
Strategic Interventions: Intersections between Gender-Based Violence & HIV/AIDS

**Report by
Bernedette Muthien**

**On behalf of the
Gender Project
Community Law Centre
University of the Western Cape**

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CONTACT DETAILS:

Bernedette Muthien

Email: bmuthien@icon.co.za

PO Box 12992, Mowbray, 7705,
Cape Town

Tel: +27-21-448 2112 / 447 2252

Fax: +27-21-448 2112

Mobile: +27-83-345 0552

Helene Combrinck

Gender Project

Community Law Centre

University of the Western Cape

Private Bag X17, Bellville, 7535

Email: hcombrinck@uwc.ac.za

Tel: +27-21-959 2950 / 2353

Fax: +27-21-959 2411

Website: www.communitylawcentre.org.za

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LIST OF ABBREVIATIONS

TERMS:

ART:	Anti-retroviral therapy
CBO:	Community-based organisation
GBV:	Gender-based violence
HPV:	Human Papilloma Virus
NGO:	Non-governmental organisation
PEP:	Post-exposure prophylaxis
PWAs:	Persons (living) with AIDS
STD:	Sexually transmitted disease (outdated form of STI)
STI:	Sexually transmitted infection
VAW:	Violence against women
VCT:	Voluntary counselling & testing

ORGANISATIONS:

CGE:	Commission for Gender Equality
GRIP:	Greater Nelspruit Rape Intervention Project
MRC:	Medical Research Council
TAC:	Treatment Action Campaign
WCNetVAW:	Western Cape Network on Violence Against Women

1. INTRODUCTION

This report describes a project that emerged from a particular identified need, namely, what are the intersections between gender violence and HIV/AIDS respectively in South Africa, given the extent of both, and what services if any are available to address both. More significantly, given the background of both the author and the Gender Project in combating gender-based violence, what is the impact of HIV/AIDS on (largely female) survivors of gender violence (rape/sexual assault and domestic violence), what are their needs, and how can these be met.

Southern Africa is at present confronted with two key epidemics¹: HIV/AIDS and gender-based violence. When gender-based violence is combined with HIV/AIDS, these two scourges are even more lethal than each when viewed as mutually exclusive. Since the prevalence of HIV/AIDS in South Africa is at least 10% of the population nationwide, it can be assumed that women (and less frequently children and men) who are subjected to coercive sexual intercourse, from stranger rape to sexual intercourse in relationships subject to domestic violence, are at greatest risk of being infected with HIV, in part due to their lack of power to negotiate safer sex practices. The United Nations Population Council asserts that women's "HIV status is strongly associated with partner violence":

HIV-positive women were 2.68 times more likely than HIV-negative women to have experienced a violent episode by a current partner... young HIV-positive women (18-29 years) were ten times more likely to report partner violence than young HIV-negative women. [*Horizons*, 2001: 3]

According to Tanya Jacobs²,

Abuse makes women more vulnerable to infection. After disclosure [of HIV status] women are also subject to violence. The same socio-economic factors that make [women] vulnerable is the same context before and after infection... Gender inequality fuels both [epidemics]... Gender inequality and the interface [between gender-based violence and HIV/AIDS] is *fatal*. [original verbal emphasis].

Disclosure of HIV status could also lead to death, as the infamous case of Gugu Dlamini, who was stoned to death by (largely male) members of her rural community, attests. As Susan Holland-Muter³ puts it, there is an "idea of women as disease carriers like STDs. Women are always at fault and responsible for giving [STDs] to men".

Given this powerful causal link, this project sought to identify two key issues:

- (1) perceptions of the intersections between gender-based violence and HIV/AIDS; and

¹ The use of the word 'epidemic' in this paper is not an allusion to disease (and its concomitant medicalisation), but instead alludes to the "wide prevalence of something usually undesirable", as defined in *The Oxford English Reference Dictionary* [1996].

² Telephone interview, 29 August 2002, original emphasis. Jacobs is a public health specialist, and contracted by the Consortium on Violence Against Women to compile a report on the intersections between domestic violence and HIV/AIDS.

³ Interview, 10 April 2002. Holland-Muter is Training Manager at an NGO, GETNET (Gender, Education & Training Network), and spoke in her personal capacity.

- (2) proposals (preferably practical) on how to address the intersections appropriately.

The two distinct fields of gender-based violence and HIV/AIDS respectively are traditionally dichotomised. This means for example that a survivor of gender-based violence would first need to access an organisation dealing with the violence, and then a separate organisation dealing with HIV/AIDS (for voluntary counselling and testing, for example). Even organisations working on gender-based violence specifically are dichotomised according to the type of violence they deal with. This specialisation by service providers adds to the burden, emotional and financial, of the survivor of gender-based violence, who has to travel to, and seek support from, various disparate organisations, which often are not in communication with one another. The reasons for this lack of communication are more complex and are explored later in this paper.

This project hoped that intersections between gender-based violence and HIV/AIDS identified by respondents would encompass issues beyond the issue of provision of post-exposure prophylaxis for rape, which at the time of the interviews⁴ was a key campaign by especially gender-based violence organisations and activists.

This report outlines the research methodology, a preliminary definition of gender-based violence, as well as a background discussion of women's subordinate status in the first section. In the second section, existing programmes for survivors of gender violence are discussed, both in the areas of rape and domestic violence. The third section briefly notes stakeholders' needs already identified in other surveys, while the fourth section itemises this project's respondents' recommendations, on four different levels. The fifth section of the report discusses additional issues that emerged, including varying conceptualisations of gender-based violence, the status of women, the epidemics of gender violence and HIV/AIDS in South Africa respectively, anti-retroviral therapy, infant and child rape, why rape is so challenging to convict, as well as same-sex violence. The final sixth section of the report discusses models of service clustering, while the seventh section briefly charts the ways forward. Appended are the list of interviewees, a bibliography, as well as the questionnaire used during structured interviews.

1.1. Research methodology

This research consisted of a literature review, as well as both formal interviews based on a structured questionnaire, as well as informal meetings with stakeholders.

The questionnaire elicited the nature of activities of the interviewees regarding gender-based violence, HIV/AIDS, and the intersections between these two respective fields. Since there is such a wide range of conceptualisations of gender-based violence, interviewees' understandings of this concept was also explored in the questionnaire. So too specific questions elicited concrete recommendations from respondents.

⁴ The majority of the interviews occurred during March and April 2002. The report was concluded during August and September 2002.

For the first time in South Africa, and probably Africa more generally, 5, of the total 25 questions, enquired about lesbians and bisexual women (queer women), and violence against these women specifically, as well as whether services accommodated these women, and if not, requested recommendations to address blatant discrimination and/or lack of attention. These questions emerged from anecdotal evidence that lesbians and bisexual women were specifically targeted for sexual assault or rape on account of their (perceived) sexualities, as well as evidence of largely heterosexist service provision and discriminatory practices on the part of both service providers and other clients who access services (e.g. in shelters for battered women). The hypothesis was that if queer women are specifically targeted for rape due to their sexualities, then perhaps they are at greater risk of rape than heterosexual women, and hence the potential for HIV infection for them is greater. Their conditions will of course be exacerbated by heterosexism and homophobia.

The project was focused largely on organisations that provide services in the area of gender-based violence (GBV). The majority of organisations and individuals interviewed are active in the field of combating GBV, while only one organisation interviewed, Treatment Action Campaign (TAC), is focused on HIV/AIDS. Some organisations are engaged in investigating the intersections between GBV and HIV/AIDS, including the INTERSECT campaign coordinated in the province by the Western Cape Network on Violence Against Women (WCNetVAW); research on HIV and violence against women by the Medical Research Council (MRC); and research on HIV & domestic violence by the Consortium on Violence Against Women⁵. While these three specific projects are underway, still no clear direction as to the specific intersections between GBV and HIV/AIDS has yet emerged.

This project is focused on GBV against female adults, rather than children or men, as defined by law, although issues cross-cutting across age, ethnicity, sexuality and even gender emerged from the interviews.

This study centrally drew on the excellent work of Vetten & Bhana [2001] and Julia Kim's study of rape and post-exposure prophylaxis (PEP) [2000].

⁵ The Consortium is a collaborative project between the Gender Project of the Community Law Centre, the Gender, Law & Development Project of the Institute of Criminology at the University of Cape Town, Rape Crisis Cape Town, and Women on Farms Project. The Consortium commissioned consultant Tanya Jacobs to conduct a desktop / literature survey of domestic violence and HIV/AIDS, publication forthcoming.

Due to limited resources, the study was largely located in the Western Cape, with 30 people from 28 different organisations having been interviewed. A brief breakdown of interviewees' organisations is tabled below:

Urban	20
Peri-urban	1
Rural	7

NGO	17
Government	8
Academic	3

Due to the resource constraints of both funding and human resources, the project was also limited in terms of time, since the structured interviews occurred over an intense nine days, from 3 to 12 April 2002. This time period included a provincial conference in a rural area, 3 - 5 April, convened by the Western Cape Network on Violence Against Women, where the all the rural respondents were interviewed. The limited resources did not allow travel to other rural areas to balance more representatively the rural-urban dichotomy and afford even greater rural representation. Despite this, 35% of the study's respondents are rural-based, and hence fairly well-represented in terms of contemporary urban-based surveys. The limited capacity also did not afford any interviews with clients of service providers. Interviews with health care service providers and/or researchers were also provincially based, despite the fact that all the health workers and/or researchers work both nationally and internationally. This provincial focus may mean that some of the project's observations and/or recommendations may not be easily extrapolated nationally.

1.2. Preliminary definition of gender-based violence (GBV)⁶:

The following conceptualisation serves as the working definition of this project, which is the survey's preliminary understanding of GBV. According to the Committee on the Elimination of Discrimination Against Women (General Recommendation No 12), gender-based violence is defined as:

violence that is directed against a woman because she is a woman, or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, and threats of such acts, coercion or arbitrary deprivation of liberty.

The Declaration on the Elimination of Violence Against Women notes three key spheres in which gender-based violence may occur or which may perpetrate and/or condone such violence: the family, the community and the state⁷. December Green [1999] adds one further site of gender-based violence, i.e. the economy. The concept of gender-based violence should accordingly be broadened to also include the notion of economic abuse, which has been defined in the South African Domestic Violence Act [1998] to include 'the unreasonable deprivation of economic or financial

⁶ Cf Muthien & Combrinck [2002].

⁷.Article 2(a) – (c) of the Declaration on the Elimination of Violence Against Women UN General Assembly Resolution 48/104, 20 December 1993.

resources or the unreasonable disposal of household effects in which the victim / survivor has an interest⁸. Thus gender-based violence includes acts or threats of acts that are physical, sexual, verbal, psychological, and/or economic. A discussion of respondents' definitions of gender-based violence follows later in this report under issues that emerged from this study (section 5.1).

2. CURRENT SERVICES FOR SURVIVORS OF GENDER-BASED VIOLENCE

The Provincial Department of Social Services recently established a gender-based violence programme, which Deborah van Stade⁹ inspired and largely drives. However, this government department still does not address the links between gender-based violence and HIV/AIDS. Jennifer MacMaster¹⁰ mentions that "the Wynberg office talks about cooperation between Gender-Based Violence and HIV Coordinators respectively". According to Macmaster, while their "stress is on children", they

need to get involved in broader work, for example VCT should be more extensive at clinics. We need to look at family circumstances. Political-economic structures. We need to uplift communities before we can address the little things. People need to think more in terms of what they themselves can do to contribute, across sectors and levels.

Bulelwa Mshumpela¹¹ notes that:

Khayelitsha Rape Crisis does attend training and workshops done by TAC [Treatment Action Campaign], we do work very closely with HIV/AIDS counsellors at our health centres through awareness raising talks about rape and the issue of AZT. Also our counsellors were involved at the Thuthuzela Rape Centre where rape survivors are being given AZT. Also we are involved in setting up skills development programmes for people living with HIV/AIDS, that is being done here in Khayelitsha.

Organisations working on gender-based violence specifically are dichotomised according to the type of violence they deal with, such as Rape Crisis with its three offices (Athlone¹², Khayelitsha and Observatory) which work exclusively on rape and sexual assault, while organisations such as NICRO (Cape Town, Athlone offices and other satellite offices) and MOSAIC work on domestic violence largely. This specialisation by service providers adds to the burden, emotional and financial, of the survivor of gender-based violence, who has to travel to, and seek support from, various disparate organisations, which often are not in communication with one

⁸ .Sec 1(ix)(b) of the Domestic Violence Act 116 of 1998.

⁹ Van Stade is Assistant Director with the Provincial Department of Social Services. She also serves on the Board of Management of the Sarah Baartman Centre for Women & Children, and on the Western Cape Network on Violence Against Women's management committee.

¹⁰ Interview, 11 April 2002. MacMaster spoke in her personal capacity. She is Chief Social Worker and HIV/AIDS Coordinator for the Provincial Department of Social Services in Wynberg.

