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IMINYANGO

"I had nowhere else to go":
Domestic violence, housing and HIV/AIDS

During 2006 to 2007, the Gender Project at the Community Law Centre conducted research on the role of informal community structures (such as street committees) in determining access to housing for women at risk of gender-based violence and HIV in three communities in Cape Town, ie Langa, Manenberg and Mfuleni. This project was undertaken in partnership with the Centre's Socio-Economic Rights Project and the Saartjie Baartman Centre for Women and Children. The project formed part of a broader programme, implemented by the International Center for Research on Women, with the objective of reducing women's and girls' vulnerability to HIV by reinforcing their property and inheritance rights.

As part of the research, interviews were conducted with twenty residents of shelters for women who had experienced domestic violence. The purpose of the interviews was to gather qualitative information about the links between domestic violence, access to housing and the interviewees' vulnerability to HIV/AIDS. A further objective was to establish whether shelter residents had approached informal community structures for assistance with access to housing or domestic violence prior to coming to the shelter.

Our interviews with the residents of shelters for women experiencing violence showed firstly that these women's access to housing depended greatly on their relationship with others. In response to the question with whom they had lived before coming to the shelter where the interview was conducted, only one respondent answered that she had lived on her own. Respondents were also asked who the official owners or tenants were of the dwellings where they lived before coming to the shelter. Again, only one respondent held ownership or tenure in her own name.

We asked shelter residents about their minor children, since we assumed that being the primary care-taker of young (twelve years and younger) children shapes women's housing options in two ways. Firstly, it means that she has to physically make provision for a place for them to stay; secondly, it also means that she has to make provision for child-care facilities when she goes to work (or seeks employment). Ten of the respondents had two or more children with them in the shelter, while six respondents had one young child with them in the shelter.

It was clear from these responses that the respondents bore a heavy burden in terms of responsibility for young children. It was further clear that the housing difficulties experienced by the respondents had also taken their toll on their children. Women with young children living with them in the shelter (as well as living outside the shelter) reported that their children had been traumatised by 'upheavals' and a lack of stability. Some shelter residents further explained that their children were upset in that they missed their fathers (who were also the abusive perpetrators). This points to the complex dynamics of domestic violence, and may contribute to our understanding of why women return to the abusive situation upon leaving a shelter.

In response to the question whether they believed that the abuse they experienced had increased their risk of HIV infection, nine shelter residents answered in the affirmative. For all these respondents who indicated that the abuse they experienced did increase their risk of HIV infection, the

'Iminyango' is the isiZulu word for 'doors'. This title is derived from the following explanation for the intersection between gender-based violence and HIV/AIDS, given by a survivor of domestic violence (who had also contracted HIV from her abusive partner):

"Gender-based violence happens behind closed doors and HIV is killing women behind those closed doors. The solution is to break down those doors."

risk factor appeared to be their partner's promiscuity. One respondent explained that although her boyfriend had numerous affairs with other women, she stayed in the abusive relationship because she had nowhere else to go. She however went for an HIV test every month.

The findings from our interviews with the shelter residents confirmed observations from other settings, ie that access to housing can play a key role in mitigating women's vulnerability to domestic violence in the South African context, and that this in turn may reduce women's risk of HIV infection. These findings also in turn linked up with the results from the other components of the study, which indicated that informal community structures can play an important role in advancing access to housing for women vulnerable to domestic violence and HIV, but that this role is currently under-utilised.

At present there is no housing policy or programme that makes specific provision for women experiencing domestic violence (or for any other vulnerable groups, such as persons with disabilities or persons living with HIV and AIDS) in existence at provincial or local government level in the Western Cape province of South Africa. However, "special needs" policies are currently being developed and draft versions have been circulated and discussed at consultative workshops. These are significant advances to ensure improved access to adequate housing for women who experience domestic violence, and will hopefully contribute to ensure that women are not forced to return to high-risk abusive situations because they literally have nowhere else to go.

The full research report entitled ***"The Role of Informal Community Structures in Ensuring Women's Right to Have Access to Adequate Housing in Langa, Manenberg and Mfuleni"*** *can be accessed at www.communitylawcentre.org.za.*

See also ***"Women's Property Rights as an AIDS Response: Lessons from Community Interventions in Africa"*** *for a report on the ICRW programme at www.icrw.org/docs/property-rights/2007-wpr-community interventionsafrica.pdf.*

