Violence against women and the burden of HIV-AIDS in Sub-Saharan Africa

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Patriarchy establishes men's domination over women, restricting women's self-determination in domains as profound as marriage, fertility, work, education, inheritance, and sexuality. Intimate partner violence and coerced, exploitative sex are two especially harmful expressions of underlying patriarchy. Sexual abuse in childhood and early adolescence exposes girls to sexually transmitted infections, results in younger pregnancies, damages their mental health, and even augurs premature aging. Later in life, the hidden and often chronic burden of violence in marriage or intimate relationships endangers women's health in numerous ways, from direct injury to a reduction in their immunity to viruses and other medical conditions. Rape and other forms of intimate partner violence generate severe stress, often for long stretches in a woman's life. It is especially important to chronicle violence against women in societies that are on the brink of health crises. In sub-Saharan Africa, among the most pressing health threats is the pandemic of HIV-AIDS. Although the geographic focus of the present paper is on the African continent, the gender-based dynamics fanning the pandemic in Africa are widespread in other regions of the world. In the Pacific, Papua New Guinea is especially poised for such a health disaster, sharing many of the same risk factors, including gender disparities, which underlie the spread of HIV in Africa (Howe, 2002).

In our paper, we review the research literature on violence against women and girls in various regions of sub-Saharan Africa and the juncture of violence with HIV-AIDS. We then report on findings from a population-based survey performed in an urban centre in northern Tanzania in which we explore indicators of gender inequality, the measurement of different forms of violence against women and, finally, the link between women's victimisation and their HIV status.

According to the World Bank, gender-based violence accounts for about 5 per cent of healthy years of life lost to women in developing countries. The threat of escalating mortality due to AIDS lends weight and urgency to the topic. Gender-based violence potentially

magnifies the risk for HIV in women throughout many regions of the world. Without addressing violence against women, the disease will erupt and flourish for many years to come in Africa and other geographic locations. Additionally, to the degree that gender-based violence fosters depression in women, it may account for more quality of life years lost, since depression contributes substantially to the global burden of disease (Murray, 1996). Sixty per cent of the AIDS cases worldwide are concentrated in sub-Saharan Africa, though the continent holds only 10 per cent of the world's population. Countries in sub-Saharan Africa are the only ones in the developing world where there has been a decline in real income (per capita GDP) over the past twenty years. People are becoming poorer across sub-Saharan Africa, and the spectre of HIV-AIDS has followed closely on the heels of retracting income. At the outset of the pandemic, women were targeted as the primary 'vectors' of the disease through their role as sex workers or through their apparent willingness to have multiple sexual partners (i.e., their 'promiscuity'). Such theories were promoted throughout the research literature in the 1980s, and still hold currency, especially among some academics and journalists in sub-Saharan Africa.

There are emerging facts of the virus, however, which belie women's central role in its propagation. One stunning finding is the gender disparity in infection rates among young Africans. Women under twenty-five are more likely to be infected with the HIV-1 virus than men of the same age by several-fold. The chasm exceeds ten years before men converge on the same rate of infection. For instance, in Tanzania, 7 per cent of women from a population-based sample who were between the ages of twenty and twenty-four, tested positive for HIV-1 as compared to well under 1 per cent of the men in the same age range; and 12 per cent of women aged twenty-five to twenty-nine tested positive in contrast to the 3 per cent of their male counterparts (Kapiga *et al.,* 2004). Over time and across older cohorts, the gender gap closes, but is projected to resurface again in terms of earlier mortality: women necessarily must die before male peers in age if they are infected earlier. Mounting statistics of a gender gap in infection rates among monogamous married women, have inspired alternative narratives to the 'woman as vector.' Clearly another dynamic is at work. That dynamic unwinds at the nexus of gender inequality, violence, and disease. Worldwide, gender inequality, as reflected in income and educational disparities, translates into high rates of sexual