¹¹ Completed questionnaire sent via email, April 2002. Mshumpela is the Training & Public Awareness Co-ordinator of Rape Crisis, Khayelitsha. She also serves on the management committee of the Western Cape Network on Violence Against Women.

¹² Ilse Ahrends of the Sarah Baartman Centre for Women & Children comments that "it needs to be noted that Rape Crisis' and NICRO's Athlone offices are at the Centre as partners in an attempt to provide a more holistic service". Comments received 17 September 2002.

another. Respondents themselves readily acknowledged this fragmentation, and their desires and efforts to improve existing, and provide more holistic, services.

In practice, it is commonly known what happens when a woman gets raped and seeks support from multiple service providers, with characteristic delays and re-stimulation of trauma. To name one example, a rape survivor typically needs to visit a number of different service providers of discrete services, including the police (to lay a charge); the district surgeon (for forensic examination and evidence collection); a health professional for STI and pregnancy testing and prophylaxis for pregnancy and STIs as well as other medical treatment; counselling for the rape trauma; as well as counselling for HIV/AIDS if tested positive; usually all separate and distinct services offered by different institutions not usually connected with each another. This merry-go-round of accessing services often results in further trauma for the survivor, not to mention further taxing limited emotional and financial resources. This is particularly related to gender, with Ferdi Franz¹³ noting that women (rather than men) more frequently tend to drop out of clinical trials, probably due to women's larger burdens of responsibilities with fewer resources available to them.

2.1. Programmes for Rape Survivors

In a drastic move away from this traditional sectarianism, two key programmes for rape survivors in the Western Cape provide significant inspiration: the Western Cape Rape Protocol, and Thuthuzela Care Centre.

A few gender-based violence activists, notably medical professionals Lynnette Denny and Lorna Martin¹⁴, devised what is now called the **Rape Protocol**, which is being implemented in the Western Cape, and possibly nationally. The Protocol is a collaboration between the Departments of Health and Justice, the National Directorate of Public Prosecutions, the police and local NGOs. The Protocol aims to provide a safe place where rape survivors can receive medical care and counselling, can bathe and change clothes, and tell their stories to specially trained and caring police officers, as well as be offered HIV counselling and testing and be provided with anti-retroviral medication (AZT). Medical staff are trained in gathering physical evidence for prosecution, and designated police officers and special prosecutors work exclusively on these rape cases, usually tried in one of two special Sexual Offences Courts in Wynberg and Cape Town respectively.

The **Thuthuzela**¹⁵ Care Centre is based at GF Jooste Hospital in Manenberg, Cape Town. Their project is also being replicated in other cities around the country - in East London, Umtata and soon in Soweto. Thuthuzela was the test site for trial implementation of the Rape Protocol.

¹³ Interview, 11 April 2002. Moolman is Training & Public Awareness Co-ordinator of Rape Crisis Cape Town. She is based at their Heideveld office, located in the Sarah Baartman Women's Centre.

¹⁴ Both Denny and legal practitioner Bronwyn Pithey were actively involved in Rape Crisis Cape Town over many years, while Martin has worked closely with both of them and was involved with POWA (People Opposing Women Abuse), an NGO based in Gauteng province.

¹⁵ Thuthuzela means 'place of care'.

During interviews many respondents referred to inadequate health services, long waiting periods before treatment is received at health facilities, and more significantly, abusive overworked medical staff. While diplomatically phrased, even the Democratic Nursing Organisation of South Africa (DENOSA)

recognizes that women generally keep quiet about violence affecting them. Within the nursing profession, the code of silence that exists, often makes nurses know that patients are HIV... Health workers, particularly nurses, are the first people who see an abused woman when she comes to the clinic or hospital. Abused women are far more vulnerable to HIV because of their low self esteem... the challenge lies with how to provide support for *nurses both as victims and as caregivers of domestic violence*. [Zulu, 2000/1999: 6-7, emphasis added]

While many respondents noted abuse of patients by especially nurses, empathy is rarely shown towards notoriously overworked and underpaid health care staff. Nor are health care workers, the majority of whom are women, acknowledged as survivors of gender-based violence themselves in need of care and support. As with the DENOSA programme on domestic violence, a compassionate and holistic approach is greatly needed.

Under the care of Medical Superintendent Dr Ferdi Franz¹⁶, GF Jooste Hospital sought to minimise its waiting period for out-patients seeking treatment. Simultaneously Dr Franz wanted to ensure that adequate care was provided and that patients were not subjected to staff that are overworked, underpaid, stressed and abusive. Not only did GF Jooste Hospital manage to significantly reduce its waiting time for outpatients, it actively strives to have patient care be compassionate and non-abusive. It is especially appropriate then that the pilot Thuthuzela Project was placed under such considerate management, and with such dedicated staff.

What is significant about both the Rape Protocol and Thuthuzela Care Centre, is that they are located in public health care facilities. They are thus subject to governmental scrutiny and control, and largely subject to government funding. If the state chooses to, as in the case of GRIP¹⁷, it may withdraw funding and even shut down the project's work¹⁸.

So too these projects are focused on rape and/or sexual assault to the exclusion of other forms of gender-based violence, such as domestic violence or battery. Hence a more comprehensive approach to dealing with generic gender-based violence, and HIV/AIDS, is needed.

¹⁶ Since the interview, Dr Franz moved from GF Jooste Hospital to teach at the University of Cape Town's Medical School. Dr Franz is a former community doctor, with over twenty years' service in Cape Town townships.

¹⁷ Greater Nelspruit Rape Intervention Project (GRIP) is an NGO that was housed in a government hospital at the time the government disapproved of GRIP's provision of post-exposure prophylaxis to rape survivors. The Provincial (Mpumalanga) Department of Health evicted GRIP from its hospital premises because GRIP persisted in providing PEP against government policy at the time.

¹⁸ The South African government initially did not approve of anti-retroviral therapy, and forced all government-based projects to comply with this. The government has since agreed to provide post-exposure prophylaxis to rape survivors, as well as to the provision of anti-retroviral therapy to pregnant women to help prevent mother-to-child transmission of HIV (MTCT).

2.2. Programmes for Domestic Violence Survivors

The only domestic violence Shelter that is closely examined in this report is the Sarah Baartman Shelter¹⁹. In the Sarah Baartman Centre's external evaluation report of 2002, the evaluator, Riaan Els, comments on the differences between other Shelters and the Sarah Baartman Centre:

The major difference, as is to be expected, resided in the "proximity of services" dimension, with all or most of the services being on-site at the Centre, whilst other shelters had to refer their clients to such service providers when in need of their service...

Some of the comparative shelters do provide second-stage accommodation (or [child] after-care programmes), and they confirm the value of (or need to have) such facilities. In some instances, the shelter programmes offered by the comparative organizations appear to be more varied and comprehensive than these offered by the Saartjie Baartman Centre for Women and Children. However, past clients (who had attended more than one facility) criticize these organisations for enforcing a particular belief system and for being overly rigid/disciplinarian in style...

By comparison to the other shelters, the approach followed by the Centre appears to be more developmental in nature, offering a comprehensive range of services on-site, including educare services for the children of the women, and focusing on the economic empowerment of women. [2002: 59]

The Sarah Baartman Centre is discussed in greater detail in section 6 of this report, under models of service clustering, including the current development of its second-stage shelter. What Els' evaluation does evince is that the Centre is the only of its kind in the province, providing holistic on-site services to survivors of domestic violence. No other shelter, irrespective of underlying philosophies and provision of existing second-stage accommodation, offers such a wide array of services.

Other domestic violence service providers, from the various offices of NICRO Women's Support Services, to MOSAIC Training Service and Healing Centre for Women, focus on domestic violence exclusively. All shelters, and domestic violence programmes, focus on domestic violence to the exclusion of gender-based violence (including rape) more generically. Section 5.1.1. offers a discussion of the need for more inclusive and generic gender-based violence shelters.

Rural organisations, and rural advice offices in particular, find themselves confronted with a wide array of client needs, including domestic violence. These rural organisations, confronted with vast geographic areas, limited resources and inadequate training, are perhaps nascent models of reactive holistic service provision.

Beyond Thuthuzela and our province's Rape Protocol in public health care facilities, and the Sarah Baartman Centre, what should be explicated are the needs of

¹⁹ See Section 6 on clustering services. The original name of the Centre is the Saartjie Baartman Centre. However, due to contention about the use of the diminutive of Sarah Baartman's name by European colonisers and the history of exploitation of Sarah Baartman (also called the Hottentot Venus), the Centre is looking to change its name to the Sarah Baartman Centre, and the Manager of the Centre, Synnov Skorge and other staff, partners and clients advocate using the name Sarah Baartman, hence its use in this paper.

organisations (especially NGOs and CBOs), and how these are provided for and can strategically be improved (e.g. some populations are more vulnerable than others, such as outdoor sex workers and men who have sex with other men). Do service providers, for example, need education materials, crisis intervention, post-exposure prophylaxis (PEP)?

3. NEEDS PREVIOUSLY IDENTIFIED

Regarding the intersections between GBV and HIV/AIDS, the needs already identified by the work of Vetten & Bhana, Julia Kim, and others, include:

- ❖ Training GBV organisations in HIV/AIDS, a need identified by the majority of interviewees;
- ❖ Training HIV/AIDS organisations on gender analysis, as well as gender-based violence, as identified by the Treatment Action Campaign's Siphon Mthathi²⁰;
- ❖ Destigmatising both GBV and HIV/AIDS (and its intersection) for workers and clients, identified by most respondents;
- ❖ Develop and support one stop centres, e.g. GRIP and Thuthuzela.

In addition to these needs, a study in Tanzania²¹ recommended that:

- Community-based efforts are needed to address sexuality and violence and to combat HIV/AIDS;
- Further research on HIV and violence are critically needed.

4. VARIOUS ISSUES THAT EMERGED

4.1. Definition of Gender-Based Violence (GBV):

In a conference presentation, Faeza Khan [2002] maintains that gender-based violence evolves in part from women's subordinate status, and is crosscutting:

one in four women are abused (Medical Research Council, 1999); one in every six deaths is due to femicide (Centre for the Study of Violence & Reconciliation, 1993); 52,860 rapes and attempted rapes were reported during 2000 (South African Police Services); with statistics highly conservative due to the extent of under-reporting.

According to Lisa Vetten [2001], the 'Victims of Crime Survey' conducted by Statistics South Africa found that approximately half of all women who admitted to having been raped reported the matter to the police".

Khan also asserts that abused women use the primary health care system as their first point of entry. She mentions that the 49th World Health Assembly during May 1996 adopted a resolution declaring violence against women a public health priority. The Department of Health: Western Cape Province²² also affirms "that violence (including sexual violence against women, men and children) is one of the most

²⁰ Interview 8 April 2002. Mthathi is the Treatment Literacy Coordinator of the Treatment Action Campaign.

²¹ *Horizons*, 2001: 4.

²² "Provincial Policy on the Management of Survivors of Rape", November 2000, Circular No: H 91/2001.

pervasive and common public health problems and deserves to be prioritised in the allocation of resources and in the services available to such survivors." Lyn Denny also asserts that the incidence of rape specifically, rather than other forms of gender-based violence, is equivalent to that of tuberculosis in the country, "approximately 300 in every 100,000" and hence "rape is our number one public health problem" and should be considered a "national emergency".

Gertrude Fester²³ notes that gender-based violence is exacerbated by the unequal power relations between men and women, and defines gender-based violence as:

any violence premised on the inequality between men and women, and because of male power and the dominant patriarchal relations and ideology, men feel justified to commit violence against women, with the emphasis on power relations between men and women... Both violence and power are justified in terms of culture and religion, with the reigning patriarchal ideology substantiating it.

Naeema Abrahams²⁴ defines gender-based violence as an act or threat due to gender status. Siphon Mthathi of TAC notes that "neglecting our rights as women is a significant form of violence against women":

The poverty issue is linked to GBV because women at the lower end of the economic spectrum are economically dependent and therefore more vulnerable to all sorts of violence (even in their own homes). Same with HIV - with poverty women again are worst off. So it's important to solve the question of poverty and important for women to take up the struggle against poverty because we suffer the most. Until poverty is dealt with we can never have full freedom as women. And HIV will never be dealt with because women will always be in subjective relationships where we have to rely on men's goodwill.

Faeza Khan notes that gender-based violence is "perpetrated due to women's gender status in society, and hence the term *gender-based violence*".

Synnov Skorge and Ilse Ahrends²⁵ assert that gender-based violence sounds like a euphemism, even domestic violence sounds like a euphemism. Since we don't deal with men, gender means *women* for us. The *threat* of abuse is often stronger than actual abuse. We deal specifically with violence against women, perpetrated by men - in our faces - partners, brothers, fathers. [original verbal emphases].

