their partner, family and community (Rothenberg et al, 1995), and even death as a direct result (Watts & Garcia-Moreno, 2000). Maman et al's 2001 study in Tanzania found that 51% of women communicating their HIV status to their partners reported a negative reaction<sup>ii</sup>. The same social and economic factors that make women vulnerable to HIV infection shape their experiences once they are infected. An HIV positive woman will therefore often have to bear a double burden of infection and abuse. Social marginalisation and poverty add to this trauma.

This is further reinforced by the stigma attached to HIV infection. Masindi (2003) suggests that the stigmatisation, which affects more women than men, may include amongst others, the following experiences: domination, oppression, harassment, punishment, blame, prejudice and anger which may result in violence.

#### INTERVENTIONS: A CRITICAL REVIEW

There is a need for interventions that address gender and HIV/AIDS but there are few examples from which to draw conclusive evidence regarding the appropriate context and structure (UNAIDS, 1999). As discussed above, there are political,

biological, economic and social factors that make women particularly vulnerable to both domestic violence and HIV infection. It is imperative that these factors are considered in respect of ALL programmes focusing on domestic violence, HIV prevention and the treatment of HIV/AIDS. Current interventions and messages of how to practice 'safe sexual intercourse' reinforce gender stereotypes and do not, on the face of it, promote the transformation of power relationships within sexual interactions.

Fundamental to addressing the HIV/AIDS pandemic is a critical reappraisal of the notions of sex and sexuality. Denial, blame and silence are often part of the experiences of women who live with abuse and/or HIV/AIDS. The experiences and views of women who are infected and affected by HIV/AIDS need to inform programmatic interventions. An example of how this can be done is seen in the work of *Voices and Choices*, a project developed by an international network run for and by HIV-positive women. They raise the following important points:

- The development of self-help groups and networks needs to be encouraged and supported.
- Media must be educated to ensure that portrayals of HIV positive women are realistic and do not stigmatise.
- Both conventional and complimentary health care must be made accessible and affordable.
- Health care providers and communities must be educated and trained about women's risk and needs.
- Up-to-date and accurate information about all the issues affecting women living with HIV/AIDS should be easily and freely available.
- Economic support must be provided for women living with HIV/AIDS in developing countries to help them to be self-sufficient and independent.
- There must be a recognition of the fundamental human rights, including socio-economic rights, of all women living with HIV/AIDS.

## SAFER SEXUAL INTERCOURSE STRATEGIES: NEGOTIATING CONDOM USE

The dominant discourses around promoting safer sexual intercourse, particularly for younger people, are the ABC messages:

- Abstinence
- Be faithful to your partner
- Condomise - use a condom every time you have sexual intercourse

However, these messages largely support an understanding that decisions around safe sexual intercourse are based on individual choices. They do not acknowledge the web of social and power relations that mediate human interaction (Gillespie, 1997). Unequal power relationships between women and men make it very difficult for women to 'negotiate' or talk about sexual intercourse. Watts and Garcia-Moreno (2000) suggest that domestic violence and the fear thereof is likely to affect a woman's ability to negotiate the context in which sexual intercourse takes place and whether or not she can insist on the use of condoms. In fact, Bujra (2001) argues that it is not the lack of knowledge about safer sexual intercourse that is the problem, but rather women's ability to apply it in a context of gender inequality.

The existing model emphasises the provision of information and the encouragement of 'healthy' choices, but fails to acknowledge the impact of social relationships and power that determine the ability to take action. Current safe sexual intercourse messages that target men and women, make the incorrect assumption that sexual relationships are equal and ignore the very real power inequalities that exist. Threats of violence and/or illness through HIV infection from a partner make it difficult for women living in a violent relationship to mediate these choices. The reality is that a condom is only as useful as women's ability to negotiate its use.