and partner violence (Yodanis, 2004). The thesis of our paper is that it is through such violence that women are uniquely subjected to the threat of HIV-AIDS. Gender inequality establishes the conditions for the spread of sexually transmitted disease, and emerges as a necessary, if not sufficient, precursor to the HIV pandemic. Among the conditions are sexual abuse, especially of minors, the lack of alternatives for women in abusive relationships, and even women's lack of power in condom use for protection (Wingood & Clemente, 1997). There are regions of the world (e.g., the Middle East) where women have little economic or political power, yet the infection rates are low at least in part because of cultural constraints on men's sexual access to girls, and because of the strict proprietary boundaries surrounding girls and women. In sub-Saharan Africa women face the disenfranchisement but none of the protection that patriarchy affords.

Tanzania is a country veering perilously close to the shoreline of African pandemics such as AIDS, tuberculosis, and malaria. It is among the poorest of African nations, with an annual GDP per capita of $270 in 2000, and a life expectancy at birth of about forty-five years. As many as one in ten Tanzanians are seropositive for the HIV virus, with women's rates overcoming men's by 30 per cent (CIA, 2003). During the past decade, the Kilimanjaro region of Tanzania had the fastest growing HIV prevalence rates in east Africa (Setel, 1999), making the country a targeted location for research. Between 1992 and 1997, for example, sentinel surveillance of women visiting antenatal clinics showed the number of pregnant women with HIV-1 increasing by a factor of five; among male blood donors the increase was by a factor of about four (Setel, 1999).

Violence could amplify the risk for women further. It is important to establish what the rates are of sexual assault and intimate partner violence among Tanzanian women. It is also important to identify those features of culture and the political economy that might place women at heightened risk for violence in order to craft policies and interventions which could derail the present course of HIV-AIDS in sub-Saharan Africa.

Prevalence of intimate partner violence in sub-Saharan Africa

Partner violence appears throughout different regions of sub-Saharan Africa. For example, one convenience sample from Sierra Leone revealed that a staggering 66.7 per cent of women recounted lifetime

exposure to partner violence. Other population-based surveys have also yielded some fairly high rates: in the rural Rakai District of Uganda, 20 per cent of women reported partner violence during the preceding year, with 30 per cent reporting lifetime prevalence (Koenig *et al.,* 2003). A South African household survey uncovered 9.5% of women with a 12-month prevalence and 25 per cent with a lifetime prevalence of partner violence (Jewkes *et al.,* 2001). Given such elevated rates, it is surprising that so few researchers have undertaken studies on this topic in sub-Saharan Africa. The threat of escalating mortality due to AIDS lends special weight to the topic, yet gender-based violence as a contributing force has been under the radar until quite recently.

Prevalence of sexual violence in sub-Saharan Africa

Researchers also have documented high rates of sexual assault across regions of sub-Saharan Africa. In South Africa, more than one in five South African women reported forced sex during the preceding twelve months (Jewkes *et al.,* 2001). Adolescent girls are especially vulnerable to sexual exploitation. Worldwide, nearly half of sexual assaults are perpetrated against girls age fifteen or younger (United Nations Report on the Status of Women, 1995) and a similar pattern applies to sub-Saharan Africa. More than one in four adolescent girls and young women in Ghana (Ankhoma, 1996) report sexual abuse experiences. Sexual violence in East Africa appears to be equally commonplace. Twenty-one per cent of sexually experienced females reported that they had ever experienced sexual coercion in a study of Kenyan adolescents ages ten to twenty-four; women experiencing coercion were more likely to have had three or more sexual partners and to have experienced symptoms of reproductive tract infection (Erulkar, 2004). A significant number of women in sub-Saharan Africa are coerced or raped, during their first sexual encounter, often before they are fifteen or sixteen years of age. In a household survey, 14 per cent of sexually active women in the rural Rakai District of Uganda reported 'forced sex at first intercourse' (Koenig *et al.,* 2003; Koenig *et al.,* 2004). In this study, younger age at first intercourse increased the likelihood that it was coerced. Women experiencing forced first intercourse were more likely to have ever been pregnant, to indicate that their most recent pregnancy was unintended, to have had two or more sexual partners, and to have one or more genital tract symptoms

at survey date; they were also less likely to have used a condom at last intercourse. At least one study identified 30 per cent of secondary school girls in Tanzania having a history of sexual abuse (Matasha *et al.,* 1998).