Cheryl Ayogu²⁶, Coordinator of the Western Cape Network on Violence Against Women, maintains that "socio-economic violence is also gender-based violence". She suggests that the definition of GBV should go "beyond legal definitions", and that they "as a Network need this definition to be much broader".

²³ Interview 3 April 2002. Gertrude Fester is Commissioner on the Commission for Gender Equality (CGE).

²⁴ Completed questionnaire returned via email, 9 April 2002. Abrahams is Specialist Scientist with the Gender and Health Research Group of the Medical Research Council.

²⁵ Interviewed together, 8 April 2002. Skorge is the Manager of the Sarah Baartman Centre for Women & Children, while Ahrends is the Centre's part-time Psychologist. Despite the need for full-time psychological services, the Centre's "shoe-string budget", according to Skorge, can only accommodate a part-time position.

²⁶ Interview, 10 April 2002. Also present was Lungiswa Memela, the Network's Metro Coordinator and HIV/AIDS specialist.

Most respondents define gender-based violence very broadly, including socio-economic issues such as poverty and unemployment (largely premised on the patriarchal gender system which violates women on all levels: direct/personal, structural, and cultural²⁷).

Debbie van Stade notes that gender-based violence "includes poverty and all forms of violence - land evictions, no access to services". As a member of the Secretariat of the World Court of Women, she maintains that the "philosophy of the Courts sees behind the traditional view of violence against women, to see culture and tradition, globalisation and modernisation as gender-based violence. The main parameters of society need to be challenged because it contributes to GBV".

As one Anonymous contributor to the GENDER-AIDS listserv²⁸ put it:

The root cause of HIV/AIDS and all the diseases of poverty (which could be eradicated in a few years with half the resources released by the USA in the days following the 11th September 2001) is an irrational, deeply unjust international economic order.

Notably rural respondents made the following comments:

Nombulelo Renene: "offspring of anger, financial situation and alcoholism".

William Syzaar: "Tot system is the main contributing factor to domestic violence. Lack of food, debt (with a bookie on the farm), etc.".

Riana Spamer²⁹: "Any action that is violent, has a negative impact, results in discrimination, contradicts an individual's basic human rights and that is directly or indirectly aimed against the woman".

Florence Syzaar: "This is not only about men who abuse women. Women also abuse other women, verbally and physically. We must make behavioural change, of minds, combat socialisation. We don't have to be what parents made us. We have the right to happiness and to change. For example, interdicts won't be effective if your mind hasn't changed".

Barbara Rass³⁰ maintains that "When women don't make use of their sexuality and don't know who they are and therefore become open targets to DV". Jillian Gardner³¹

²⁷ A man rapes a woman, which would be direct / personal violence. She lays a charge and finds herself in court confronted by legal mechanisms that are not necessarily designed to protect her, such as overworked and disinterested (often male) police, prosecutors and judges, which is a form of structural violence. Then she is cross-examined by an often male defence attorney for the perpetrator, who asks her questions like what she was wearing at the time of the rape, why she was at that place at that time, etc, making her feel as if she asked to be raped and as if she deserved the rape, hence the term 'victim blaming'.

²⁸ 16 September 2002. Email gender-aids@healthdev.net or URL www.archives.healthdev.net/gender-aids.

²⁹ Completed questionnaire returned in Afrikaans via email, early April 2002. Spamer is Senior Social Worker with the Department of Social Services, based in Vredendal, a rural town. Spamer is also the gender and gender-based violence coordinator for her area.

³⁰ Interview, 11 April 2002. Rass was Manager and Founder Member of the United Sanctuary Against Abuse, and is Chair of Atlantis Women's Forum for the Abused. Both organisations are based in Atlantis, a peri-urban area outside Cape Town.

³¹ Interview, 11 April 2002. Gardner is former Outreach Programme Manager of the NGO, SWEAT (Sex Workers' Education & Advocacy Taskforce).

also notes that "most women are just stupid because they don't understand they have something men want, that is a kind of power which they don't realise and know how to use". What Rass and Gardner propose is that women use their sexuality to attain their goals. This sadly cynical view is far from ideal, and one cannot but hope that women will be valued for much more than their sexuality, e.g. their skills, expertise and/or intelligence. Gardner further comments³²:

I am not of the opinion that women use only their sexual power to attain their goals. Indeed I agree women ought to be valued for much more (being complete human beings and all) In the context of sex work, women workers far outnumber transgender workers and men. Most clients are men. If women could realize that they have something to offer these men (not only sex, but also companionship, and probably the skills and expertise you refer to), then perhaps it would put them in a better position to negotiate. There is sometimes a tendency for us as women to see ourselves in a weaker position, when this may always not be the case in reality. This is possibly linked to our socialization, we're only supposed to have sex in certain contexts - doing sex work is wrong! Men are in a sense encouraged to explore their sexuality (with women preferably)... So sex workers internalise that what they are doing is wrong; men don't have to worry about that because it's okay, they're men, they can have as much sex as they can afford. Consequently this may result in them taking an inferior position when negotiating with clients/men. Women need the money, and offer the sex; men have the money and buy the sex.

A few respondents, notably those familiar with historical-materialist and/or postcolonial feminist discourses, noted the need to include various other levels and units of analyses, including ethnicity, class, sexualities, and age.

Susan Holland-Muter defines gender-based violence as "including all violence perpetrated as a consequence of one's gender identity and position of power, including violence between men and men, women and women, men and women. Speaking of sex workers, Jillian Gardner asserts that gender-based violence goes beyond VAW [violence against women] because most rent boys experience the same issues in their work... Same with transgendered - because they're more vulnerable due to their status in society - society is very ignorant about these issues. Though the majority of reports [of GBV] are from women [sex workers].

Gardner further clarifies³³:

Transgender persons may be more vulnerable than the women doing sex work. I do not have conclusive evidence to back this up, but logic dictates that this may be so considering their marginalization from mainstream society. Transgender sex workers are stigmatised because of their gender and also because of the work they do. If they are HIV+ the stigma is three-fold. There is always the risk of customers discovering that they are t/g [transgendered], feeling that they have been deceived and becoming violent. Gender identity should possibly also underlie our work. Yes, many male workers also experience violence but this is seldom reported.

Holland-Muter cites a "continuum of violence", ranging from economic and emotional abuse to physical abuse. She asserts that "capitalism or poverty is not GBV because of different interfaces between things, rather than causes, such as class, race, age,

³² Email communication, 19 September 2002.

³³ Email communication, 19 September 2002.

sexuality." She affirmed the need for a multi-sectoral analysis "because of the interfaces, rather than excluding them".

Benita Moolman³⁴ asserts that she does not:

like the term GBV because it fixes violence into understandings of gender because violence is very complicated. Same-sex violence: is this gendered?! There are numerous levels of race, class, sexuality, and GBV doesn't encompass this complexity. I prefer the term - I don't know if we need to group everything together - sexual violence, with rape as a form of this. It can be more broadly defined because it moves beyond gender. Gender fixes the way we respond to various levels of violence. Sexual violence can be racialised, etcetera. Gender has history attached to it which sexual violence doesn't. For example male rape, 'making men into women' - into 'what [kind of] woman'?! Radical feminism is a way of using gender to the exclusion of all else, which is a problem. We need a multi-approach.

While offering this thoughtful analysis, Moolman resists being labelled a postcolonial feminist with the request to not (statically) "fix" her (in any position or way).

The next two sub-sections, on Shelters for survivors of GBV, as well as the notion of a continuum of violence, is significant in terms of holistic service provision, which includes HIV. If *all* forms of GBV are to be combated more effectively, and both the risk and treatment of HIV infection are to be addressed in relation to the critical intersections between GBV and HIV, then it may be important to view GBV as inclusive and multivariigated, and that service provision should address GBV as holistic and all forms of GBV as intrinsically interrelated, and that these services should of necessity incorporate HIV and other STIs.

4.1.1. Shelters for survivors of gender-based violence:

Reinette Evans³⁵, the Director of Rape Crisis Helderberg, mentions that she is working towards establishing a safe house specifically for rape survivors. She asserts that rape survivors can often not return home after the rape, especially if they were raped by husbands or partners and/or family member(s), and more so with incest. Evans maintains that "domestic violence shelters are not appropriate for rape survivors because rape trauma is significantly different to trauma experienced due to domestic violence - rape trauma is usually ongoing".

Synnov Skorge³⁶, Manager of the Sarah Baartman Centre for Women & Children³⁷, confirms that rape and sexual assault survivors who sought refuge in their Shelter experienced greater difficulties with settling into the Shelter. This is mainly because the Shelter largely caters for, and directs their services at, survivors of domestic violence. Skorge suggests that domestic violence survivors freely share their physical, emotional and financial experiences of abuse and only share experiences of sexual abuse once greater levels of intimacy are reached with fellow-residents in

³⁴ Interview, 11 April 2002. Moolman is Training & Public Awareness Co-ordinator of Rape Crisis Cape Town. She is based at their Heideveld office, located in the Sarah Baartman Women's Centre.

³⁵ Interview, 4 April 2002.

³⁶ Interview, 30 August 2002.

³⁷ For more information on the Centre, cf Section 6.1.

the Shelter. This is problematic to survivors of sexual assault, who are also reluctant to disclose details of their assault, but are still requested to do so by residents who have survived domestic violence. Faeza Khan also mentions that "people, especially rural, don't talk about sexual abuse, because they struggle with the public/private dichotomy".

Skorge suggests that their Shelter should more consciously begin to cater for *all* survivors of gender-based violence, including rape and sexual assault, and that services should cater for all abused women. She further proposes to in future educate Shelter residents about the need for greater sensitivity towards those who have survived sexual violence. In Skorge's own words³⁸:

I think it is a good idea to say that a shelter can be for both DV survivors and sexual abuse / rape 'only' survivors if the shelter is upfront about its 'dual' purpose and in its ethos, group work and other programmes cultivates an understanding of respect, and freedom about (non)disclosure. In fact, I would take it a step further to say that shelters would benefit from expanding their services as long as this is well supported by programmes and well- trained, sensitive staff so that shelters can become more welcoming and healing spaces for more women - DV survivors in both hetero- and same sex relationships, incest survivors, rape survivors etc. I feel it is unacceptable that in a shelter space some forms of abuse are 'acceptable' and more easily spoken about than others, something that we are trying hard to combat in our shelter.

4.1.2. Continuum of violence?:

An interesting issue emerged around different levels of violence. Holland-Muter suggests that there might be different levels of violence and instruments of violence, as well as different levels of force and/or coercion. And hence she posits the "idea of a continuum of violence, from economic to physical". She challenges the notion that some rapes are worse than others, questions how one could possibly measure trauma, which most respondents agree with. The notion of a linear continuum of violence might be inappropriate since it may imply that some forms of violence are more or less severe than others. More appropriate would be Johan Galtung's model of violence as interdependent axes of a triangle: physical/direct, institutional / structural and cultural³⁹.

4.2. Women's subordinate status:

What did emerge very clearly from the majority of respondents is the fact that due to women's subordinate status in society, women's choices are severely limited in a number of significant ways. In a patriarchal system women are disempowered both by the oppressive system and by their own internalisation of its values, and hence women often tend to remain in (rather than timeously exit) relationships that are violent physically, psychologically and/or economically.

So too, in attempting to determine and exercise their own sexualities, the vast majority of women often have to defer decisions about sexual practices to their usually male partners. Thus safer sex practices, such as the use of condoms and

³⁸ Email communication, 5 September 2002.

³⁹ *Peace by Peaceful Means* [1996, 197-210].

femidoms, is often at the discretion of male partners who are all too frequently not in favour of prophylaxis. The mere introduction of condoms into a heterosexual relationship may elicit violence from a male partner. As Riana Spamer puts it,

Especially women on farms are subject to their husbands or partners that they don't have the right to refuse sex. Some women are not allowed to go to clinic. Because many more mature women (not the youth) are illiterate, they suffer heavily of unemployment and thus have no access to resources. It also happens that some men "give" their wives to other men as a gift for the night. The wife may not refuse. Schoolgoing girls are more inclined to leave school due to financial reasons and are sort of forced to take care of their smaller siblings which results in her being more inclined to early pregnancies, etc. Alcohol abuse also plays a determining factor in GBV and leads to bed-partners sleeping around.

In addition, if the relationship is already abusive and/or violent, the one partner often engages in multiple relationships, and thus increases the risk of sexually transmitted infections (STIs, including HIV) for the other partner. Spamer notes that "female carers of HIV positive people are usually victims of family violence which leads to sores and injuries on their bodies and which heightens infection with the virus". Given this increased risk of STIs, if the abused partner wishes to introduce safer sex practices into the relationship, this may further elicit violence.