Putting these safe sexual intercourse principles into practice is difficult for women, particularly in developing countries, where even such practical considerations as condom availability act as a further constraint. The notion of 'safe sexual intercourse' is mediated through the 'economics' of women's dependence on their male partners for

financial and other support. Many women face an impossible choice between the chance of being infected with HIV and the risk of alienating their partner, which may result in estrangement and consequent poverty. Basset and Mhloyi (1991) go as far as characterising this as a choice between 'social death or biological death'.

The context in which these messages are communicated needs to be addressed by implementing strategies that sustain awareness and promote behaviour change. This must be done by allocating resources to information and education campaigns that challenge coercive sexual practices and empower women to negotiate their sexuality. These messages and preventative strategies must be informed by women's experiences.

## ACCESS TO HEALTH SERVICES

Public health services are often the point of first and only contact for abused women. Health workers can identify abuse and intervene at an early stage, as abused women often interact with the health care system for routine or emergency care before turning to criminal justice or domestic violence services (Kernic et al, 2000). This offers an opportunity for the health sector to play a critical role in addressing the needs of women in relation to both domestic violence and HIV/AIDS. To this end, a primary health care package should be offered at all centres, including maternal and child health services, sexually transmitted infections, HIV/AIDS support and counselling (Abdool Karim, 1998). Voluntary counselling and testing (VCT) be used as a vital entry point for care and prevention.

However, we must consider the possibility that many women in abusive relationships may not use VCT services, as they fear further violence. Breaking this barrier requires building capacity and non-discriminatory attitudes in the health and related sectors, as well as overcoming barriers to access. Within the health sector, programmes that address HIV counselling and testing offer an important opportunity to identify, assist and support women who are at risk of violence. Patterns of past and present abuse can be used to identify and appropriately refer women who are at higher risk of contracting HIV.

Partner notification, as encouraged by the health sector's VCT programmes, as a way of promoting safer sexual intercourse practices, may make a woman more vulnerable to abuse. Partner notification is therefore often NOT the most appropriate advice to be given by health staff. Careful training, addressing both the professional skills and attitudes of health staff in dealing with both HIV/AIDS and domestic violence is needed. Modules on gender and gender-based violence should be incorporated into VCT training programmes and policies.

## LEGAL AND POLICY FRAMEWORKS

A supportive policy and legislative context for women is crucial for containing the spread of the HIV/AIDS epidemic and mitigating its impact. Transformative policies that address power inequalities between women and men should aim to decrease the gender gap in education, improve women's access to economic resources, increase women's political participation and protect women from violence (Expert Group, 2000). The HIV/AIDS framework developed by UNIFEM, provides a useful and important basis for the development of policies and programmes, recognising as it does the complex and diverse realities of women, men and children's lives (Tallis, 2002)<sup>iii</sup>. Internationally, we are also seeing an emerging discourse on the relationship between human rights and HIV/AIDS. This discourse is increasingly providing us with new tools and strategies to fight both the pandemics of domestic violence and HIV/AIDS.

That the recognition of a relationship between HIV and domestic violence has not yet adequately been translated into legislation and policy is illustrated in the Domestic Violence Act (116 of 1998). This Act fails to recognise the role of the health sector as a partner with the criminal justice system in meeting the needs of women experiencing domestic violence. There is no responsibility placed on the health sector to identify abuse, provide comprehensive care, referral and documentation for medico-legal purposes. The Act is substantially weakened by this omission, resulting in a missed opportunity to provide a crucial point of access to state services, particularly in rural areas.

Vetten & Bhana (2001) report that responses to HIV/AIDS on the one hand, and to violence against women on the other, exist in a parallel rather than complementary manner. They also note that, to date, rape-related concerns have driven policy and legislative reform to a greater degree than issues related to other forms of violence against women, such as domestic violence. They call for amendments to the DVA in order to specifically protect women who are abused after disclosing their HIV status, and to ensure that abandonment is viewed as a form of economic abuse.

## INTEGRATION OF PROGRAMMATIC WORK

It is impossible to extract HIV/AIDS from problems associated with poverty, gender inequality and exploitation - yet few HIV/AIDS control programmes integrate these factors (Rao Gupta et al, 1993). It is however crucial that this be done across service delivery, capacity building, research and advocacy programmes if they are to be effective. For example, programmes that aim to prevent all forms of violence and/or provide support for women who have been abused provide a potential platform to talk with women about their risks of HIV infection and other STIs (Maman et al, 2000).