Gender-based violence and HIV

Across continents, child sexual abuse creates the risk for later victimisation and poor adult health outcomes. Such a pattern indicates that coerced first sex, or child sexual abuse, may limit women's choices while launching them onto dangerous trajectories. Child sexual abuse is associated with poor health (Walker *et al.,* 1999) and HIV risk for women from affluent, economically developed regions of the world (Wingood & Clemente, 2001; Zierler *et al.,* 1991). In North America, women sometimes are infected through intravenous drug use, stemming in part from child sexual abuse (Dembo *et al.,* 1992), but sexual transmission is the primary route to infection in Africa.

Intimate partner violence also relates to HIV risk among women especially as assessed in patient populations. In Soweto, South Africa, women attending antenatal clinics showed an elevated odds of HIV if they reported intimate partner violence or relationship control (Dunkle *et al.,* 2004). Additionally, Tanzanian women at a voluntary testing clinic were more likely to report partner abuse if they were HIV-positive, with abused women under the age of thirty about ten times more likely to have the virus than non-abused women in the same age cohort (Maman *et al.,* 2002). In sub-Saharan Africa, child sexual abuse (as measured in queries of 'forced first sex') is reported more often by women who are HIV-positive. Even controlling for several other risk factors, coerced sex at first intercourse remained a strong predictor for HIV positive status among rural Ugandan women (Koenig *et al.,* 2004).

A lifetime perspective on violence against women

Many women married to abusive husbands have a prior history of gender-based violence, and especially child sexual abuse. The chance that any given woman might encounter a violent partner may be equal in the population as a whole, especially when intimate partner violence is so commonplace. However, in many communities the distribution of partner violence is not random because some women have predisposed risk factors which limit the spectrum of men who

might be available to them as partners. In addition, family members might have enforced marriage arrangements unfavourable to the women. Women with a sexual abuse history in sub-Saharan Africa, therefore, are likely to have retracted marriage options. Gender-based violence in their early lives could also set the stage for later abuse in marriage and further hardships, including increased susceptibility to HIV. One aim of our study, thus, is to examine the life span risk profile for HIV, from adolescent forced sexual experiences to adult exposure to intimate partner violence.

The Tanzanian Study

Data Collection Methods

Our findings are derived from a population-based survey completed in 2003 of 2019 women in the Northern Tanzanian city of Moshi, the central urban district of the Kilimanjaro region. Moshi has a population of more than 100,000 and has an established presence of Chagga and Pare tribal members, but attracts people from many different tribes throughout Tanzania. It is the centre for coffee bean processing and distribution for Northern Tanzania, and because it lies at the base of the glacier-capped peaks of Mt. Kilimanjaro, it also has a tourist industry.

The household survey

In selected households from a random sample in Moshi all women aged twenty to forty-four were invited to participate in the survey interview. In-person interviews occurred between November 2002 and March 2003. The one-time interview included questions about socio-economic characteristics, sexual practices and marriage, pregnancy histories or parity, and gender-based violence. Women provided informed consent. All interviews were in-person and conducted in Swahili by local nurses. There was no monetary compensation provided to the participants. To protect confidentiality, interviewers ensured privacy and returned to interview the women at convenient times. The interviews took between one and two hours. In addition, women were asked to provide blood for HIV testing and other health-related tests.

