WOMEN IN SOUTH AFRICA
Intentional Violence and HIV/AIDS: Intersections and Prevention

ANNE OUTWATER
Johns Hopkins University

NAEEMA ABRAHAMS
South Africa Medical Research Council

JACQUELYN C. CAMPBELL
Johns Hopkins University

South Africa is experiencing the turbulent aftermath of apartheid and the ravages of HIV/AIDS. Levels of violence are extremely high. In South Africa, violence has become normative and, to a large extent, accepted rather than challenged. Unusual for sub-Saharan Africa, there is a strong national research institute and rigorous data-based scientific literature describing the situation. Much of the research has focused on violence against women. This article reviews the intersection of HIV/AIDS and violence in the lives of women in South Africa. The evidence for the need for positive change is solid. The potential for positive change in South Africa is also very strong. There are suggestions that an African renaissance based on the principle of ubuntu has already begun on national, community, family, and individual levels. If so, it can lead the way to a society with decreased levels of violence and decreased levels of HIV transmission.

Keywords: South Africa; sub-Saharan Africa; HIV/AIDS; violence; women; ubuntu

South Africa has a per capita income of about $3,000 per year (World Bank Group, 2002). Even though this has fallen more than $700 since apartheid ended, South Africa is still one of the wealthiest countries in sub-Saharan Africa (SSA). Most of its health parameters are better than other countries in SSA. However, life expectancy is 53 years (Population Reference Bureau, 2002) and
falling and the discrepancy between the richest and poorest segments of society in terms of health and economics is one of the most dramatic in the world.

Nearly 80% of South Africans (and most people of SSA) are members of the large Bantu language group. Ubuntu, a philosophy and way of life that is the spiritual foundation of many African societies, is a central cultural factor and not easily translatable (Loew, 2003). Ubuntu both describes being human as “being-with-others” and prescribes what being-with-others should be all about (Loew, 2003). Ubuntu pertains to the promotion of the common good by building community through shared humanhood. A human being strives to develop ubuntu through relationships. Individuals only exist in their relationships with others, and as these relationships change, so do the characters of the individuals (Shutte, 1993). Violence is not needlessly used, but in the just defense of the community, it can be used. In the Bantu cultural literature, a person who manifests ubuntu is one who is kind, helpful, not quarrelsome, slow to anger, generous, helpful to others, cooperative, and courageous (M. M. Mulokozi, personal communication, 2003). The actions of people such as these can create a net through sharing wealth and resources in ways that help people cope with and absorb risks that would otherwise be overwhelming to the individual (Eyakuze & Simba, 2003).


the principle of caring for each other’s well-being . . . and a spirit of mutual support. . . . Each individual’s humanity is ideally expressed through his or her relationship with others and theirs in turn through a recognition of the individual’s humanity. Ubuntu means that people are people through other people. Umuntu ngumuntu ngabantu. It also acknowledges both the rights and the responsibilities of every citizen in promoting individual and societal well-being. (p. 18, par. 18)

South Africa, a country of 42.8 million people, is a young democracy emerging from a totalitarian state. The legacy of apart-
heid is still strong. Black South Africans largely live in former homelands, an inheritance of apartheid. The lack of economic opportunities within those areas forced many Africans to work as migrant laborers. Husbands return periodically to reunite with their wives and maintain their families. Typically, the homelands are inhabited by women, children, and old and sickly men who have returned from the mines. Urban townships flourish on the outskirts of the bigger cities where young men and women migrate seeking better opportunities. In both the homelands and the urban townships, unemployment is high and its ramifications (including crime, illegal firearms, and alcohol abuse) are widespread.

The transition from apartheid to democracy has been associated with escalating violence. SSA is one of the most violent countries in the world. Widespread interpersonal violence and crime have affected all members of South African society; violence has become an accepted form of conflict resolution (Masuku, 2001). In addition, more than 20% of the adult population is living with HIV/AIDS (fully 10% of the world’s HIV cases), more than half of which are women. Heterosexual women are the segment of society with the fastest growing rates of HIV transmission. It is believed that there are already 420,000 orphans due to HIV/AIDS in South Africa (UNAIDS, 2002).