As Jacobs puts it

There is a need for re-directing resources. Much money is given for distributing condoms and superficial talk about using condoms. But what does this mean for abused women who have no control over when and how sex happens? So using condoms means nothing to her. The actual violence, and fear of violence, act as a barrier to women to protect themselves. Most heterosexual relationships have an element of power and inequality. Female sexuality is about passivity, which is the opposite for males. Most women can't use condoms normally, let alone when they are abused. We need to make women more aware of their sexual rights and their bodies... To abused women safe sex messages also mean nothing... Gender inequality is the primary barrier to women protecting themselves.

Thus women's traditional subordinate status and lack of power in relationships expose them to STIs, and HIV infection in particular. The conventional subordinate role of women in a patriarchal society also leads and contributes to gender-based violence in the form of rape and/or domestic violence. As Naeema Abrahams notes,

In theory there must be a link [between gender-based violence and HIV/AIDS] since the root cause of both of these epidemics is the power imbalance between men and women. There is strong evidence that most new infections are amongst young women. The link is most likely to be strongest for sexual violence and amongst people who are in intimate relations.

Lungiswa Memela⁴⁰ affirms that survivors "*can* rather than *do* [contract] HIV through rape" and that "more women [are infected with] HIV through relationships (rather than rape)". Hence the majority of respondents to this survey identified the fact that the risk of infection becomes greater when a relationship is abusive.

⁴⁰ Interview 10 April 2002. Memela, an experienced HIV/AIDS counsellor, is the Metro Coordinator of the Western Cape Network against Violence Against Women. Also present was Provincial Coordinator of the Network, Cheryl Ayogu.

Noting some of the gendered dimensions to treatment of HIV/AIDS, Faeza Khan⁴¹ of the Gender Advocacy Programme (GAP) responds that "women bear the costs of HIV, as carers of the sick and orphans, are more exposed to infections due to their physiology, are more vulnerable to violence due to power dynamics and the different roles women take on in communities which prejudice them".

Abrahams suggests that "infection occurs most likely in circumstances where women are not able to protect themselves. It is most likely to happen to women who are poor - their economic status increases their risk for both [gender-based violence and HIV/AIDS]". Thus issues such as economic status, geographic location (urban-rural), access to education and information (e.g. literacy) all impact on and exacerbate women's traditionally subordinate status in society, and the choices available to women to combat both gender-based violence and HIV/AIDS.

Benita Moolman of Rape Crisis goes further than this. She speaks of:

women's bodies as the site of transmission - the body is violated, beyond the psyche, etc. - the body as an instrument, a vehicle, a weapon. The same is true for HIV with the body as a target where all this is located. The link is women's bodies, including issues of identities and sexuality, masculinity.

In this way women's physiology itself, and the politicisation (and denigration, exoticification, eroticisation) of women's bodies, is integrally tied to the conventional subordination of women in society.

4.3. Epidemic of GBV in South Africa:

A question that continuously emerged during this investigation centres on why South Africa in particular is experiencing an epidemic of gender-based violence. Universally acknowledged is the fact that South Africa is still suffering of the dual legacies of violence perpetrated by various colonial and apartheid regimes over at least three centuries, exacerbated by the imperatives of capitalism. The post-apartheid democratic government of President Thabo Mbeki, with its neoliberal structural adjustment programmes that has seen poverty amongst especially black people decidedly worsen, has not even attempted to stem the proliferation of generic societal violence, let alone gender-based violence more specifically.

Given centuries of conflict across ethnicities, cultures and classes, contemporary South Africans have almost entirely internalised systemic violence and routinely employ violence as a means to deal with conflicts⁴². This model of (hierarchical and exclusive) power and systemic violence fuels gender-based violence specifically. The construction of masculinities, across ethnic or racial lines, borne from decades of border wars and internal conflict, and the brutalisation of both women and men under apartheid, has led to the routine use of violence in domestic conflict, and the overt sexual aggression that sees females as sexual objects and prey rather than as empowered agents of their own sexuality.

⁴¹ Interview, 8 April 2002.

⁴² Cf Muthien 2002(b), 2001, 2000.

Lyn Denny refers to the structural constraints of contemporary South Africa, when she notes that "60% of men in Khayelitsha are unemployed, demasculinised, unskilled and very angry". She notes the "fractured family structure, (poor) self-esteem, with many people not reaching their potential". The frustration and hopelessness of this situation certainly contributes to the proliferation of gender-based violence in our country. And without addressing these structural issues directly, gender-based violence will never be stemmed, let alone eradicated.

4.4. Epidemic of HIV/AIDS in South Africa:

Whether South Africa has a uniquely high incidence of HIV is debatable, given the fact that Uganda's often cited success with combating HIV/AIDS is being questioned by independent experts⁴³, and that most developing countries do not have the mechanisms and/or resources to monitor, let alone combat, HIV infection.

Lyn Denny proposes that the high incidence of HIV in the country is related to the early age of onset of sexual activity, and the fact that a LoveLife survey revealed half of all adolescent sexual intercourse as non-consensual, with the bulk (35 - 40%) of all rape survivors being in their teens⁴⁴. Approximately 10% of all rape survivors are already HIV+ at the time of the rape, according to Denny.

Meerkotter⁴⁵ notes that the viral load of an HIV+ person who is receptive during penetrative sexual intercourse, irrespective of consent, with another HIV+ person, will dramatically increase, and hence hasten the onset of, or exacerbate, AIDS. Thus irrespective of rape survivors' HIV status at the time of trauma, their HIV/AIDS susceptibility will be exacerbated by rape.

Given the proliferation of gender-based violence in South Africa, along with the archaic patriarchal tradition of non-monogamy for men, combined with a contested and divided government programme on the issue, as well as wholesale societal denial of the issue, like ostriches in a garbage dump, it is not surprising that our country is confronting an epidemic of HIV/AIDS, and that we are far from beginning to stem the tide of infection with HIV and death due to AIDS.

4.5. Anti-Retroviral Therapy (ART) and Resource Constraints:

In the context of resource constraints, the question of whether expensive medication, such as ART, is appropriate stimulates critical debate. A broader question that was raised by a few respondents is whether Universal Health Rights in the form of expensive drugs is appropriate when there is no food, shelter, water/electricity or sanitation. In the case of dialysis, heard by the Constitutional Court, the state argued

⁴³ Cf postings during early September 2002 on the listserv gender-aids@healthdev.net, URL: archives.healthdev.net/gender-aids.

⁴⁴ Synnov Skorge also notes that "the Rape Crisis statistics at the Sarah Baartman Centre say the same".

⁴⁵ Interview 12 April 2002. Meerkotter is a Legal Researcher with the Gender Project at the Community Law Centre, UWC, and also works closely with TAC.

successfully against the plaintiff and asserted that the high costs of dialysis would detract from the benefit of providing basic health care (such as inoculating children against easily treatable diseases). On the basis of the principle of progressive realisation of rights, the state conceded that it had an obligation to provide health care, but that it could only do so with limited resources, and hence the state had to weigh costs and benefits, and at least provide the most basic of care until it is able to provide further care when more resources become available. The Constitutional Court ruled in favour of the state, and the plaintiff eventually died due to kidney failure.

What are the implications of resource constraints, and pressure to allocate resources appropriately, for gender-based violence? In the case of rape, the majority of cases are not reported. Hence AZT only reaches a small percentage of survivors.

According to Lynnette Denny [2001], "only 50% of women present to a medical facility within 24 hours of rape", with 72 hours being the maximum delay allowed for PEP to be effective. So only half of those who seek medical treatment, and only a percentage of these survivors report the case to the police, are actually eligible for post-exposure prophylaxis (PEP), and not everyone chooses to take PEP.

So too if between 10 and 25% of raped women are already HIV+ at the time of being raped, they too are excluded from PEP.

Even in the case of those on PEP, there is a high non-compliance (dropout) rate. According to Lynnette Denny [2001] "only approximately 25% of women return for follow up".

This raises the issue of who controls discourse, whose issue ART is, and who, and which issues, actually get attention. This issue is a reflection of class, race or ethnicity, as well as gender. This especially given the legacy of apartheid in South Africa, where class still largely remains yoked to race or ethnicity, and is inevitably compounded by gender.

As Benita Moolman so eloquently asserts:

Resources need to be allocated differently - too much money is spent on AZT. We need to spend money on adolescent clinics to give them [adolescents] access to info, IECs and services. A paradigm shift is needed so for example the Education Department needs to address the intersection from an early age. We need more coordination between government departments - we can't talk about AZT without talking about poverty, water and sanitation, food, transport. Thuthuzela - when survivors are tested and they're already positive - so what's the use of AZT then?

HIV/AIDS is a very public issue and also very gendered. Men are more likely to be infected than raped, therefore HIV/AIDS is a men's issue and hence a public issue. In a postcolonial context development issues of poverty and economics are of critical importance, but instead we place more resources on AZT, etcetera. We need a much broader political level, rather than merely gender, to address issues of resource allocation, priorities, and so forth South Africa is more than merely patriarchal (which it is also). Bourgeois white women, for example, buy into history in terms of resource allocation because their issue is AZT and they don't have to worry about food, sanitation, etcetera.

Hence Moolman and others assert that addressing any issue without paying attention to people's basic needs, such as food and housing, is not only misguided, but also ultimately ineffective. This has been shown to be the case with combating e.g. tuberculosis, where nutrition, access to clean water and sanitation are as important as medication and complying with medical treatment. Judith Lewis⁴⁶ of the World Food Programme also emphasises the importance of paying attention to nutrition needs: "when on anti-retroviral therapy people need adequate nutrition because the drugs are very hard on people's systems".

So too HIV/AIDS and gender-based violence are gendered issues. Since HIV/AIDS affects men, it has become a state and public priority. And until it is shown that GBV also affects the broader society, and particularly men, in economic and other terms, it will remain to be viewed as a 'women's issue'.

Barbara Rass speaks of mother-to-child-transmission (MTCT) of HIV, and notes that mothers die due to AIDS and leave "aids orphans - they need homes over the long-term... no one looks deeper at the future implications of mother to child transmission...This is the issue of the day". Irrespective of the arguable merits of MTCT, if one merely provides mothers with ART at the time of childbirth, the mother's illness is not combated, eventually leaving orphans in need of care and further burdening an already stretched state budget. More holistic treatment, which includes long-term medication for the mother after childbirth, should be provided, let alone considered, or else consequences could be severe in the future. Thus Rass appropriately refers to the present generation as a "lost generation".

In addition to this, class impacts critically on resource constraints. If one is dying of hunger, one is less concerned whether one has a disease or not and more concerned with finding food to eat. Hence viewing HIV/AIDS, gender-based violence or any other issue to the exclusion of people's basic needs is myopic. It is precisely for this reason that the Treatment Action Campaign's work does not speak of combating HIV/AIDS in isolation of basic survival needs. And the reason one of the leaders of HIV/AIDS activism in the country, Zackie Achmat, refuses ART until it is freely accessible to each South African who needs it. And not merely to those who can afford it and are its loudest advocates.

4.6. Infant and Child Rape:

This discussion of infant and child rape has been incorporated due to the common (mis)perception of an increase of this form of rape due to the myth that sex with a child may cure HIV/AIDS.

Health and GBV service providers unanimously note that infant and child rape has been prevalent long before the 1980s when HIV/AIDS became public knowledge. Various people interviewed at the Wynberg Sexual Offences Court, notably Tughfa Hamdulay⁴⁷ and Jennifer MacMaster, both social workers, as well as Magistrate

⁴⁶ Interviewed on *SABC3 News* at 20h00 on 16 September 2002.

⁴⁷ Interview, 11 April 2002. Hamdulay is the Social Worker at the Sexual Offences Court in Wynberg.

Daleen Greyvenstein⁴⁸, attest to this. Both Drs Lynnette Denny⁴⁹, a gynaecologist, and Lorna Martin⁵⁰, a pathologist, individually support this view from years of working in the public health system. Dr Ferdi Franz⁵¹, former Superintendent of GF Jooste Hospital, similarly verifies between six and seven thousand cases of child rape during the fifteen years he spent as medical practitioner on the Cape Flats. At GF Jooste Hospital he encountered between two and six raped children daily. Van As et al [2002] cite Martin: "I have seen rape of babies periodically during the whole of the last decade in which I have been working as a district surgeon and forensic pathologist, and have not particularly seen more recently".

In a conference presentation [2002] Rachel Jewkes notes that there have always been toddler and baby rapes in South Africa, and that this is found in many countries. In the same presentation, Jewkes attempts to "set the origins of the myth in cultural, geographical and historical context". She asserts that "there is no evidence that in any of the recent baby/toddler rapes men were seeking HIV cures".

Jewkes cites Dr James Devon in Scotland during 1913: "There is a curiously persistent and widespread belief that a man who suffers from venereal disease can get rid of it by having connection [sex] with a virgin". Vetten and Bhana [2001] also support this historic fact: "This is not unlike beliefs which proliferated in nineteenth century England claiming that sex with a child would cure syphilis (Leclerc-Madlala, 1997)".