Measuring gender-based Violence

Forced first sex

Women were asked to describe the first time they had sexual intercourse, specifically ‘How would you describe the first time that you

had sex? Would you say that you: (1) wanted to have sex; (2) you did not want to have sex but it happened anyway; or (3) were you forced to have sex?' This question has been used in previous studies of African women (e.g., Chapko, 1999; Koenig *et al.,* 2004). Responses were recoded into a dichotomous variable by collapsing those who reported unwanted first intercourse with those who reported forced first intercourse.

Intimate partner violence

Three items assessing intimate partner violence were administered, two of which came from a brief screening tool used in emergency department in the United States (McFarlane et al., 1995): 'In the last 12 months [or ever in your life] how often has your husband or partner: (1) Insulted or sworn at you? (2) Hit, slapped, kicked or otherwise physically hurt you? (3) Threatened to hurt you physically?'

Empirical Findings

As displayed in Table 1, 20.5 per cent of the women reported threats or actual physical abuse, with 15 per cent describing threats and 16 per cent experiencing actual physical forms of abuse. Slightly more (24 per cent) reported lifetime exposure to partner violence, suggesting that they were still with the husband who accounted for both past year and lifetime abuse. Additionally, a very high proportion of women disclosed forced or unwanted sex at first intercourse (26 per cent).

Characteristics of women disclosing partner violence

Women who experienced intimate partner violence during the twelve months prior to the survey, were similar to other women on several demographics such as tribe and religion. On the other hand, those variables in the survey, which date back to the women's earlier life and experiences, do distinguish women who are married to violent husbands (see McCloskey, Williams, & Larsen, 2005 for further details). We found that more women in violent marriages than non-violent marriages report that they were forced to have sex at first intercourse and that their education was terminated. We also found that more abused women were in polygamous marriages than non-abused women. Abused women had more children than non-abused women. Our findings taken together reveal a life trajectory marked by gender-based violence and personal loss for many Tanzanian women, culminating in early mortality. Women with forced sexual experiences

Table 1: Percentage of Tanzanian women reporting different forms of gender based violence[1]

Type of Violence	Item	In the last 12 months		At any time (includes last 12 months)	
		Number of women	%	Number of women	%
Physical					
	Threatened to hurt you physically	209	15	243	17
	Hit, slapped, kicked, or otherwise physically hurt you	234	16	279	20
	Any Physical Violence	**288**	**20.5**	**332**	**24**
Coerced first sex	Unwanted or Forced first Intercourse (combined)			466[2]	26

[1] N=1,446 the number of women with partners during the year prior to the survey
[2] Out of a total of N=1835 women surveyed

differ from other women in their marriage patterns, with more polygamous unions. Furthermore, the quality of marriage for women with coerced sexual histories is diminished with a higher number of women reporting intimate partner violence. It is important to note that early sexual abuse derails women's education, either forcing them into early marriage, or disrupting their lives to the point that they are unable to continue in school. Sexual coercion is a significant contributing factor to women's school attrition.

The relation of gender-based violence to HIV in women

Women married to abusive men endure many hardships, but perhaps the highest price they pay is with their own life and health. Women who were forced to have sex during their first sexual encounter were more likely to be HIV-positive. Fully 17 per cent of women with forced sex histories were HIV positive in contrast to 10 per cent who 'wanted' to have sex at their first encounter. Although only 5 per cent of women who were forced to have sex actually married their assailants, these women are several times more likely to be HIV positive in adulthood than other women (see Figure 1).

It is likely that such marriages were imposed by family members. Finally, the type of marriage union correlates with HIV-1 rates, with 19 per cent of those women in polygamous unions testing positive in contrast to 9 per cent in monogamous marriages (see Figure 2).

Discussion

Our research suggests that features of women's early life presage partner violence, including forced first sexual relations. Various authors have identified gender inequality as laying the foundation for HIV (c.f., Zeirler & Krieger, 2002), and our study provides evidence for at least one important expression of that gender inequality leading to a life trajectory of risk for HIV and other sexually transmitted disease.