WOMEN

Strongly patriarchal societal organizations are characteristic of most of the indigenous and nonindigenous peoples inhabiting South Africa (Morrell, 1998). Racism and sexism were part of the apartheid ideology. The demise of apartheid resulted in the transformation of the South African sociopolitical environment with gender equality becoming a pivotal factor in the building of the new democracy.

Two population prevalence studies have documented high levels of violence against women and that one in four women reported having been abused by a partner (Jewkes, Levin, & Penn-Kekana, 2001; South African Law Commission, 2002). A prevalence study
among working men in Cape Town found that 42% of them reported the use of physical violence and nearly 16% reported use of sexual violence against an intimate partner with whom they had a relationship in the past 10 years (Abrahams, 2002). Intimate partner sexual violence may have important links to the high HIV-infection rates (Maman, Campbell, Sweat, & Gielen, 2000). For example, in the United States, regardless of ethnicity, HIV-positive women had more sexual partners, more STDs, and more severe histories of abuse than did HIV-negative women (Wyatt et al., 2002). In six U.S. cities, women at highest risk of domestic violence were demographically similar to women at high risk of HIV infection (Cohen et al., 2000).

The South African constitution, said to be one of the best in the world, entrenched the right to freedom from violence and inequality. The government stated that it would comply with the Beijing Platform of Action (Office of the President of South Africa, 1994) and many governmental departments planned radical changes. Two important statutory processes have also occurred. The new Family Violence Act of 1993 was passed and then implemented as the Domestic Violence Act 116 in December 1999. The new Bill on Sexual Offences currently being drafted will ensure that South Africa has one of the most progressive laws concerning violence against women in the world (South African Law Commission, 2002). A network of nongovernmental organizations (NGOs) addresses domestic violence, including providing shelters for battered women in the major cities (Park, Fedler, & Dangoor, 2000) and important community-level prevention initiatives (Singhal, Usdin, Scheepers, Goldstein, & Japhet, 2002).

Although all of these policy and legal changes are important, they are ineffective if the enabling environment at the community level for the implementation of the changes is not present. A recent evaluation of the new Domestic Violence Act found that although there was an increase in the number of requests for protection orders, there was not an increase among women applicants. Women continued to experience secondary victimization at the hands of the criminal justice system (Mathews & Abrahams, 2001).
VIOLENCE

VIOLENCE AT NATIONAL AND COMMUNITY LEVELS

In South Africa, violence has become normative and, to a large extent, accepted rather than challenged (Simpson, 1992; Wood, Maforah, & Jewkes, 1998). It is presented as one of the few ways that township men have to assert their masculinity (Leclerc-Madlala, 1997). The most recent injury mortality surveillance study found that homicide was the leading cause of death, accounting for 45% of all nonnatural deaths. Eighty percent of victims were male, 70% were Black (slightly less than their percentage of the population), and 37% were young adults between the ages of 15 and 29 years. More than half of the homicides were inflicted by firearms and a third by a sharp instrument (Burrows, Bowman, Matzopoulos, & van Niekerk, 2001).

The causes of violence in South Africa are multifactorial; prominent is the legacy of apartheid (Gilbert, 1997; Jewkes, Abrahams, & Mvo, 1998). One of the consequences of decades of apartheid state-sponsored violence and reactive community insurrection is that for many people, physical violence has become a first line strategy for resolving conflict and gaining ascendancy. Violence is used in a variety of settings: in disputes between neighbors, in work settings (Abrahams, 2002), in health care settings (Jewkes et al., 1998), and against the elderly (Keikelame & Ferreira, 2000).

It has been suggested that men are often reacting as victims themselves and have to take on a persona that serves as a coping mechanism for the risks and dangers of everyday working lives (with real men being regarded as brave, fearless, and willing to risk death, for example, in the mines, in order to fulfill their role as breadwinners), leading them to disregard their safety from HIV/AIDS and to perpetrate violence against those weaker than themselves (Campbell, 2000).
VIOLENCE AGAINST WOMEN
AT HOUSEHOLD AND INDIVIDUAL LEVELS