Jewkes postulates most convincingly that this false attribution was due to "reluctance to identify male family members as perpetrators even when that was obviously the case; and reluctance to accept that child rape could be linked to sexual gratification (albeit through exercise of power)". Interests served, she maintains, were in favour "of the ruling elites (men) as it enabled public outrage to be channelled without challenge to male sexuality and the hallowed institution of the family within which much of the rape occurred". She suggests that instead of the virgin cure myth, the real reasons these child rapes occur are due to "the same unrestrained male sexuality which expresses itself in the rape of older women, or even politicians and media blaming people with HIV rather than recognising the need to transform social values on male sexuality".

Speaking to Van As et al, Jewkes lays the blame "for the very high levels of interpersonal violence" on the country's past:

Many people in South Africa have been extremely brutalised by the political violence in our past, the disruption of families and communities, high levels of poverty and the very high level of violence of all forms. Much of this violence is directed towards women and girl children - a result of the marked gender inequalities in our society, a culture of male sexual entitlement and climate of relative impunity in which rape is perpetrated. The root of the problem of infant rape, as with rape of older girls and

⁴⁸ Informal interview, 6 June 2002, at Rape: Rethinking Male Responsibility Conference, University of the Western Cape.

⁴⁹ Interview, 12 April 2002.

⁵⁰ Informal interview, 18 April 2002, during SAGBVHI conference in Johannesburg. Martin served as District Surgeon in numerous areas over many years.

⁵¹ Interview, 9 April 2002.

women, substantially lies at these more mundane doors. It should be regarded as part of the spectrum of sexual violence against women and girls.

Ultimately, Helene Combrinck⁵² maintains, the inability of the child to fight back and/or report the attack (unlike adult survivors) lies at the heart of the proliferation of this social ill. Combrinck asserts that all rape, but child and infant rape in particular, is the result of power, and the perpetrator's desire to assert power over the survivor, rather than issues of sex or sexuality. To support her classical hypothesis, Combrinck cites two seminal texts, Lloyd Vogelmann's *The Sexual Face of Violence*, which records rapists' own justifications for their crimes in which they assert that rape is about power and not sex, as well as December Green's *Gender Violence in Africa*⁵³.

Whether rape is about sex and/or sexuality, or about power, or combinations of these factors, remains debatable both within and outside feminist and gender-based violence circles. Incontrovertible, however, is the fact that the proliferation of infant and child rape has less to do with its myth as a cure for HIV, and more with systemic issues such as issues of male sexuality (invariably yoked to power), and a lack of adequate and appropriate attention to the issue by politicians, the media and the general public.

As Jewkes says to Van As et al:

Infant and child rape will only be prevented if all forms of violence can be reduced in our society, poverty reduced, and a climate of gender equality and respect for women and girl-children promoted. I think that rape ought to be redefined. All acts of coercive sex should be regarded as rape, irrespective of the circumstances. And communities should develop an environment where men are deterred from rape through threat of punishment. To do this, more resources are needed for expanding the provision of medical staff trained in sexual assault examination and extending police and social work capacity for investigating and assisting rape cases.

4.7. Why rape is challenging to convict:

The high risk of HIV infection during rape makes it even more important to combat rape, and to prosecute and imprison rapists, if only to prevent the perpetrator from repeating the act of rape and possible HIV infection. However, conviction of most rapists has been relatively less successful, as well as very challenging, for various reasons.

The Thuthuzela project has an 80% conviction rate, according to Ferdi Franz, compared with a national average of 20%. Magistrate Daleen Greyvenstein attests that the Wynberg Sexual Offences Court only takes to trial cases that have a higher probability of conviction, and excludes other cases where, for example, the rape survivor was intoxicated (under the influence of alcohol and/or drugs) at the time of the rape and/or the case was reliant on third party witnesses due to the incapacity of

⁵² Informal interview, 16 April 2002. Combrinck is Senior Legal Researcher with the Gender Project, Community Law Centre, UWC.

⁵³ In particular pp68ff.

the survivor to testify in court. This careful case selection is also the reason why Thuthuzela is said to have such a high conviction rate, beyond the obvious merits of the project.

Helene Combrinck maintains that rape conviction is more related to "a broader philosophical issue that is inextricably tied to a legal system premised on adversarial practice". A former sexual offences prosecutor, Combrinck mentions, for example, the fact that prosecutors have to "disclose evidence to the defence but that reciprocity on the part of the defence is not obligatory". Other issues Combrinck cites include widespread corruption within the legal-judicial system (public and private) and the police services, as well as systemic issues such as an overburdened judicial system, and prevailing patriarchal attitudes within society generally and the legal-judicial system particularly.

Irrespective of whether cases are carefully selected by the Thuthuzela project and the Sexual Offences Courts, until compulsory minimum sentences for rape are implemented, providing at least some form of deterrence for this sociopathic trend, rape will remain a leisure activity for many South African men.

4.8. Same-Sex Violence

We believe it is the first time that a survey of this kind included specific questions on same-sex GBV, which we intended to determine the extent of rape of lesbians and bisexual women by men on account of their sexuality, or "curative rape", which we knew to be pervasive from anecdotal and minimal recorded evidence⁵⁴. What we discovered from especially domestic violence (DV) organisations⁵⁵ and Triangle Project⁵⁶ is that the spectrum of GBV also applies to same-sex relationships.

Faeza Khan asserts that "domestic violence is not absent from same-sex relationships. At NICRO, as a counsellor, I dealt with such cases over five years. I encountered well over 50 cases out of about 2000 cases in total". Benita Moolman confirms that she too encountered same-sex domestic violence during approximately three years of working at NICRO. Khan attests that she received a number of mainly telephone crisis calls from women who were being abused by their female partners, some seeking placement in shelters⁵⁷. Khan mentions that a number of the phone calls were "once-off calls because the women want help but can't come out [of the closet]... due to public prejudice and because it is difficult to get out of these

⁵⁴ Two queer anthologies edited by men (Gevisser & Cameron, 1995, and Krouse, 1993) as well as Triangle Project's recent women's camp that focused specifically on violence and sexuality and was designed to assess needs that would be addressed broadly. Benita Moolman of Rape Crisis assisted with facilitating Triangle's women's camp.

⁵⁵ E.g. Faeza Khan who now coordinates the Gender Advocacy Programme's Domestic Violence Programme, was formerly a social worker with NICRO, an NGO that works largely with domestic violence issues.

⁵⁶ Triangle Project is an NGO that "challenges homophobia and works towards the appreciation of sexual diversity". Triangle "offers a number of medical and counselling services to the LGBT (lesbian, gay, bisexual and transgender) community".

⁵⁷ The shelters were independent and not managed by NICRO.

relationships". Barbara Rass comments about her peri-urban (sometimes considered rural) community:

In Atlantis most dykes are in the closet. For those who are out of the closet, there is some verbal harassment, but no physical violence... But there is a lot of DV in dyke relationships - most are afraid to come out in the open and seek help - their fights are more severe because of the more sacred bond [between women].

Khan asserts that same-sex domestic violence is about "power imbalance rather than gender... The dynamics of the relationship is the same irrespective of the gender of the perpetrator or victim... And hence the complications regarding disclosure of [sexual] preference where heterosexuals are largely favoured". Moolman suggests that it concerns "how we internalise power and violence and ways of dealing with conflict". To help combat some of these issues, Khan⁵⁸ "includes issues of sexuality in the training around domestic violence and gender".

Susan Holland-Muter suggests that

Dykes suffer all kinds of violence due to their sexuality, including internalised lesbophobia, on a continuum with death at its most extreme. The extent is invisibilised because dykes don't see it as violence because it's so normalised. It's also not seen by the broader community as an issue. Therefore little attention or funding is given to it. It is also a taboo issue and so leads to more embarrassment. Domestic violence operates on the same continuum. Emotional and psychological violence is as pervasive as with het. Lesbian relationships face greater pressures because they are more invisibilised, with the control of movement and insecurity issues further adding to the invisibility.

Dawn Betteridge⁵⁹ of Triangle Project supports this:

Lots of women are held hostage by their sexuality, which is closeted. This is compounded by DV, which is also closeted. There are stereotypes about perpetrators as men, and for many [dykes] they have idealistic ideas about same-sex relationships as free of violence. Dykes are not equipped to handle this and the system is not geared to assist them. If the relationship is not happening, how can violence be happening?

Since services are geared towards heterosexual women, lesbians and bisexuals face not only the silence and stigma about their sexuality, but also about their experiences of GBV. This may be compounded by the political implications of debunking conventional idealisms about lesbian relationships. As Parenzee⁶⁰ puts it, "societal expectations of women would lead to social disbelief that women can be violent towards their women partners". Synnov Skorge notes that "letting their side down cuts across class, race and sexuality: white women in the shelter feel the same way, that they're letting the side down". Reporting DV may exacerbate the double-edged invisibility of lesbianism and same-sex violence.

⁵⁸ Comments via email, 26 September 2002.

⁵⁹ Interview 9 April 2002. Betteridge is Director of Triangle Project.

⁶⁰ Completed questionnaire, returned 5 April 2002. Parenzee is Senior Researcher with the Gender, Law & Development Project of the Institute of Criminology, University of Cape Town. Parenzee is also a member of the Consortium on Violence Against Women.

Needless to say, this needs to be addressed both by conventional gender-based violence organisations (including shelters), in terms of making their services more sensitive and open to all women irrespective of sexualities, as well as the need for queer⁶¹ organisations to work with their queer constituencies on addressing this issue. As Synnov Skorge puts it, homophobic

paranoia is even worse than for HIV. Lesbian sexuality is an even greater threat for women's sexuality, with the false belief that lesbians are a danger to children - what they [shelter residents] fear is that lesbians would sexually molest their daughters and/or sexually molest other shelter residents. So, for example, they won't go into the bathroom if a lesbian is there already. The biggest fear of moms is of their boys being feminine.

Skorge asserts that she wants "to do sexualities training with [their] staff", as well as "anti-bias workshops". Dawn Betteridge identifies the "need for a [queer women's] support group on GBV". Triangle Project recently published a number of pamphlets addressing safer sex and health issues for lesbian and bisexual women⁶².

Gertrude Fester notes that black lesbians and bisexual women often have to relocate homes due to gang threats. She asserts that "racism intersects with sexuality and gender", especially when black lesbians have to leave townships to live in white areas for their own safety." Based on "mostly phone-ins and sometimes referrals" at Rape Crisis Khayelitsha, Mshumpela comments:

I think for Africans/black women it is still an issue (culture), especially in our townships there is a lot of violence towards lesbians... I can say that these women are being targeted because of their sexuality, a group of assailants known to the survivor prove a point of her 'womanhood' by sexually assaulting her. Lesbians find it more difficult to disclose rape/violence because they are going to be blamed first due to their sexuality and not being taken seriously about the rape issue.

Sipho Mthathi notes:

I know it happens a lot, especially in rural areas. Women don't love men and know what'll happen to them and then they stay in relationships [with men] because of fear. Some women are beaten by men who want to make them 'normal'. A friend came out to her boyfriend and he beat her to a pulp... Stories aren't publicised enough... While I'm heterosexual, I associate men with violence, and as a lesbian I would feel much more violated if I was raped. If I am raped because I'm a dyke, there'd be an added sense of wanting to cause harm because of my sexuality - the man is king and therefore he can rape a dyke. If an assailant knows a woman's sexuality then this fact would add a sense of wanting to cause harm.

⁶¹ "The use of the term 'queer' in this paper is an acknowledgement of the radical queer movement's understanding of sexualities as inclusive of the entire spectrum of sexualities that are not heterosexual, such as (am)bisexuality, androgyny and transgenderism. The term queer is more inclusive than the conventional terms 'gay' and 'homosexual' that do not account for alternatives to the dichotomies of gay-straight and hetero-homo, which usually refer to men to the exclusion of women. It is also more radical since it directly confronts (and affronts) the dominance of heterosexism by re-appropriating the historically pejorative 'queer'." The same applies to the (re-appropriated) term 'dyke' used in this paper by both the author and some respondents. Cf Muthien, 2002(a).

⁶² Pamphlets include "Lesbians, Bisexual Women & Safer Sex: Know the facts", "Lesbians, Bisexual Women & HIV: Know the facts", and "Lesbian & Bisexual Health Issues: Breaking the Silence".

Women who are raped due to their sexuality, according to Dawn Betteridge, happens in

all communities, but it's predominant in african and coloured communities, from the stories I've heard. Most black women want to come out with info in for example workshops, but white women want to come out only in for example counselling sessions. Some stories relate to mothers in the black community who set up 'curative' rapes and other families encourage rape to result in pregnancies in the hope that this will have the survivor refocus on the child instead of her sexuality. The definition of rape in the public eye is still heterosexist. [original verbal emphasis].