Relevant information about gender-based violence as well as appropriate skills to negotiate safer sexual relations and for providing shifts in economic resources to assist women should be central components of HIV/AIDS intervention strategies. To this end the HIV/AIDS and gender-based violence sectors should work closely on issues of research, capacity building and advocacy. Existing networks within the domestic violence and HIV/AIDS arenas would be strengthened through the formation of strategic coalitions. Muthien's (2003) review of the Saartjie Baartman Centre also highlights the utility of clustering service provision to victims of gender-based violence. This cluster of services should include, at the minimum, voluntary testing and counselling facilities.

## MEN: THE MISSING LINK

The social context which shapes the relationships and interactions between women and men needs to be taken into account. The transformation of patriarchal domestic relations can only be achieved through also implementing education and prevention campaign targeted at men. Social environments where gender equality becomes normalised and accepted are essential to addressing both domestic violence and HIV/AIDS.

## AREAS FOR FURTHER RESEARCH

It is critical that policy and legislative changes, interventions and programmes are informed by strong and focussed research. The extent to which domestic violence may occur as a direct result of being HIV positive remains an important area for further empirical investigation.

A useful report from a WHO workshop held in 2000 to set the research agenda on violence against women and HIV/AIDS outlines further key research questions. These include:

- The degree to which being HIV positive affects the risk of violence.
- How much violence can be attributed to HIV and how much is ongoing.
- Whether disclosure increases the risk of violence.
- Strategies needed to ensure that disclosure of HIV status does not put women at further risk of domestic violence.

In addition, the following areas must be addressed using both qualitative and quantitative methodologies:

- Female infectivity, including woman-to-woman transmission and recognition and support for lesbians living with HIV/AIDS.
- The degree to which abuse and violence increase the risk of HIV infection for women.
- Models for the implementation of multisectoral programmes and services.

On a broader level, there is a need to open debates, evaluate current interventions from a gender perspective and formulate co-ordinated and

comprehensive responses that deal with both domestic violence and HIV/AIDS.

## SOME IMPORTANT STATISTICS

While statistics can never accurately reflect the devastating impact that HIV/AIDS and domestic violence has on the lives of women, it is nonetheless important to consider that:

- The number of people living with HIV/AIDS worldwide totalled 42 million at the end of 2002.
- While the African continent contains 11% of the world's population, 60% of the world's total HIV infections are found there (See Maman et al, 2000).
- An estimated 3.5 million new infections occurred in Sub-Saharan Africa in 2002, and 2.4 million Africans died of the disease.
- Women make up 58% of HIV-positive adults in Sub-Saharan Africa, 55% in North Africa and the Middle East, and 50% in the Caribbean.
- In South Africa, the 25-29 year old age group is most at risk of infection with an HIV prevalence rate of 28% (Nelson Mandela Foundation / HSRC HIV/AIDS Survey 2002).

## REFERENCES AND RESOURCES

Abdool Karim, Q. (1998) 'Women and AIDS -the imperative for gendered prognosis and prevention policy' in *Agenda* 39

Albertyn, C. (2000) 'Using rights and the law to reduce women's vulnerability to HIV/AIDS' in *Canadian HIV/AIDS Policy and Law Review* 5 72

Bujra, J. (2000) 'Targeting men for a change: AIDS discourse and activism in Africa' in *Agenda* 44

Collins, J. and Rau, B. (2000) *AIDS in the context of development*, Paper No 4 UNRISD Programme of Social Policy and Development, Geneva: The United Nations Research Institute for Social Development

Doyal, L. (1995) *What makes women sick: Gender and the political economy of health*. London: Macmillan

Genderaids electronic discussion group: Gender-aids@hivnet.ch

Gielen, A., O'Campo, P., Faden, R, and Eke A. (1997) 'Women's disclosure of HIV status: experiences of mistreatment and violence in an urban setting' in *Women & Health* 25(3)