Statistics from 1996 show that in comparison with 89 Interpol member states, South Africa has the highest ratio of reported rape cases per 100,000 people (Bollen, Artz, Vetten, & Louw, 1999). This, however, represents the tip of the iceberg, as most sexual abuse does not get reported to police (Jewkes & Abrahams, 2002). The use of certain forms of violence by men to control and punish women in particular situations is perceived as socially acceptable to all ages of both sexes (Wood & Jewkes, 1998). Nationally, an overall lifetime prevalence of having been “forced or persuaded to have sex against their will” was reported by approximately 7% of women (Jewkes & Abrahams, 2002). In a study of risk factors for teenage pregnancy, 32% of the pregnant teenagers and nearly 18% of the nonpregnant teenagers reported having forced sex or rape as their initial sexual experience (Jewkes et al., 2001). Similar results were reported among Transkei scholars (Buga, Amoko, & Ncayiyana, 1996). Richter found that of 864 people younger than age 20, 17% of the males reported forcing and 28% of the females reported having been forced to have sex (Swart-Kruger & Richter, 1997).

Sexual violence is common among younger women. The South African Demographic Health Survey (Medical Research Council & Measure DHS+, 1998) found that the youngest age group (ages 15-19) were twice as likely as the oldest age group (ages 45-49) to report sexual violence (Medical Research Council & Measure DHS+, 1998). Police statistics showed similar rates: Forty percent of the victims reporting rape and attempted rape for the period 1996-1999 were younger than age 18, the demographic group at greatest risk for HIV infection.

Powerful qualitative studies as well as population-based quantitative studies have revealed a cultural acceptance of violence. Women and girls are most easily looked on as victims, but the situation is complicated and the subtleties difficult to interpret (Jewkes & Abrahams, 2002; Madu, 2001; Wojcicki & Malala, 2001). A study done in three of South Africa’s nine provinces on 2,232
women found that 10% of them reported being physically abused in the past year and one in four is abused in their lifetime. Eighty percent of the same cohort reported that their partners talk to them about family problems and respect their opinions and between 80% and 91% of them say that their partners touch and hug them in loving ways. The proportion of women raped or subjected to physical violence in the previous year who described themselves as abused ranged from 46% to 68% (Jewkes, Penn-Kekana, Levin, Ratsaka, & Schrieber, 1999).

Wood et al. (1998), reporting on Xhosa-speaking adolescent pregnant women in the poorest township, found that male violent and coercive practices dominate sexual relationships. Conditions and timing of sex were defined by their male partners through the use of violence and through the circulation of certain constructions of love, intercourse, and entitlement to which the teenage girls were expected to submit. The legitimacy of these coercive sexual experiences was enforced by female peers who indicated that silence and submission was the appropriate response. Informants indicated that they did not terminate the relationships for several reasons; as well as peer pressure to have a male partner, teenagers said that they perceived their partners loved them because they gave them gifts of clothing and money.

Twenty-two of 24 informants reported having been beaten by their partners on multiple occasions. Assault was described as occurring primarily when women attempted to refuse sexual intercourse. Forced intercourse, which they said they experienced with their partners, could never be termed rape because “it is with your boyfriend and there is something between you” (Wood et al., 1998). The taboo against discussion of sex and sexual intimacy in daily discourse is very strong and the language used to describe love making is also the language used to describe a violent sexual act.

One of the reasons that women find it hard to leave their batterers is the few resources at their command. Poor education as well as lack of job opportunities secure and entrench financial dependence on men who can provide (Mathews & Abrahams, 2001).
SEXUAL RELATIONSHIPS IN SOUTH AFRICA

Premarital sexual activity and child bearing are a socially accepted and common feature of South African relationships (Makiwane, in press). Studies on the sexual behavior of South African teenagers have shown that many young people are sexually active (Buga et al., 1996; Matshidze, Richter, Levin, & McIntyre, 1998; Swart-Kruger & Richter, 1997). In general, the average age of first sexual intercourse is between 14.8 and 16.4 years for girls and 13.4 and 14.3 for boys (Buga et al., 1996; Matshidze et al., 1998; Swart-Kruger & Richter, 1997; Wood et al., 1998). Qualitative studies have shown that young women are encouraged to become pregnant by their partners to demonstrate love, fertility, and womanhood (Swart-Kruger & Richter, 1997; Varga & Makubalo, 1996; Wood et al., 1998) and such a pregnancy is much more tolerable than the possibility of infertility (Jewkes et al., 2001).

