

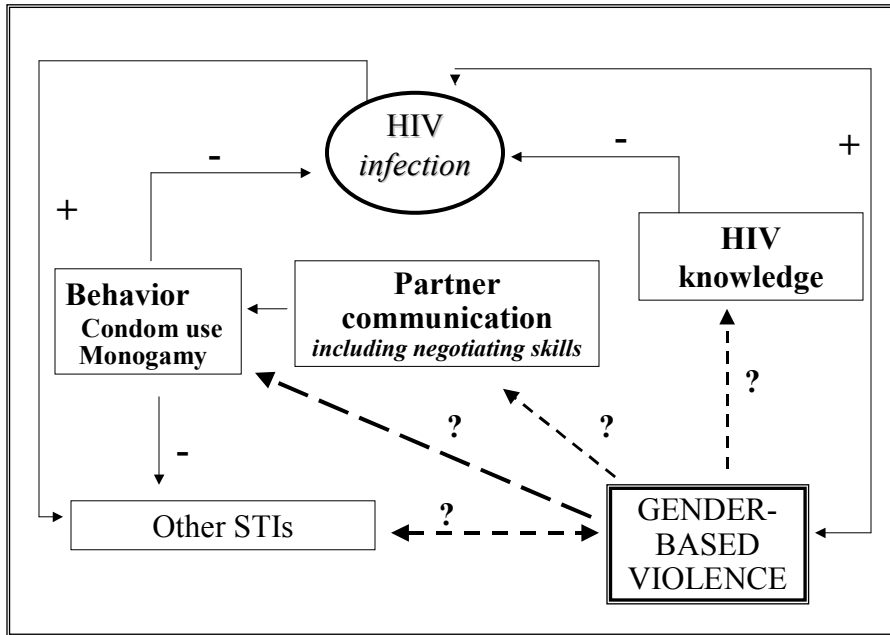
Gender-based violence (GBV) is being increasingly acknowledged as both a risk factor for HIV/AIDS and a possible consequence of actions and behaviors related to HIV/AIDS, particularly related to testing for the infection (Kristner 2003, WHO, 2000). Studies in communities hard-hit by HIV/AIDS suggest both that HIV-positive women have a larger number of physically violent partners in their lifetimes than do HIV-negative women and that HIV-positive women are more than twice as likely to report current experience of violence and greater frequency of violent events than HIV-negative women (Maman, Mbwambo et al. 2002). Most of the conceptual pathways linking GBV and HIV/AIDS discussed in the literature focus on behavior related constraints such as the abused women's inability to negotiate safe sex, seek testing, counseling and treatment, and the higher rates of sexual risk-taking found among persons who have experienced violence, particularly sexual violence in childhood (WHO 2000; Heise et al 1999). Added to this list is the fact that GBV is a likely contributing factor to a woman's risk of contracting a sexually transmitted infection (STI), a co-factor of HIV/AIDS (Zierler, Witbeck, and Mayer 1996).

Despite increasing evidence of GBV as a risk factor in the spread of HIV/AIDS, it is unclear how generalizable the findings are beyond the individual community, clinic, or specific sub-population in which they were assessed. More importantly, perhaps is the fact that it is still unclear how GBV increases women's risks of acquiring the infection. Which of the conceptually relevant pathways are in fact supported by empirical evidence and are the most consistently important? Answers to this question will help design policies and programs that not only try and reduce the prevalence of GBV but act to weaken the ways in which GBV acts to disempower women from adequately protecting themselves from the risk of infection.

This paper adds to the conceptual and community-level research on GBV and HIV/AIDS by evaluating selected hypothesized linkages within a population-based comparative framework. Specifically, the paper uses Demographic and Health Surveys data to examine how and whether women's experience of spousal violence compromises their ability to avoid HIV infection in four developing countries, namely Cambodia, Haiti, the Dominican Republic (DR), and Zambia. These countries are selected because they all have relatively high prevalence rates of HIV/AIDS and the DHS in these countries included questions on domestic violence and HIV knowledge and related behaviors. While Zambia, in keeping with HIV prevalence rates in sub-Saharan Africa has the highest rate of these four countries, 20 percent, it is notable that according to UNAIDS, Cambodia has the highest adult prevalence rate of HIV/AIDS, at 2.7 percent, in Asia and Haiti has the highest in the Caribbean region, at 6.8 percent. The DR with a prevalence rate of 2.5 percent is one of the hardest hit by the epidemic in the region.

The diagram below lays out the conceptual framework for the paper. Since population based data on HIV prevalence linked to information on individual characteristics and behaviors are not available, only the dotted linkages are explored in the paper. In other words, the central question examined in the paper is: to what extent does the experience of violence effect the factors that put women at increased risk of contracting HIV infection. The risk factors examined include:

- Knowledge of HIV/AIDS and ways of avoiding infection
- Condom access and use
- Number of sexual partners in the past 12 months
- Spousal/partner communication and gender role attitudes
- Has had an STI; has sought treatment
- Communication of STI status to partner



Using both bivariate and multivariate statistical techniques, the paper will put into context the gendered underpinnings of the risk of HIV/AIDS by documenting how GBV, net of other characteristics such as poverty and education, compromises women’s access to information and prevents them from engaging in behaviors that would limit their risk of infection. In addition, the paper will document the much higher risks of STI’s among abused women and their lower access to treatment.

Illustrative tables:

Table 1: Percentages of all women and currently married women (age 15-49) reporting violence.

Country	By anyone ever (all women)	Spousal violence (currently married women)	
		Ever	In the past 12 months
Cambodia	23	18	15
Dom. Rep.	17	22	11
Haiti	35	29	21
Zambia	59	48	27

Table 2: Logistic regression results: Odds ratios of having a sexually transmitted infection (STI) or a symptom of an STI in the 12 months preceding the survey among all ever-married women.

Explanatory variables	CAMBODIA	DOMINICAN REPUBLIC	HAITI
Ever experienced violence by husband: Ref. cat.: Never experienced spousal violence			
Ever experienced spousal violence	1.78**	2.59***	1.92***
Wealth quintile: Ref. cat.: Lowest quintile (Poor)			
2nd. quintile	ns(-)	ns(+)	ns(+)
3rd. quintile	ns(-)	ns(-)	ns(+)
4th. quintile	ns(+)	ns(-)	ns(-)
Highest quintile (Richest)	ns(+)	ns(-)	ns(+)
Individual characteristics			
Age	ns(-)	ns(-)	ns(-)
Number of years of education	ns(+)/-	ns(-)	s/ns(-)
Number of children ever born	ns(-)	ns(-)	s(-)
Marital status: <i>Ref: Never married</i>			
Married once	ns(+)	ns(+)	ns(-)
Married more than once	ns(+)	ns(+)	ns(-)/(+)
Husband's drinking: <i>Ref: Never drunk</i>			
Sometimes drunk	ns(-)	s(+)/s(-)	ns(+)/(-)
Frequently drunk	ns(-)	ns(+)/s(-)	ns(+)/(-)
<i>Dummy variables</i>			
Regularly exposed to media	ns(+)	ns(+)	s(+)
Employed	ns(-)	s(+)	s(+)
Household characteristics			
Urban	ns(+)/(-)	ns(+)	ns(-)/(+)
Nuclear	ns(+)	ns(-)	ns(+)
Constant	s(-)	s(-)	s(-)
s: Coefficient is significant at p<0.10; ns: Coefficient is not significant at p<0.10			
s/ns: Coefficient is significant in some models but not others; +/-: Coefficient is positive in some models but not in others			

References

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