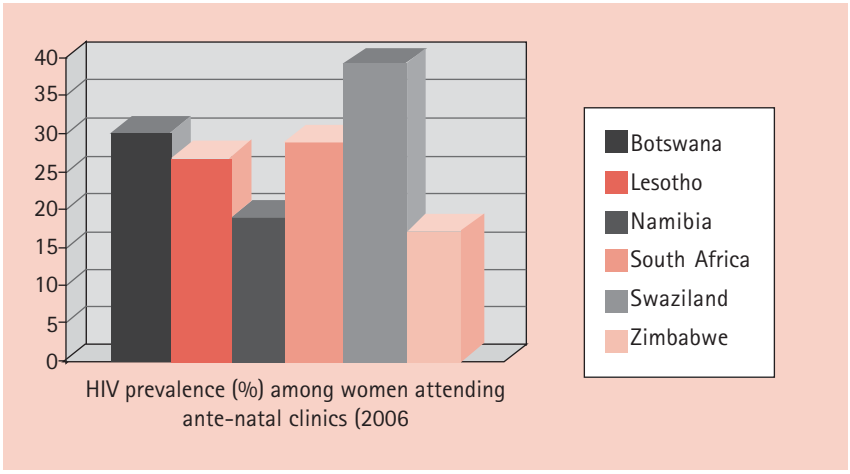
HIV/AIDS in Southern Africa

Is the picture changing?

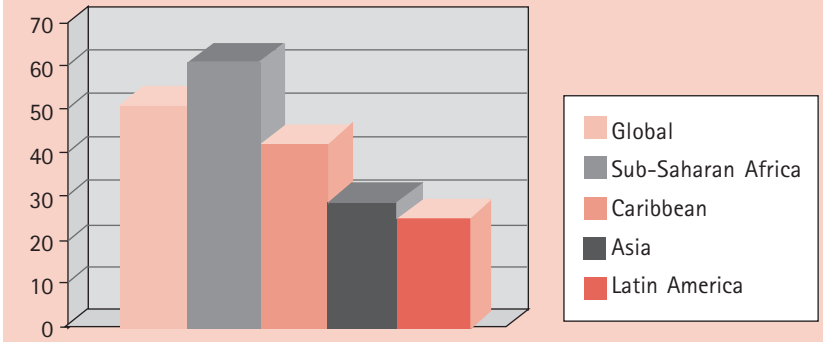
UNAIDS (with the World Health Organisation) has just released the annual HIV/ AIDS update on the global AIDS pandemic, with statistics and analysis relating to recent international developments. Drawing on the 2007 UNAIDS update, this article provides a brief overview of information relevant to southern Africa.

The first significant observation is that the overall prevalence rate (estimated at 33.2 million in 2007) shows a decrease of 6.3 million persons (compared with the estimate of 39.5 million published in 2006). The single biggest reason for this decrease is a major reassessment of the epidemic in India. Estimates were also revised elsewhere, particularly in sub-Saharan Africa - most notably Angola, Kenya, Mozambique, Nigeria and Zimbabwe. Significantly, in both Kenya and Zimbabwe there is increasing evidence that a proportion of the decline is due to a reduction of the number of new infections, which is in part ascribed to a reduction in risky behaviours.

(The report points out that the differences between the estimates published in 2006 and those published in 2007 result largely from refinements in methodology, rather than trends in the pandemic itself. For this reason, one



HIV prevalence (%) among women attending ante-natal clinics (2006



% of women among adults living with HIV & AIDS (UNAIDS/WHO 2007)

should be cautious about comparing the 2007 estimates with those published in 2006.)

Zimbabwe has shown a decrease in HIV prevalence among pregnant women attending ante-natal clinics from 26% in 2002 to 18% in 2006. Among young pregnant women (in the age group 15 to 24 years) there has also been a decline in the HIV prevalence rate, which was 21% during 2002 and currently stands at 13%. It can be emphasized again that the declining trend reflects a combination of very high mortality and declining HIV incidence, related in part to behaviour change such as avoiding sex with non-regular partners and consistent condom use with non-regular partners.

South Africa is considered to be the country with the highest number of HIV infections in the world. The 2006 UNAIDS update states that 30% of pregnant women attending ante-natal clinics tested HIV positive, while the current report lists a percentage of 29%. This difference is not significant enough to confirm that infection levels have peaked and may be levelling off.

The prevalence levels for Swaziland and Lesotho remain critically high. Findings from a new population-based survey show that 26% of adults (15-49 years) in Swaziland are living with HIV, whereas 38% of women in the age group 25-29 years attending ante-natal clinics in Lesotho in 2005 tested positive.

The epidemic in Botswana appears to be showing a decline on a number of levels, although the overall prevalence is still very high. In 2001, the prevalence among pregnant women attending ante-natal clinics was 36%; this had decreased to 32% in 2006. A similar trend can be distinguished among younger pregnant women: in 2001, young pregnant women aged 15-19 years had an HIV prevalence rate of 25%, which decreased to 18% in 2006 and for the slightly older age group of 20–24 years, the prevalence rate had declined from 39% to 29% during this period.