Cohabitting relations are generally accepted, and about 1 in 10 women interviewed in the national survey were living with a partner. This same prevalence was reported by Matshidze et al. (1998) in their study on men. Relationships are also often referred to as casual, with nearly half (46%) of young men reporting their current relationships as casual (Swart-Kruger & Richter, 1997). Having multiple concurrent partners has also been reported. Men were more likely than women to report more than one current sexual partner; 28% reported two or more partners at the time of the interview (Matshidze et al., 1998). In qualitative studies with young men in Umtata, the number of girlfriends was important in attaining position and status among peers, and having multiple girlfriends was an indication of “successful manhood” (Wood & Jewkes, 1998).

Abdool-Karim (2001), reporting on a cross-sectional survey done in the early 1990s in KwaZulu-Natal, found that 62% of women thought their male partners had a right to multiple partners and 49% did not believe they had a right to refuse sex with their partners. Fifty-one percent of the women said their partners would get angry if they were asked to use condoms, 30% said their part-
ners would leave them, and 28% said their partners would threaten violence. Violence or the perceived threat of violence seemed to be a strong deterrent to adopting prevention measures.

The overwhelming majority of the above studies also described the role of sexual coercion within these relationships and the grave implications for the risk associated with HIV/AIDS in young people. Sexual coercion not only often prevents the use of protective measures but may also result in vaginal and/or anal trauma that increases the risk of HIV transmission (Maman et al., 2000).

HIV/AIDS AND ITS INTERSECTION WITH VIOLENCE AGAINST WOMEN

AT THE NATIONAL AND COMMUNITY LEVELS

The president of the South African Medical Research Council, Dr. Malegapuru Makgoba, stated that no disease has challenged the ethical and moral principles of a society such as has HIV/AIDS (Republic of South Africa, 2000). HIV-1 first appeared in South Africa in the early 1980s, but it was not until the early 1990s that it started to spread significantly. There are approximately 4.7 million to 5.3 million HIV-infected South Africans. Almost all the socioeconomic improvements of postindependent Africa are being reversed, if not wiped out, by this epidemic. Life expectancy, which had risen from the mid-40s to the 70s, has been reversed. He believes that Africa requires different approaches to those used by developed countries. In Africa, HIV/AIDS has different patterns of transmission, higher rates of infection, the presence of different opportunistic infections, and higher frequency of STDs. In addition, virological and host factors may influence the dynamics of the spread, the latter being affected by poor socioeconomic conditions and malnutrition. The South African Department of Health has noted that the immediate determinants of the epidemic include behavioral factors such as unprotected sexual intercourse and multiple sexual partners and biological factors such as the high prevalence of sexually transmitted diseases. Underlying causes include
socioeconomic factors such as poverty, migrant labor, commercial sex workers, the low status of women, illiteracy, lack of formal education, stigma, and discrimination (Republic of South Africa, 2001).

The structure of the economic system of apartheid in South Africa was based on migrant labor. Sex worker services emerged in response to the migrancy laws that removed men for long periods from their rural homesteads (Moodie, 2001). A seroprevalence survey in a rural community in KwaZulu-Natal found that women who saw their sex partners less than 10 days per month were 15 times more likely to be infected with HIV than women who saw their partners more frequently; about half of the women in the peri-urban community and about three quarters of the women in the rural community saw their sex partners less than 10 days per month. An important issue is the importance of child bearing in these communities, because a woman’s ability to have children is central to her status and worth in the relationship. The majority of the women received money from their partners; their exclusion from the formal economy, high rates of unemployment, and few years of education limited their opportunities for economic independence (Wilkinson & Abdool-Karim, 1995).