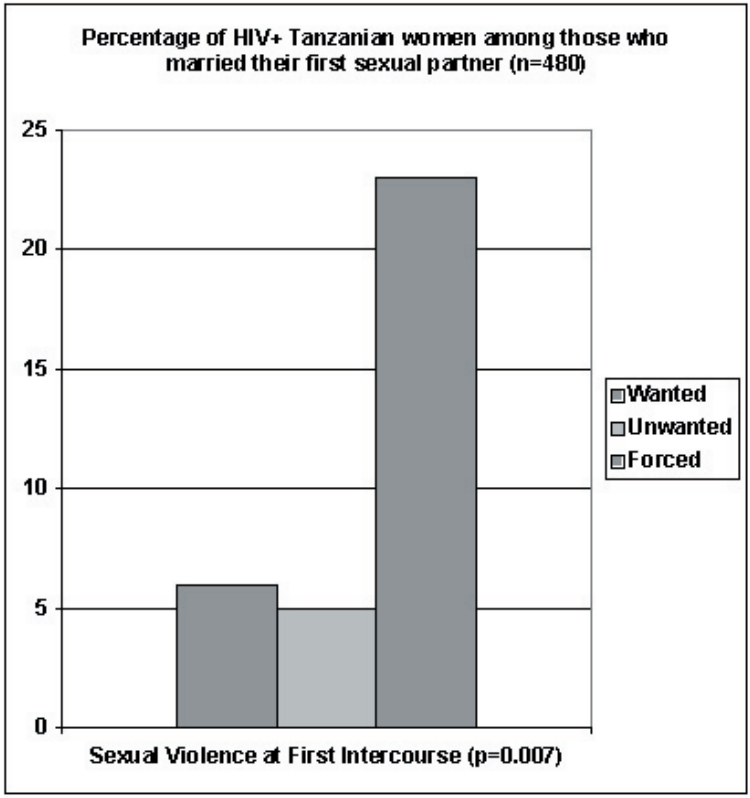

Figure 1

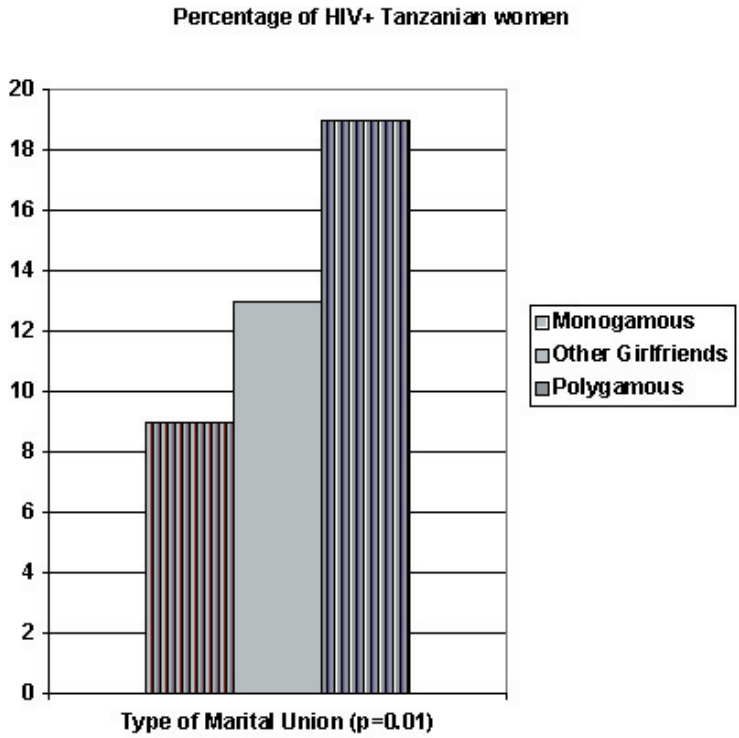

Figure 2

Sexual abuse during early adolescence can interrupt the formation of women's human capital, launching them into early marriage and the risk for infectious disease. But women's education buffers against partner violence. The importance of girls' education, therefore, is paramount for their ultimate freedom from violence and their wellbeing. If educational institutions can be strengthened to meet the unique needs of women, and to provide safe environments for learning, the first step to end gender-based violence across the lifespan and, ultimately, the spread of HIV-AIDS, could be launched. Ensuring equity in education and promoting secondary education should be a primary aim.