Betteridge asserts that rape of women by women is

Far more common than we'd care to acknowledge. It's easier to think of perpetrators as male and this makes it easier to handle. Women target women in gay venues due to their vulnerability. There was a story about children in a Cape Flats school with many girls coming out - they form gangs and perpetrate violence because it's their understanding of relationships - you're either victim or perpetrator or woman/man - the perpetrator is the one in charge. It's about sexual identity issues and how youth perceive sexual relationships and in a violent context this is their only understanding. With a gang culture and sexual initiation into gangs - belonging comes from sexual violence.

Fester suggests that "it is worse for lesbians in every sphere, for example medical treatment". She maintains that the "intersectionality of oppressions is important since it compounds one's experience of oppressions, for example they love you on the stage as an artist, but they don't want you as part of the family". The issue of lesbianism is further exacerbated by the large-scale invisibility of women in general.

The issue of sexualities, Fester notes, is a "challenge for the CGE since not much has been done on sexuality and homophobia. Poor rural women are the focus of the CGE, but what about the poor rural dyke, who is most invisible and at risk?"

Holland-Muter notes that it is very difficult to organise around the issue of same-sex domestic violence, since there is a common perception among lesbians that the "enemy' is outside. But we should admit that the 'enemy' is also inside and confront how to deal with this and create safer spaces". Debbie van Stade also notes that "legislation and policy hasn't filtered down". Her government department staff are opposed to "same-sex adoption"⁶³...We need staff sensitisation about sexualities, rights, etc. - we need advocacy and lobbying as opposed to service rendering".

Dawn Betteridge suggests the

need for campaigns about new concepts of rape and sexual violence in the public eye, both queer and straight, beyond penis enters vagina. We need a more overt campaign on sexual violence generally, and making women aware of the fact that this [same-sex GBV] is as serious as heterosexual violence.

⁶³ During early September 2002, a woman judge succeeded in her application to the Constitutional Court to have legislation overturned preventing her from jointly adopting children with her lesbian life-partner. While the right of same-sex partners to adopt children has been recognised for some time in our law, this particular case centred on whether such partners may jointly adopt children, (i.e. both become the adoptive parents instead of only one), similar to adoption by a married heterosexual couple, where both parents have rights and duties regarding custody and guardianship.

Holland-Muter suggests that post-exposure trauma is "very individual for each individual experience". She notes issues of

self-esteem, support networks, internal and external resources. What might be different with lesbians is that curative rape would cause an added dimension or trauma. If it's just generic rape, there is the impact on the dyke partner, especially regarding access to heterosexist services and support, like family support.

Van Stade asserts that "trauma is trauma... Regarding [same-sex] domestic violence, people are more shocked. This has never been put on the public agenda and we need to lift the lid". Barbara Rass also comments:

It's harder for dykes because they're not into that [heterosexual intercourse]. Even for them to overcome rape is harder. It's about power - male strength over women. Therefore it's harder for dykes to accept, the very thing they fear, the very thing they're not into. They may be targeted by men because they're perceived as almost virgins - as both a threat and object of desire.

Dawn Betteridge comments on the consequences of 'curative' rape:

Some consequences of rape may be more difficult for dykes, for example why they're raped - sexuality becomes public knowledge when charges are laid. Some dykes may renounce the victim because they're seen as unclean goods - some dykes have very narrow ideas of sexuality, for example you can't be a dyke if you've ever had sex with a man in the past. Questions are asked: did you invite it, and so on, same as with straight women, from both the public and one's own peer group. This is very painful for dykes... In reality dykes don't want to know, that being a dyke could expose one to such violence. It also poses challenges in counselling - compounding rape with sexual identity is very difficult especially with the majority of lay counsellors who are accessible to the public... We have to include general societal violence [in our work], in addition to violence that's specific to dykes - how the general conditions impact on sexuality or not, for example dykes in shebeens with men buying them drink and their exposure to sexual violence - they knowingly expose themselves because of lack of money. This is very interesting, but what as an organisation can we do about this, and how can we handle it?

Benita Moolman of Rape Crisis also notes the "myth of dykes as virgins and therefore the desire to rape her". She comments on the "levels of silence" which are usually problematic" and asks, "how does the sector silence especially same-sex relationships? There are no specific services and these need to be developed - all rape is not the same and therefore we need different services for different types of rape."

Dawn Betteridge comments on the

perception that HIV does not affect dykes - there is minimal literature on HIV and dykes. But because of GBV, dykes are at higher risk, especially specifically [if violated] on the basis of [their] sexuality. Triangle has to ensure its literature states this. We can't tackle this in a specific way as an organisation, but should mainstream the issue. Triangle focuses on men and HIV, but we need to repackage the issue and encourage women to test for HIV, perhaps as a sub-issue to why they come in. Broadly, women are very susceptible to [HIV] infection, but they are always referred to heterosexual organisations. The organisation needs to create understanding. Lesbians who have sex with men are also a huge issue.

Notably rural respondents refer to men raping male homosexuals and male transvestites, most of who are engaged in some form of sex work⁶⁴. Florence Syzaar refers to routine police harassment as a

witch hunt on lesbians and gays. The police pick them up, hose them with water and drop them off in deserted areas. They harass them in public and at gay pickup points. [Queers] also have rights. One [cross dressing man] was forced to wear men's clothing, especially in church. They eventually allowed her to wear a woman's pants suit instead.

Florence Syzaar notes that queers who report rape or sexual assault "don't have support. They get laughed at by the police and are further harassed, especially gay men". Renee reports "ignorance in the community" and the "castration and murder of a gay man". William Syzaar notes the "severe possibility of assault, especially on farms", when gay people come out of the closet. Both Renee and William Syzaar mention that the "courts have negative attitudes and discriminate against gays".

It is interesting to note that rural respondents refer to male homosexuals and transvestites as female by consistently employing feminine pronouns and calling them "women", "girls", etc.

Skorge asserts that "most women are feeling heterosexual sex is on its way out due to the risk of HIV infection - women are no longer tied to permanent monogamous relationships [with men], for example due to greater economic freedom. Most people fall in the centre of the continuum [of sexualities]". On Skorge's optimistic note of greater sexual freedoms for women especially, service clustering as a model for strategic intervention, in the context of the intersections between gender-based violence and HIV/AIDS, is explored below.

5. RESPONDENTS' RECOMMENDATIONS

While no one concrete strategy emerges, respondents identified the following strategies, which has been sorted into three different levels:

- The macro level refers to broader government policy and legislation;
- The meso level is focused on organisations' needs and priorities;
- The micro level pertains to communities and individuals specifically; while
- The large number of rural and peri-urban respondents ((40%) necessitated a special note of their particular needs and concerns.

5.1. MACRO level (government / policy / legislation):

(a) Increased **government commitment** to addressing the issues individually as well as their intersections, as an interdepartmental government approach (e.g. Thuthuzela Project and Rape Protocol). Penny Parenzee notes an "urgent need to ensure inter-sectoral working of [government Departments of] Health, Justice, SAPS

⁶⁴ A large number of rural respondents are based in Beaufort West, a large town well-known for its outdoor sex work, often frequented by truckers who regularly pass through the town. It is also known for transvestite sex workers.

[South African Police Service] & Welfare, even Housing". Parenzee suggests some form of:

Lobbying for joint working together of various government departments to ensure implementation strategies to safeguard women who are vulnerable to further violence because of HIV status, or vulnerable to HIV infection due to nature of relations.

Sipho Mthathi of TAC maintains that we

need a more aggressive approach to the way women's issues are put on the public political agenda. Statutory gender bodies should publicise their constraints like their severely limited budgets. We need a much more outspoken community of women to point out the limitations in government policy and action in addressing women's issues. Government needs to deliver funds for women's programmes.

(b) Increased **government funding** / resource allocation to combat both epidemics, including funding for, and support of, shelters and other kinds of organisations, as well as development of educational programmes and materials on the issues.

(c) The **education system** needs to address both issues (and **broader sexualities training**) from an early age (starting in primary schools). Sipho Mthathi asserts that we:

need intensive education programmes that should start at school and include communities and tertiary institutions. Education should move beyond prevention (which is too narrow) and include broad education on gender (beyond nice posters). Also about relationships because this is the key with HIV - conducting relationships, boundaries, rights, especially with women.

Benita Moolman of Rape Crisis asserts that "women's bodies need to be spoken of more. We always talk about it after the fact, for example AZT. We need to shift, before this, what are we telling women about their bodies? Why are we not advocating Rape Crisis', sexual and reproductive health and rights?!" An important issue that emerged was the fact that educators themselves are perpetrators of abuse, and hence they should be trained to not merely screen for and prevent generic abuse, but trained to not be abusers themselves.

(d) **Sensitising health care and social services workers to prevent abuse** of patients regarding stigmatisation and discrimination (of especially GBV and STIs), as exemplified by e.g. GF Jooste Hospital. Jennifer MacMaster attests that "social Services give very bad treatment to Stage 4⁶⁵ AIDS grant applicants", but her office attempts to address this. She mentions that especially "intake clerks who are very bureaucratic and have little education, and those frustrated with high case loads and little resources, capacity, etc. also largely discriminate against [HIV] positive people". This especially since "most clients of social services are women". The Western Cape has initiated a fast-track procedure to ensure speedy access to disability grants for PWAs. Debbie van Stade also notes the need to train domestic violence counsellors on GBV and HIV, and the fact that her government department is at present embarking on a project to train community-based domestic violence counsellors. Anneke Meerkotter of the Community Law Centre asserts the need for, beyond one-stop centres (like the Thuthuzela Project),

integrated health care (including GBV and HIV) on the ground, for example at primary health care level. Health workers and others need a referral list of GBV/HIV

⁶⁵ Terminally ill.

organisations. We need GBV support groups in the same way as some have HIV support groups in clinics, etcetera.

While an excellent initiative, the government's existing Batho Pele project, a code of conduct for all government departments dealing with the public, should be rigorously implemented and monitored, with state employees who are found guilty of misconduct either rehabilitated (re-educated) and/or severely dealt with. There are also many other guidelines which workers are subject to and which should be monitored.

(e) An **intersectoral partnership between government, NGOs and research institutions** is necessary. As Mshumpela says, "I think we need more research and partnership by NGOs, government and academic institutions". Gertrude Fester of the Commission for Gender Equality notes that even within government cooperation is necessary, e.g. she stressed the importance for the 3 statutory gender bodies⁶⁶ to form a strategic partnership in order to avoid duplication, and due to limited resources and capacity experienced by especially the CGE and the Parliamentary Committee. At the first National Gender Summit during August 2001, convened by the CGE, all 3 statutory bodies defined violence against women, HIV/AIDS, and poverty as pertinent issues affecting women. This is one way in which institutions can unite, even if merely on a policy level, to define and combat mutual issues. Fester also requests that the CGE should be used more strategically to support the existing work of NGOs, and mentions that the CGE has a Complaints Division in each province, and that the CGE could intervene if a problem exists especially at magisterial level. The CGE does referrals to NGOs due to the excellent work of these NGOs.

(f) Naeema Abrahams suggests that "we need a group of experts to **develop a national strategy** which will bring all the important players on board - similar to the SAGBVHI⁶⁷".

(g) The **provision of ART** in the case of rape and to reduce the risk of mother-to-child transmission of HIV⁶⁸.

(h) Gertrude Fester notes that government and civil society need to ensure that **laws are implemented**. There is no purpose to having radical legislation, such as the Domestic Violence Act of 1998, if it is not implemented and offenders prosecuted, convicted and appropriately sentenced. Spamer suggests further that "protocols should be established to ensure implementation. People should be prosecuted if they do not fulfil their duties".

⁶⁶ The Commission for Gender Equality, the Office on the Status of Women (in the President's Office), and the Parliamentary Committee on the Monitoring and Improvement of the Quality of Life of Women.

⁶⁷ South African Gender Based Violence and Health Initiative, administered by the Medical Research Council, with experts including social scientists and medical and legal experts.

⁶⁸ Since the start of this needs assessment, the government agreed to provide ART to rape survivors and to HIV-positive women in labour.

5.2. MESO level (organisational):

(a) **Development of educational programmes and materials**, for selves and clients, with a large need to focus on youth. Many respondents suggest that the earlier the education begins, the better, preferably beginning in preschool and/or primary schools. Tughfa Hamdulay suggests that "an effective medium is through life skills programmes":

In the sex offender diversion programmes, life-skills are taught and issues of gender (stereotypes) and socialisation are tackled and challenged. Victim empathy, prevention and relapse of crime are also emphasised. A few HIV/AIDS programmes have been conducted, aimed at community and general staff.

As Barbara Rass puts it, education "from the cradle to the grave...will empower especially young(er) people to understand and say 'no'". Education on HIV should include prevention, treatment, healthy living, rights, and caring for PWAs. Education on GBV should include surviving and reporting GBV, the Domestic Violence Act, options and services, and that GBV is not the survivor's fault (internalised victim blaming). All education programmes on HIV and GBV should include discussion of access to social security and other state services.