Many studies in South Africa have shown that high levels of HIV knowledge do not necessarily lead to sexual behavior that inhibits STD or HIV infection (Abdool-Karim, 2001; Abdool-Karim, Abdool-Karim, & Nkomokazi, 1991; Campbell, 2000; Leclerc-Madlala, 1997; Wood et al., 1998). There is, for example, evidence that the cultural ethos of ubuntu for Zulu youth is very strong and has been perhaps reversed from its original meaning. The strategies once used by youth to forge a sense of community and brotherhood in their struggle against apartheid have been used as a perverted response to HIV/AIDS. In KwaZulu-Natal townships in 1995—the middle of the decade in which the HIV prevalence in their province was skyrocketing from less than 1% to more than 36%—a youth culture emerged in which youth displayed a strong sense of group destiny. They avoided a definite HIV diagnosis and at the same time sought to spread the infection so as “to die together.” “Knowing that one is infected with the AIDS virus was accepted not only as a
death sentence but also as a passport for sexual license,” as a way to share the burden (Leclerc-Madlala, 1997, p. 369; Wojcicki & Malala, 2001). This desire for a group destiny is said by informants to be the fueling of documented increases in rape incidences.

AT THE HOUSEHOLD AND INDIVIDUAL LEVELS

HIV seroprevalence among first-time antenatal clinic attendees in South Africa rose from .76% in 1990 to 10% in 1995 to 24% in 2000 (Abdool-Karim, 2001).

The studies reviewed below show that communication about sexual matters between friends, parents, or even partners was rare. There was a widely perceived powerlessness of girlfriends, wives, or sex workers to negotiate safe sex. Threat of violence from male partners was common. Generally, early sexually activity was culturally tolerated; parental guidance appeared almost nonexistent. The ideals held by both mothers and daughters were different from widespread practice. A study that now seems like premonition was done in 1990, a time when the HIV/AIDS epidemic was still less than 1% in South Africa. One hundred twenty-two Zulu-speaking mothers were randomly chosen in a Black township near Durban. Their factual knowledge of HIV/AIDS transmission and prevention methods was high. Yet, their risk, characterized by a high pregnancy rate and a high proportion of children by more than one partner, was also high. No mother had experienced condom use with her partner; two thirds believed that a doctor could cure the disease. Not one had spoken with their teenage children about AIDS and 89% had not discussed contraceptive methods (Abdool-Karim et al., 1991). By 2001, the HIV/AIDS rate in this province was 36%.

Teenagers make up a quarter of all mothers in Transkei, and more than 75% of them are unmarried. Of 1,025 Xhosa-speaking girls in Grades 5 through 7, 75% had had sexual intercourse. Knowledge of reproductive biology was low, as was contraceptive use; 23% had ever used modern contraceptives and less than 20% had used condoms. The reasons identified for initiating sexual activity were as follows: forced by partner (28%), peer pressure
(20%), carried away by passion (15%), to prove normality (12%),
to prove love of boyfriend (10%), tantalizing movies and films
(9%), seeking physical pleasure (4%), and desire to be a mother
(1%) (Abdool-Karim, 2001).

The reasons identified by sexually inexperienced girls for not
initiating sexual activity were belief in religious values (25%), fear
of pregnancy (24%), wish to wait till marriage (20%), fear of AIDS
(16%), not emotionally ready for sexual relationship (9%), and fear
of sexually transmitted diseases including HIV/AIDS (6%). The
majority of both groups did not approve of premarital sex while still
at school. They disapproved of sex education and free distribution
of contraceptives in schools (Abdool-Karim et al., 1991).

Pregnant teenagers reported that their mothers had not given
them any information about reproductive matters, beyond a warn-
ing that once they started menstruating “to stay away from boys”
(Wood et al., 1998). Female peers also would not explain. Sexual
initiation was reported to have been a shock for most of the teen-
agers, who described the act as very painful. Peers indicated that
silence is the appropriate response. “I thought that was the way
things were supposed to be between a boy and a girl.” The girls
believed they were not allowed to demonstrate desire and initiate
sex; sex was bad—an activity you are forced to do by someone who
is stronger than you. Wojcicki and Malala (2001), working in
Durban, and Campbell (2000) at the mines found that sex workers
and their clients also do not talk about matters relating to sex and a
respectful prospective client never refers to sex directly but rather
uses a range of euphemisms such as that he loves her.