- Gillespie, C. (1997) 'Women's HIV risk reduction efforts and traditional models of health behaviour: a review and critique' in *Women's Health* 3(1)
- Heise, L. and Elias, C. (1995) 'Transforming AIDS prevention to meet women's needs: A focus on developing countries' in *Social Science and Medicine* 40(7): 931
- Heise, L., Ellsberg, M. and Gottemoeller, M. (1999) 'Ending Violence Against Women Population Reports' Series L, No 11. Baltimore, Johns Hopkins University School of Public Health, Population Information Program.
- Human Rights Watch (1995) *Violence Against Women in South Africa*. New York: Human Rights Watch.
- Kernic, MA; Wolf, M; Holt, V (2000) 'Rates and relative risk of hospital admission among women in violent intimate partner relationships' in *American Journal of Public Health* v 90 no9 Sept 2000. 1416
- LeClerc-Madlala, S. (2001) 'Demonising women in the era of AIDS: on the relationship between cultural constructions of both HIV/AIDS and femininity' in *Society in Transition* 32(1)
- Maman, S., Campbell, J., Sweat, M. and Gielen, A. (2000) 'The intersections of HIV and violence: directions for future research and interventions' in *Social Science and Medicine* 50.
- Maman, S., Mbwambo, J., Hogan, M., Kilonzo, G., Sweat, M. and Weiss, E. (2001) *HIV and Partner violence: Implications for HIV voluntary Counselling and Testing Programs in Dar es Salaam, Tanzania*. New York: The Population Council Inc.
- Masindi, N. (2003) 'Understanding HIV/AIDS-related stigma' in *WHP Review* 44, Autumn 2003
- McGeary, J. (2001) 'Death Stalks a Continent' *Time Magazine* 12 February 2001
- Muthien, B. (2003) *Strategic Interventions: The intersections between gender-based violence & HIV/AIDS*. Paper presented on behalf of the Gender Project, Community Law Centre, University of the Western Cape at the Amanitare Conference, 4-7 Feb 2003, Johannesburg.
- Parenzee, P., Artz, L. and Moul, K. (2001) *Monitoring the Implementation of the Domestic Violence Act: First Research Report*. Institute of Criminology, University of Cape Town, South Africa
- Piot, P. (1999) *HIV/AIDS and Violence Against Women*. Speech by the Executive Director UNAIDS to the Commission on the Status of Women, Forty-third session, Panel on Women and Health. United Nations, New York.
- Rao Gupta, G. (2000) *Gender, sexuality and HIV/AIDS. The What, the Why and the How*. Paper presented at the plenary session of the XIII International AIDS Conference, Durban.
- Rao Gupta, G. (2000) *Approaches to empowering women in the HIV/AIDS pandemic*. Paper presented at the Expert Group Meeting on the HIV/AIDS Pandemic and its Gender Implications held 13-17 November 2000
- Rothenberg, K. and Paskey, S. (1995) 'The risk of domestic violence and women with HIV infection: implications for partner notification, public policy, and the law.' in *American Journal of Public Health* 85(11): 1569
- Strebel, A. (1995) 'Whose epidemic is it? Reviewing the literature on women and AIDS.' in *South African Journal of Psychology* 25(1): 12
- Tallis, V. (1998) 'Aids is a crisis for women.' in *Agenda* 39
- Tallis, V. (2000) 'Gendering the response to HIV/AIDS: challenging gender inequality.' in *Agenda* 44
- Tallis, V. (2002) *Gender and HIV/AIDS - Overview report*. Bridge Cutting Edge Pack, Institute of Development Studies, University of Sussex
- Tillotson, J. and Maharaj, P. (2001) 'Barriers to HIV/AIDS protective behaviour among African adolescent males in township secondary schools in Durban, South Africa.' in *Society in Transition* 32 (1) 83
- Travers, M. and Bennett, L. (1996) 'AIDS Women and Power' in L Sher, C Hankins and L Bennett (eds.) *AIDS as a Gender Issue: Psychological Perspectives*, London: Taylor and Francis.
- UNAIDS (1999) *Gender and HIV/AIDS: Taking Stock of Research and Programs*. United Nations, Geneva.
- UNAIDS (2001a) Gender and HIV factsheet [http://www.unaids.org/fact\\_sheets/index.html](http://www.unaids.org/fact_sheets/index.html)
- UNAIDS (2001b) Gender and HIV/AIDS [http://www.unaids.org/fact\\_sheets/ungass/index.html](http://www.unaids.org/fact_sheets/ungass/index.html)
- UNIFEM (2001) *Turning the tide: CEDAW and the Gender dimensions of the HIV/AIDS pandemic*. United Nations, Geneva
- Van Rensburg, D., Friedman, I., Ngwena, C. et al (2002) Strengthening local government and civic responses to the HIV/AIDS epidemic in South Africa. Centre for Health Systems Research and Development.
- Vetten, L. and Bhana, K. (2001) *Violence, Vengeance and Gender* Centre for the Study of Violence and Reconciliation, South Africa.
- Watts, C. and Garcia-Moreno, C. (2000) Violence against women: its importance for HIV/AIDS prevention and care. *AIDS* Vol 14 Supplement 3, p S253
- Weiss, E. and Rao Gupta, G (1998) *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention*. Washington, DC: International Center for Research on Women.
- Weiss, E., Whelan, D. and Rao Gupta, G. (2000) 'Gender, sexuality and HIV: making a difference in the lives of young women in developing countries.' in *Sexual and Relationship Therapy* 15(3): 233
- World Health Organisation (Gender and Women's Health) (2000) 'Violence Against Women and HIV/AIDS: Setting the Research Agenda' Meeting report, Geneva, 23-25 October 2000
- WHO/UNDP (1995) *Women and AIDS: Agenda for Action*. Geneva. Switzerland