In Mozambique the epidemic has again started to expand after appearing to have stabilised in the early 2000's. HIV prevalence among women attending antenatal clinics was lowest in the northern provinces (an average of 9% in 2004), but in the central and southern provinces prevalence ranged from 20% to almost 27% (in 2004).

According to the 2006 update, 19% of pregnant women who attended ante-natal clinics in Malawi tested HIV positive. However, the 2007 update suggests that the situation is stabilising with a rate of 15% - 17% of pregnant women testing HIV positive, with some evidence of risk-reducing behavioural changes.

Although the availability of data is limited for the Democratic Republic of Congo, the 2007 update states that the prevalence among women attending ante-natal clinics has been relatively stable in Kinshasa, the capital, where it stood at 4,2% in 2005. However, this prevalence saw an increase in cities such as Lubumbashi, where it stood at 6.6% in 2005, and Tshikapa (8% in 2005). The fact that HIV statistics are partly unavailable implies that the above does not reflect the true situation of the national prevalence in this country.

We can therefore say that although the 2007 figures show substantial changes in the estimates of numbers of persons living with HIV worldwide, the qualitative interpretation of the severity and implications of the pandemic has altered little. This means that the picture is still looking grave for southern Africa and sub-Saharan Africa generally: the estimated number of deaths due to AIDS in 2007 was 2.1 million worldwide, of which 76% occurred in sub-Saharan Africa. Declines in this number in the past two years are partly attributable to the scaling up of antiretroviral treatment services. AIDS remains a leading cause of mortality worldwide and the primary cause of death in sub-Saharan Africa, illustrating the tremendous, long-term challenge that lies ahead for provision of treatment services.

Sources

UNAIDS & WHO ***2007 AIDS Epidemic Update*** (December 2007).

UNAIDS & WHO ***2006 AIDS Epidemic Update*** (December 2006).

Both accessible at www.unaids.org

25 November 2007

International Day for the Elimination of Violence Against Women

The date of 25 November has now generally come to be recognised worldwide as the day marking the beginning of the "Sixteen Days of Activism Against Gender Violence" Campaign, and is also honoured as International Day for the Elimination of Violence Against Women (or variations of this title). But why was this specific date selected for this important commemoration? We found that an examination of the history of this International Day gives it a much deeper dimension.

The observation of 25 November as "International Day Against Violence Against Women" began in Latin America, where it was first declared in Bogota, Colombia in 1981. The date was selected to commemorate the lives of the three Mirabal sisters, political activists from the Dominican Republic who had been violently assassinated on this date in 1960 during the dictatorship of Rafael Trujillo. The day was initially used to pay tribute to the Mirabal sisters, as well as to encourage global recognition of gender-based violence.

The Mirabal sisters

Patria, Minerva and Maria Teresa Mirabal, with their husbands, became involved in activities against the Trujillo regime during the 1950's. As political activists, they were highly visible symbols of resistance against the dictatorship and were accordingly constantly persecuted because of their outspoken activities. In spite of repeated imprisonment, the sisters continued their active participation in political activities against the leadership – to such an extent that in early November 1960, Trujillo declared that his two problems were "the Church and the Mirabal Sisters".

On 25 November 1960, while on their way to visit their husbands in prison, the sisters were assassinated. This was made out to be an accident. However, the event caused much public outcry and the death of the sisters contributed to an anti-Trujillo movement, which eventually led to his dictatorship coming to an end approximately a year after their death.

The Mirabal sisters, referred to as the "Inolvidables Mariposas" (the "Unforgettable Butterflies") have become an international symbol against the victimisation of women.

International Recognition

On 17 December 1999, the United Nations General Assembly accepted Resolution 54/134 designating this date as the International Day for the Elimination of Violence against Women. This date had already been incorporated in the "16 Days of Activism Against Gender Violence" Campaign, which was initiated in 1991 through the work of the Centre for Women's Global Leadership. This period of activism starts every year on 25 November and ends on 10 December (International Human Rights Day). The "16 Days" Campaign provides activists with an opportunity to create solidarity, raise awareness and focus specific attention on violence against women.

Sources

www.un.org/womenwatch/daw/news/vawd.html

www.cwgl.rutgers.edu/16days/home.html

"Being silent is being complicit and non-action is now a violent act"

These are the strong words of Elizabeth Mataka, UN Special Envoy on AIDS in Africa, on the occasion of the International Day Against Violence Against Women in 2007. In a statement released on 25 November 2007, she questions why we are so slow to act when it comes to violations of the rights of women and girls, especially in Africa. The needs and the rights of women should move from "the empty discussions in the margins" and be given the resources, attention and action required by the urgency of the situation. She also argues that a failure to act against violence against women should be included in the definition of violence.

Read the statement at: http://data.unaids.org/pub/ExternalDocument/2007/vaw2007_mataka_statement_en.pdf

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