The literature is moving from the view of women as passive vic-
tims found in the early 1990s to a more nuanced approach of
women as living in harsh situations often due to poverty and lack of
education but also having room for decision making. These authors
emphasize the micro decision making that occurs in the daily lives
of the sex workers and recognize that these are important compo-
nents of agency. Wojcicki and Malala (2001) quote Scott, “It [sex-
ual negotiation] should more properly be seen as dispersed constel-
lations of unequal relationships which leaves spaces for human
agency in contrast to a conceptualization of patriarchal power
which suggests a unified subordination of women” (p. 101). They are not minimizing the structural inequalities that sex workers face, or disagreeing that their coping strategies are often unhealthy, but are simultaneously emphasizing agency. Many of the networks and coping resources these women have might not previously have been explicitly acknowledged given the way in which women have sought to represent themselves as passive and unsupported.

They have urged that women not be looked on solely as victims but also as people with power who can and do make decisions and have strategies even when sometimes their actions are only at the micro-level (Campbell, 2000; Wojcicki & Malala, 2001). They suggest that the tendency to speak of women’s powerlessness is unduly simplistic and fails to take account of the range of coping strategies and social support networks that women have constructed to deal with their day-to-day life challenges.

**SUGGESTED ACTIONS FROM THE LITERATURE**

It has been suggested that the transformation of an apartheid South Africa into a democracy is a rediscovery of ubuntu (Maphisa, cited in Loew, 2003). Ubuntu is a given and a task in African societies. It is part and parcel of Africa’s cultural heritage. However, it clearly needs to be revitalized in the hearts and minds of some Africans (Koka 1997; Shutte, 1993; Teffo, 1994). The actions suggested in the literature are part of this renaissance.

Growing awareness is permeating government, evidenced by new legislation against familial violence and increased urgency in tackling the HIV/AIDS epidemic. The long battle between NGOs and the Department of Health on the treatment of HIV-positive people and the provision of drugs to decrease mother-to-child transmission has been a long process that has progressed to all levels of courts in the country. The government changed its stance in 2002 by acknowledging that rape survivors should be given post-exposure prophylaxis at public hospitals.
Structurally, apartheid South Africa was designed in a way that set the stage for high levels of violence and HIV/AIDS. Migratory work patterns separated families for long periods of time. In the new South Africa, it would seem important that families be enabled to accompany the breadwinner even to jobs that have been traditionally migratory such as those to the mines.

Legal remedies are of limited value without the full backing of the judicial system and police force. A study that evaluated the effect of the new Domestic Violence Act showed that despite the presence of the legislation, women continue to receive very little support from the criminal justice system (Mathews & Abrahams, 2001). The legal aid system needs to become more accessible and to be revised to speed up help for battered women. Jewkes and colleagues (2001) at the Medical Research Council urge that police be trained in the new legislation and in gender sensitivity. They further suggest that understanding of violence against women and strategies for inquiry and assistance of abused women must be incorporated into the curriculum for training and clinical practice of midwives, doctors, and mental health workers.

Angless, Maconachie, and van Zyl (1998) point out that welfare agencies are overburdened, leaving social workers with little time to deal adequately with the problems facing battered women. The lack of shelters and social benefits render social workers unable to offer effective options. Angless et al. (1998) make a strong call for residential shelters.

Campbell (2000) and Wojcicki and Malala (2001) believe that more open recognition of sex work as a profession can be accomplished though encouraging women to openly organize themselves in groups, which will lessen the stigma and discrimination that sex workers face at the hands of clients, managers, police, and health care workers. Understanding sexual encounters as sets of practices that are negotiated and enacted by the individual concerned creates a space for considering how inequities determine and are played out during sexual intercourse, thereby affecting individuals’ capacity to control it on their own terms. Women have constructed a range of psychosocial resources that serve to empower them in their day-to-day lives, which could form the starting point for a pro-
gram seeking to enhance women’s self-confidence in condom negotiation situations (Campbell, 2000). Many women indicate that they hold views that differ from their perceptions of the norm in their culture; it may be a sign that a process of questioning and re-examination is under way among women at the community level (Jewkes et al., 1999).

They believe that women in general have often failed to be recognized as decision makers and as actors and that this contributes to an overall negative discourse. Moreover, this focus on powerlessness obscures everyday decisions and actions in which women are, in fact, engaged. While understanding that women do suffer from a sense of powerlessness and depression, from an applied perspective, it is important to move away from the overly simplistic idea that women are powerless in sexual negotiations. At the same time, the perspective must encompass the very real danger of physical violence that women can face from intimate partners.