(b) Rass notes that, in addition to education, programmes aimed at combating both GBV and HIV/AIDS individually and as intersecting, would "be a means to job creation - could create healthy adults and build our nation - in a structured way". The issues of **job creation, skills development and economic empowerment** are of particular concern to Rass and most rural respondents, since their areas are the hardest hit by unemployment and poverty.

(c) **Improved crisis intervention.**

(d) **More holistic service provision.** A need to move away from territoriality and exclusion by either sector was identified by a number of respondents. (It is ironic that TAC is able to open one-stop treatment centres in the Eastern Cape with existing partners there, while they are confronted with resistance to form partnerships by GBV organisations in their home province, the Western Cape). Bulelwa Mshumpela of Rape Crisis contributes the following:

I think a platform for discussions need to be opened by organisations who deal with GBV only and HIV/AIDS. Also as an organisation dealing with sexual violence, we do need to network and get more information on the links [of] HIV/AIDS with sexual violence.

(e) Susan Holland-Muter suggests that

GBV organisations need to look more at HIV as a consequence of rape (in addition to traditional issues like pregnancies and other STDs). They should look at access to health services, drugs and HIV counselling (on top of rape counselling). HIV organisations need to look at the position of women regarding control of their own sexuality, and therefore should include sexuality and gender as key issues in prevention and legal advocacy work, thereby contributing to breaking down the taboo about talking about these issues. They also need to address the gender dimension of women's economic access to treatment.

She notes the link between abortion in the case of rape: "abortion should also consciously be offered as a viable choice post-rape". Holland-Muter affirms that she

would like to include HIV and gender-based violence in her generic gender training programmes.

(f) **Facilities and services need to be more easily available**, and if not free of charge, preferably needs to be as affordable as possible. E.g. the cost of (private) counselling is prohibitive and non-profit organisations like Rape Crisis usually limit the number of consultations afforded each client, primarily due to resource constraints.

So too Mirriam Sifile⁶⁹ and Griffithma Nongwe⁷⁰, both of Ceres, a rural town, assert the need to "establish women's support centres in townships or squatter camps, to support town-based advice offices, which are usually less accessible"⁷¹. Hence the need for affordable and *accessible* services.

(g) **Develop and enforce HIV policies**, as well as gender mainstreaming policies.

(h) **Provide anti-retroviral therapy (ART) to all people living with HIV**⁷².

(i) **Broader training in sexualities and STIs** e.g. Human Papilloma Virus or HPV causes cervical cancer, which causes death⁷³. HPV is also the leading cause of death, even greater than HIV, for e.g. black women in Brazil. So too HPV transmission is also a far greater risk in lesbian relationships than is HIV transmission.

(j) Naeema Abrahams of the Medical Research Council suggests "**Research** - we need to know what exactly are the links/ what mediates it/ how strong and is it the same or different for all forms of violence and also what interventions will work". Bulelwa Mshumpela of Rape Crisis Khayelitsha also supports the idea of "a research initiative...and maybe an evaluation of the work that has already been done".

(k) Gertrude Fester notes that the **media reinforces negative stereotypes**⁷⁴, especially regarding the portrayal of women as passive and the glorification of violence. Fester recommends that this be monitored and combated. Part of the Every 6 Days Campaign⁷⁵, coordinated by the Western Cape Network on Violence

⁶⁹ Sifile is Manager of the Women's Desk at the Ceres Advice Office.

⁷⁰ Nongwe works with the Nduli Women's Group, a community-based organisation in the Ceres area.

⁷¹ Interview, 4 April 2002. Sifile and Nongwe were interviewed together, at their request.

⁷² Cf section 5.2 on page 20.

⁷³ Dr Lynnette Denny founded a Cervical Screening Project in Khayelitsha, a Cape Township, several years ago. This project is particularly significant given the South African government's health policy to provide free pap smears to women over the age of thirty once in every ten years only. Denny, in a presentation to parliament during 2001, asserts that "HIV infected women develop cervical cancer and precancerous lesions at an earlier age than non-HIV infected women."

⁷⁴ The media generally, as well as advertising agencies and clients, perpetuate gender and other stereotypes, e.g. Mark Shuttleworth's First African in Space education campaign (television and print) features a young male 'nerd' surrounded by two women ostensibly only present for their physical appearance. The campaign message, "it's hip 2b²" and study science and mathematics, appeals largely to young men, with women depicted as *accoutrement*, at best, with no thought to the fact that the majority of those who excel at these subjects at school are *girls*.

⁷⁵ This Campaign is presently based in the Western Cape, with plans to expand it to the Eastern and Northern Cape provinces during 2003, and nationally during 2004. The Campaign is not just about

Against Women, is a capacity building programme to train community women to respond to, and counteract, negative media reporting on gender and gender violence issues. Community participants are trained to screen news coverage, and to write letters of complaint to editors when appropriate.

(l) Synnov Skorge⁷⁶ questions whether campaigns are always effective and notes that some campaigns "can be very dangerous" She asserts that **a critical part of any campaign is the need to have services and resources established.**

For example, for rural women who are told to say no to violence - this sounds a little like victim blaming, doesn't it? Especially in light of so few services available, and more especially in rural areas where there are no services. So a woman must say no to violence and then what?! It's extremely dangerous, for women, to have prescriptive messages as part of campaigns, without having the services and resources in place.

Skorge mentions the Clothesline Campaign⁷⁷ as one example of a campaign with "real messages".

(m) Fester emphasises the importance for a **coalition of organisations** to confront both epidemics jointly, "a total onslaught across sectors - a national battle and war against both sectors - to reflect the anger we are feeling". She asserts that the Women's National Coalition needs to be revived⁷⁸. Florence Syzaar⁷⁹ stresses "networking... We must be aware of what others across sectors are doing on this issue. We must work together and skills share".

5.3. MICRO level (communities and individuals):

(a) **Training in sexualities and STIs.** Nombulelo Renene⁸⁰ suggests that "HIV/AIDS should not be politicised and should be treated in the same way tuberculosis was". She asserts that people living with AIDS should counsel others in the same position, and that "medication goes hand in hand with nutrition, and hence [their] programme linking HIV/AIDS and food production". William Syzaar⁸¹ proposes a 3-step programme: (i) "we need the message out first [basic information about HIV/AIDS

femicide, as its name might suggest (a woman is killed by her male partner every 4-6 days). This campaign expressly aims to reduce tolerance of *all* forms of gender-based violence in society. The Campaign uses its name, Every 6 Days, because femicide "is seen as the ultimate [or most extreme] form of violence against women... if we can lower the tolerance of the 'lesser' [less fatal form of gender-based] violences (not to say that any violence is better than another) then maybe the violence will not escalate to femicide." [Cheryl Ayogu, Provincial Network Coordinator, comments via email, 26 September 2002].

⁷⁶ Interview 17 September 2002.

⁷⁷ Cf page 33 of this report.

⁷⁸ In her speech on National Women's Day on 9 August 2002, Deputy Minister of Defence, Nozizwe Madlala Routledge, also calls for the re-establishment of the Women's National Coalition or similar national women's organisation.

⁷⁹ Interview, 5 April 2002. Florence Syzaar is the Education Training and Development Practitioner for the Progress Primary Health Care Centre for Learning, based in Beaufort West.

⁸⁰ Interview, 3 April 2002. Renene is the Chief Community Liaison Officer with the Provincial Department of Social Services, based in Beaufort West, a large rural town.

⁸¹ Interview, 3 April 2002. Syzaar is the Programme Manager for a consortium of NGOs working on farms, the KKCDP or Klawervlei and Karoo Community Development Programme, with an office in Beaufort West. Syzaar refers to his constituency as "deep-rural".

and GBV]; (ii) "form support groups"; and (iii) "bring survivors into the mainstream while established structures should also reach out to end isolation".

(b) **Destigmatisation of issues.** Tughfa Hamdulay suggests "awareness programmes that dispel existing myths, in particular around HIV/AIDS and the 'virgin sex myth'".⁸²

(c) Greater commitment to **support women and people living with HIV/AIDS**, and combat GBV and the transmission of HIV. Hamdulay proposes "projects that empower and uplift women". MacMaster also suggests that "programmes need to focus on women's empowerment - education and exposure to different things - to challenge them to think beyond narrow confines".

(d) Greater **community and individual involvement (voluntarism)** in issues. Hamdulay proposes "tackling gender stereotypes and socialisation through responsible media, talk shows, positive role models, advocacy and lobbying, school curriculum, and adverts on taxis". Jillian Gardner suggests that we "all have a role to play - be more active in changing our own conditions, for example using condoms to protect oneself, protecting children, etcetera".

(e) Gertrude Fester proposes a series of "**gender dialogues** - panel discussions that are open to the public in all 9 provinces".

5.4. Respondents from **rural and peri-urban areas** noted how critical it is that resources reach them, including the "deep rural" areas (where there are absolutely no services like accessible roads, running water, electricity, nearby police stations or health care services). As rural activist William Syzaar puts it, "'core' activities should filter to the periphery, including the deep rural".

6. Clustering Services

The following strategic interventions, centred on the critical need to cluster services, and based on two actual models, are proposed by this researcher.

The Thuthuzela project, discussed previously in section 2, admirably provides a holistic service in the case of rape. However it is based within, and controlled by, a public institution, subject to government (and party political) control. The issue of government control was starkly illustrated by the case of GRIP, an NGO that was evicted from its hospital premises when its practice of distributing PEP to rape survivors contradicted government policy at the time. These programmes, while extremely effective, are also focused on rape to the exclusion of other forms of gender-based violence like domestic violence.

⁸² Cf section 5.3 on page 21.

6.1. SARAH BAARTMAN CENTRE FOR WOMEN & CHILDREN⁸³

Market forces have driven private community health care to cluster, where one building may now house general medical practitioners, psychologists, physiotherapists, a dietician, a pharmacy, and perhaps even dental services. This entrepreneurial spirit can and should be applied to the non-profit sector.

Sarah Baartman Centre for Women and Children in Manenberg, a Cape Town township, provides services in the case of GBV generically. Opened in May 1999, originally as a shelter for battered women and their children, the Centre is today a unique 'one-stop' centre for women and children who experience domestic and/or sexual violence. The Centre serves as a model of service clustering and entrepreneurial spirit by women for their own economic, social and political empowerment.

Embodying the principle of partnership, the Centre houses organisations with which it has forged strategic partnerships to provide comprehensive intervention programmes to both the Shelter residents and local communities. The Centre coordinates the activities of its partner organisations, and facilitates the development of collaborative programmes, with a representative of each partner organisation serving on the Centre's board of management.

a) Sarah Baartman Shelter for Abused Women & Children:

One of the key partners of the Centre is the Shelter for abused women and their children, with the Shelter residents democratically managing themselves. The Shelter offers a 24-hour emergency hotline for abused women and children 7 days a week. Through various personal, economic and social empowerment schemes, Shelter residents equip themselves with invaluable life and job skills to reintegrate into the world as healthier and more productive citizens within an average of 3 months. The success of this work is concretised by the number of Centre and Shelter staff who are former Shelter residents.

b) Economic Kitchen:

The Economic Kitchen is staffed entirely by Shelter residents and unemployed women from the surrounding community, who earn a wage from the very first day of training. The Kitchen caters for, amongst others, large corporations and hotel chains, and is so successful that it outsources some of its contracts to community kitchens. It also houses a dining room that serves as both a general Centre cafeteria, as well as a venue for functions organised by the Centre, its partner organisations and the wider community.

c) Soap Factory:

In partnership with a US-based NGO, Rafiki, unemployed community women and Shelter residents are trained in basic job and life skills to enhance their social and economic self-sufficiency. The women, trained to produce soap products, have

⁸³ Centre information is derived from the Centre's brochure, which this author co-produced, as well as interviews and other communications with Centre staff.

opportunity to develop communication and business skills needed for entry into an industry or a small home business.

d) Western Cape Network on Violence Against Women (WCNetVAW):

The Network plays a strategic coordinating role in the Violence Against Women sector in the province through facilitating and coordinating networking, capacity-building, advocacy and lobbying, media, documentation and information.

e) Athlone After-hours Child Abuse Centre:

The provincial Social Services Department coordinates this project that works with abused, neglected and abandoned children. They provide a critical after hours emergency service to the community.

f) Rape Crisis:

Rape Crisis shares the feminist value that women should be involved in their own healing and decision-making and empower themselves. They offer support to adult survivors of rape and sexual assault. Their services include counselling, court preparation, support groups and self-help, as well as training and education programmes.

g) SANCA:

SANCA works with people who have substance abuse (alcohol and drugs) problems. They work through prevention, education and intervention.

h) NICRO:

NICRO works with survivors of domestic violence and provides them with legal advice, counselling, as well as education and training workshops.

i) Other Entrepreneurial Ventures:

Venue hire/events management: The Centre houses several meeting and seminar rooms of various sizes, as well as a large hall. With the Economic Kitchen, the Centre is able to cater for most social and business functions.