## ENDNOTES

---

<sup>i</sup> Maman et al also suggest that a risk of HIV infection may be increased where a pattern of sexual risk taking develops as a result of childhood or adolescent sexual assault.

<sup>ii</sup> This is as opposed to 18% of women disclosing an HIV negative test result.

<sup>iii</sup> An international three-year programme just launched by UNIFEM to put gender and human rights at the centre of their strategies and policies is a slow step in the right direction. UNIFEM's action strategy will work to provide guaranteed access to prevention and treatment, make research gender-sensitive, provide sexual and reproductive health education for young people, address the issue of gender inequality in policy, and address transmission in conflict situations. The strategy will involve building capacity, and revising existing laws and policies related to HIV prevention, treatment and care. South Africa is however not one of the 10 countries that have been targeted to start this programme. (UNIFEM release 19 June 2002).

---

## ACKNOWLEDGEMENTS

The author would like to acknowledge the members of the Consortium on Violence Against Women: Lillian Artz, Raygaanah Barday, Helene Combrinck, Penny Parenzee, Nolitha Mazwayi, Kelley Moulton, Dee Smythe, Samantha Waterhouse for input and ongoing support.

Without the ongoing support, assistance and encouragement from the Open Society Foundation and in particular, Cheryl Frank, this research would not have been realised.

## FUNDED BY:



The Open Society Foundation

---



Published by the Institute of Criminology, University of Cape Town  
Private Bag, Rondebosch, 7700, SOUTH AFRICA  
[www.uct.ac.za/depts/criminology](http://www.uct.ac.za/depts/criminology)

The views of the authors expressed in this publication do not necessarily reflect those of the Institute of Criminology or the Open Society Foundation.

### To be cited as:

Jacobs, T (2003) *Domestic Violence and HIV/AIDS: An area for urgent intervention* (Institute of Criminology, University of Cape Town, South Africa).

No part of this publication may be reproduced or transmitted in any form or by any means, without prior permission.

ISBN 0-7992-2195-3

© 2003 Institute of Criminology.

All rights reserved.