Almost all authors believe that HIV-prevention programs must take cognizance that power negotiations between men and women cannot be simplistically understood as men having power and women being powerless or, on the other hand, that women are in a totally equal negotiating position. Rather, efforts should be made to elucidate the complexities of sexual negotiations between men and women. There is a bargaining process that a woman enters into. To ignore the acts of agency in the minute day-to-day practices and struggles and presume they do not exist through victim status is stripping these communities of their voices (Jewkes & Abrahams, 2002). Socialization to defer to men, the perceived impossibility of discussion of sexual matters, communal acceptance of a certain level of violence in the face of perceived noncooperation with conjugal “rights,” and the danger of being denied access to children make negotiation difficult and sometimes dangerous. But what is needed is a more nuanced account of women’s lives and sexuality, one that not only focuses on the way in which they are oppressed but also begins to develop an account of female powers.

At the familial level, it was found that the majority of Zulu-speaking mothers (98%) who had teenage daughters felt that their daughters should have their first children after marriage. The
majority said they would refuse to let their sons (82%) or daughters (87%) have more than one partner at the same time. Yet, children grow to adulthood without being given any explicit advice on how to achieve these objectives. Suggestions from this study are that mothers reduce their own risk for HIV and play a greater role in helping shape their children’s sexual behavior and reduce their risk of HIV/AIDS by facilitating better communication (Abdool-Karim et al., 1991).

Both violence against women and HIV infection are promoted by gender inequality, and addressing these will be critical in addressing these two public health problems facing South Africans. In addition, many of the youth who grew up in the last 20 years of apartheid did not go to school on a regular basis and may have been traumatized. Do they have the skills to meet the demands of the new environment?

The terms used around sexual discourse need to be clarified. Because the terms used to describe love making are also those that must be used to describe a violent sexual act, then perhaps there is a need to discuss a new concept that could be introduced into the language and thereby clarify discourse. On the individual levels, it seems evident from the findings reported here that communication between youthful couples could benefit from increased clarity. Young women culturally are not allowed to say anything about sex or decisions around sexuality. Because there is no way for them to say yes, except by saying no, it could understandably be confusing for each member of a sexual dyad trying to distinguish when no really means NO.

Research into traditional sexual teachings may illuminate this area. Were there specific people who took on that role? If so, is the role of those people still valid? If not, who can fill the role? Could it be parents, teachers, peers, or nurses and other healthworkers? If so, they need to be given the skills and correct information. A countrywide behavioral change communication campaign using traditional, interactive group and mass media techniques could work well in both gathering and disseminating ideas.
CONCLUSION

South Africa faces many challenges of which high rates of violence and HIV are among the most critical. Illuminating legislation is in place. Political awareness is high. Excellent research is being conducted to support legislation and programs. Expressions such as these, and many others that are occurring in South Africa, are consonant with ubuntu and can lead the way to a society with decreased levels of violence and decreased levels of HIV transmission.

REFERENCES


Anne Outwater has lived and worked in sub-Saharan Africa for 15 years: in a hospital, coordinating HIV/AIDS prevention activities for Family Health International, and as a medical officer for the United States Peace Corps. She has witnessed and researched the effects of HIV/AIDS especially on high-risk women and truck drivers in Tanzania. Now, as a doctoral candidate at the Johns Hopkins University School of Nursing, she is exploring how some cultures and countries, even amidst enduring patterns of violence, create and maintain peace.

Naeema Abrahams is a senior researcher working at the Gender & Health Research Group of the South Africa Medical Research Council. She has a nursing background and has a Ph.D. in public health. Her current research interests include the epidemiology of gender-based violence and the development of strategies to ensure that violence against women becomes recognized as an important public health problem in the era of HIV in South Africa.

Jacquelyn C. Campbell, Ph.D., RN, is the Anna D. Wolf Chair and Associate Dean for Faculty Affairs in the Johns Hopkins School of Nursing with a joint appointment in the Bloomberg School of Public Health. She has been the principle investigator of nine major National Institutes of Health, National Institute of Justice, and Centers for Disease Control research grants, and she has published more than 120 articles and seven books on violence against women. She is an elected member of the Institute of Medicine and the American Academy of Nursing and on the Boards of Directors of the Family Violence Prevention Fund and the House of Ruth Battered Women's Shelter.