Shelter residents also offer services such as car washing and same-day clothes ironing for a small fee.

j) The Centre works with a variety of other groups, including:

Community Organisations - from church groups to community policing forums;

Professional and Government services - medical and legal practitioners, psychologists and social workers; police, prosecutors and magistrates;

Schools - teachers, governing bodies and students;

Research - the Centre has established relations with the three key local universities, as well as a number of other local and international research institutes.

k) Clothesline Project:

The Clothesline Project centrally involves women and children who write or paint onto T-shirts testimony of their *direct* experiences of violence and abuse. This national project employs the metaphor of 'hanging out society's dirty laundry', and the public disclosure of abuse is often therapeutic for those who choose to do so.

This collaboration between the Network and the Centre is only one example of how passionate the Centre is of walking their talk.

I) Walking the Talk:

The Centre is community-based, within easy walking distance of the day hospital, police station and GF Jooste Hospital, as well as local schools and other services. Women who participate in the Centre's economic empowerment programmes earn a daily wage from the first day of training, and especially with the catering business, women are readily employed in the catering industry when they are ready to leave the shelter, usually within three months from intake date.

While the Centre continuously evolves, its fundamental principles remain the same, making replication, even in rural areas, very feasible.

What Rape Crisis Heideveld has identified is a need for a health care practitioner on site. This may be a student medical doctor and/or a nurse practitioner and/or a qualified medical practitioner willing to volunteer time at the Centre. The health sector, and medical doctors in particular (especially those in private practice), should be encouraged to do more community service. One would struggle to find a more suitable place for a resident or intern gynaecologist to gain invaluable experience in the field.

The Centre would also like to house an HIV/AIDS service provider, to precisely address the linkages that are the subject of this report. In the words of Synnov Skorge, "we need to bring in a specific HIV organisation that will also do ongoing training with other service providers in the building. We still have much work to do around safer sex and addressing fears and anxieties".

So too the Centre is working towards developing its resource centre, in collaboration with a local research and advocacy organisation, for use by shelter residents, the NGOs housed there, as well as researchers and the broader community.

Synnov Skorge also emphasises that they are still "looking for a research partner - we have a wealth of information. We want to give what's happening here a voice to inform all programmes in the country". While researchers, both local and international, traipse through the Centre each year gathering data that is rarely fed back to the Centre, establishing a collaborative research partnership with an organisation will enrich not only the Centre, but also the entire field of gender-based violence, and gender work more broadly.

While primarily funded by the provincial government for the next three years, it will need to find independent sources of funding, and continue (and even expand) its income-generation activities.

6.2. INTERSECT

INTERSECT is an international campaign, designed to raise awareness and encourage cooperation between the gender-based violence and HIV/AIDS sectors

respectively. Facilitated by the WCNetVAW in our province, INTERSECT could perhaps facilitate the replication of this clustering.

The INTERSECT Campaign aims to foster support between the two respective fields of gender-based violence and HIV/AIDS, and also to incorporate these two respective networks, rather than create a new network. Organisations aligned with INTERSECT in Cape Town need to first more concretely identify what their needs are, and how the interface between gender-based violence and HIV/AIDS presents itself in their existing work. E.g. as Rape Crisis Heideveld has done by requesting a health care practitioner for general health care, but also for voluntary counselling and testing for HIV (VCT).

7. SO WHERE TO FROM HERE?

What was discovered is that no one concrete strategy emerges for NGOs, which in itself, is a research finding, and guides the ways forward.

Regarding the way forward: the vast majority of respondents have not given the intersections a great deal of thought in terms of concrete actions, legislative measures, resources, and/or protocols. And hence this is merely a first step to get service providers to identify specific organisational needs. So the survey in and of itself proved useful by challenging basic practitioners to begin interrogating the intersections and addressing them more strategically.

Jennifer MacMaster notes that "the questionnaire challenged me to be less closed, less institutionalised... If it [issues] doesn't affect us personally so we don't have to deal with it [uncomfortable issues]". Synnov Skorge⁸⁴ also mentions that "the interview was fun and informative - a good combination! Thank you for asking such interesting questions and responding so openly to my sometimes off-the-beat 'answers'". Thus this project served a further useful purpose, that of stimulating general debate on related issues.

While the majority of respondents merely requested a copy of the final report of this survey, Bulelwa Mshumpela suggests the following:

This issue needs more attention, and the findings of any research done needs to be widely disseminated in its simplest form to a wide range of institutions. Also...a platform for further discussions needs to be created with people who are directly involved with service delivery... maybe we can **workshop the findings**, I will be honoured to be involved in whatever way. [emphasis added].

Sipho Mthathi of TAC adds: "I hope that more gender organisations will take up some of this work - it is an automatic link that has to be made practical".

Recommendations by respondents are extensive (Section 4 of this report). And while the intersections between gender-based violence and HIV/AIDS had not yet been significantly and concretely addressed before this study, the study itself certainly

⁸⁴ Email communication, 9 April 2002.

provided many respondents and their networks with much food for thought and impetus for action. The Sarah Baartman Centre is one such institution that will use this report to help them raise funds for, strategically plan, and establish an HIV/AIDS component to their model of holistic care.

The majority of respondents working in the area of gender-based violence noted at the time of interviews that they were spurred to investigate how better to address HIV/AIDS in their work. The Sarah Baartman Centre for Women & Children, according to Manager, Synnov Skorge, views "HIV work and therefore the link [between GBV and HIV/AIDS]" as "number one on our planning". Skorge asserts that

The message needs to go out about the connection between VAW and the transmission of HIV - *women* are at the receiving end and *women* are dying. Not just poverty causes HIV. Women as lambs are going to the slaughter. [original verbal emphases].

In similar vein, many respondents noted that they were committed to in future incorporating gender-based violence, HIV/AIDS and/or sexualities in their trainings and programmes.

At the time of finalising the editing of this written report⁸⁵, after significant input from relevant stakeholders, which is some period after most of the field research was completed⁸⁶, some of the respondents have informally informed the researcher that they have begun to investigate integrative HIV programmes in their regular GBV work. Two organisations that have actually started this are Rape Crisis and the Sarah Baartman Centre. At the end of 2002 GAP has mainstreamed its separate HIV project into all its other projects.

Given this, some form of meeting exploring the intersections between gender-based violence and HIV/AIDS, and charting a mutually supportive way forward for this invaluable sector, is a priority. The next step would be for the Gender Project, which commissioned this report, to convene a provincial workshop of key stakeholders and to draw on this report as well as case studies from organisations that have started to integrate HIV/AIDS into their GBV work, in order to inform decisions about future strategies and other ways forward.

*Aluta continua. Victoria escerta*⁸⁷.

⁸⁵ January 2003.

⁸⁶ April 2002.

⁸⁷ Translated from Portuguese: the struggle continues, victory is certain.

LIST OF INTERVIEWEES:

1. Naeema Abrahams, Medical Research Council (MRC), Cape Town
2. Cheryl Ayogu & Lungiswa Mëmela, Western Cape Network on Violence Against Women (WCNetVAW), Cape Town
3. Dawn Betteridge, Triangle Project, Cape Town
4. Prof Lynnette Denny, Dept Obstetrics & Gynaecology, Groote Schuur Hospital, Cape Town
5. Reinette Evans, Rape Crisis Helderberg, Somerset West
6. Gertrude Fester, Commissioner, Commission for Gender Equality (CGE)
7. Dr Ferdi Franz, Thuthuzela Project, GF Jooste Hospital, Cape Town
8. Jillian Gardner, Sex Work Education Advocacy Taskforce (SWEAT), Cape Town
9. Tughfa Hamdulay, Dept Social Services Wynberg, Provincial Administration of the Western Cape (PAWC)
10. Susan Holland-Muter, Gender Education and Training Network (GETNET), Cape Town
11. Tanya Jacobs, Public Health Specialist Consultant, East London.
12. Faeza Khan, Gender Advocacy Programme (GAP), Cape Town
13. Jennifer MacMaster, Social Services Wynberg, PAWC
14. Dr Lorna Martin, Forensic Pathologist, Groote Schuur Hospital.
15. Anneke Meerkotter, Gender Project, Community Law Centre, UWC
16. Benita Moolman, Rape Crisis Heideveld
17. Bulelwa Mshumpela, Rape Crisis Khayelitsha
18. Siphso Mthathi, Treatment Action Campaign (TAC), Cape Town
19. Griffithma Nongwe, Nduli Women's Group, Ceres
20. Penny Parenzee, Gender, Law & Development Project, Institute of Criminology, UCT
21. Nombulelo Renene, Dept Social Services, PAWC, Beaufort West
22. Barbara Rass, Atlantis Women's Forum for the Abused & United Sanctuary Against Abuse, Atlantis
23. Florence Sayzaar, Progress Primary Health Care Centre for Learning, Beaufort West
24. William Sayzaar, Klawervlei & Karoo Community Development Programme, Beaufort West
25. Miriam Sifile, Ceres Advice Office, Ceres
26. Synnov Skorge & Ilse Ahrends, Sarah Baartman Centre for Women & Children, Athlone, Cape Town
27. Riana Spamer, Social Services, PAWC, Vredendal
28. Debbie van Stade, Dept Social Services, PAWC

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APPENDIX: QUESTIONNAIRE

Gender-Based Violence & HIV/AIDS in the Western Cape

Email: bmuthien@icon.co.za

Tel & Fax: 021 448 2112 * Mobile: 083 345 0552

PO Box 12992, Mowbray, 7705

DATE & TIME OF INTERVIEW:

NAME:

ORGANISATION:

JOB TITLE / POSITION:

EMAIL:

TEL:

MOBILE:

FAX:

ADDRESS:

1. What is the geographic location of your organisation:

URBAN	
PERI-URBAN	
RURAL	

Other, please specify:

2. Is your organisation:

Local	
Regional (e.g. Southern Cape)	
Provincial	
National	

Other, please specify:

3. What is the area/suburb in which your main office is located:

4. Type of organisation:

NGO		
CBO		
Government body	National	
	Provincial	
	Local	
Union		
Private Sector		
Academic		
Donor		
Government-NGO partnership		
Individual		

Other, please specify:

5. Organisational emphasis:

GBV	
HIV/AIDS	
Intersection between GBV & HIV/AIDS	
General health service	
Other gender focus	
Development	

Other focus, please specify:

6. Activities engaged in:

Research	
(IECs) Information, education, resources & training	
Legal and para-legal services	
Advocacy & Lobbying	
Counselling	
Condom, femidom, etc distribution	
PEP distribution	
Other health-related services (e.g. care/treatment)	

Other, please specify:

7. Specify nature of activities regarding GBV & HIV/AIDS (e.g. condom/PEP distribution):

8. Who are the primary targets / recipients of your services?

9. Does your organisation deal primarily with gender-based violence (GBV)?

YES	
NO	

10. If yes, does your organisation focus on:

Domestic violence	
Rape	

Other:

11. How would you define gender-based violence (GBV)?

12. Have you noticed any links between GBV and the transmission of HIV/AIDS? If so, what are they?

13. Have you noticed any links between GBV and the care and treatment of people living with HIV/AIDS?

14. Do you think there is a need for projects/activities addressing the links between GBV and HIV/AIDS?

YES	
NO	

14.1. If yes, please describe:

14.2. If no, please explain:

15. Does your organisation engage in projects or activities that attempt to address these links?

YES	
NO	

15.1. If yes, please describe these activities and/or projects:

15.2. If no, would your organisation be interested in exploring and/or addressing these links in the future?

16. Please describe the kinds of programmes and/or initiatives that you think are needed to address the links between GBV and HIV/AIDS:

16.1. For your organisation/department/project:

16.2. More broadly in the South African context:

17. What are some of the gendered dimensions to treatment of HIV/AIDS?

18. How do you perceive, if any, the extent of gender-based violence against women who love women, lesbians and bisexuals?

19. What methodology did you use to assess the extent of rape against women who love women, lesbians and bisexuals? E.g. anecdotal, phone-ins, referrals, etc.

20. Do you provide specific services for these women? And if so, please name and discuss.

21. Who would you consider as the primary perpetrators of this violence against women who love women:

Group of assailants		
	Known to the victim	
	Unknown to the victim	
Single assailant		
	Known to the victim	
	Unknown to the victim	
Family member(s)		
Partner of victim		

Other, please specify:

22. Could you name additional and/or specific complications of this violence against women who love women. E.g. they are more vulnerable due to their sexualities, effects that are unique to these women:

23. What methodology did you use to base this assessment on? E.g. statistics (no. of cases encountered).

24. Do you have any further comments and/or suggestions:

25. How would you prefer to receive feedback on the outcomes of this survey?

Thank you very much.