The threat of social stigma usually prevents young women from speaking out about rape and abuse. In Zimbabwe, rape cases are sometimes settled out of court where the perpetrator either pays

compensation to the girl's father or pays a bride price and marries the girl to avoid bringing public attention and shame to the girl and her family. In Tanzania men incur few costs for the sexual assault of girls or women, and no costs for partner violence. Raising the toll for men in these domains, in ways that are enforceable and consistent with cultural norms, should be a priority. One further effect of forced early sexual debut may be to launch girls into transactional sexual relationships. Men assume the role of 'sugar daddies,' as they are popularly called, and exchange money and resources, and especially school fees, for sex.

One might ask whether gender-based violence and HIV in Africa pertains to the spread of HIV elsewhere in the world. In highly technological, affluent societies in Europe, North America, Australia and New Zealand, and some Asian countries, HIV propagation follows a very different course. The most notable feature is that women in wealthy nations have a low rate of infection relative to men: HIV is concentrated among gay men and intravenous drug users. What barriers keep the virus from rapidly entering the general population and disproportionately affecting women, as in sub-Saharan Africa? Women in affluent societies enjoy freedom of sexual choice, access to education, healthcare and fertility control only dreamed of by women in the most impoverished regions of the world, notwithstanding the notable income disparities within some of these wealthy nations, most notably the United States. Indeed, in the United States the virus is expanding to the poorest women of colour, primarily in the Northeast. Sexual abuse of girls and women occurs throughout the world, but such abuse with its attendant health cost is commonplace in poor African countries such as Tanzania.

Regions of the world, therefore, with pronounced gender inequality, marked by violence and potentially sexual abuse, and which are also poor, with migratory patterns of male labour, are the most vulnerable. In Oceania, Papua New Guinea is identified as displaying the characteristics of a potential pandemic, although the threat has received remarkably little attention. The conditions of abject poverty, the migration of the poorest people to urban areas such as Port Moresby, and the currently very high rate of sexually transmitted disease even among the rural population, and among women, are potential precursors to a pandemic (Caldwell and Isaac-Toua, 2002). Add to these identified risk factors the pervasive gender inequality in Papua New Guinea, and the shadow of an African-scenario pandemic looms even larger. Rural women in particular have long endured abuse and disenfranchisement,

implicated in the high female suicide rates in the rural highlands (Johnson, 1981). Their access to education is notably lower than men's, and because education is the route in Papua New Guinea, as elsewhere, for political participation, they are vastly unrepresented in government or other institutions of authority (Johnson, 1993). Gender inequality spikes among rural women. The work we have described, therefore, illuminates risk indicators which already exist in Papua New Guinea (PNG), and it is hoped that attention will be paid to avert the next regional crisis of this devastating disease. The most recent reports from PNG indicate that 1.7 per cent of adults aged fifteen to forty-nine are HIV-positive (about 50,000 people), with young women (fifteen to twenty-four years) showing twice the infection rate. Indeed, UNAIDS estimates that 124,070 deaths will result from the disease in PNG by 2020 without interventions or the development of a vaccine in the intervening years.

Conclusions

Coerced first intercourse has a major impact on women's life trajectories, even creating a heightened risk for HIV-1 infection in adulthood. Given the potentially lethal outcome of coerced sex in sub-Saharan Africa it is especially important to better understand the context of forced sex, the family and community response, and how women adapt, in order to inform prevention and intervention efforts for this damaging form of human aggression.

Women's status relates to the spread of HIV. Partner violence reflects women's disenfranchisement. There remains an urgent need to describe the context of sexual assault in sub-Saharan Africa, and elsewhere in the world, in order to better prevent it. An in-depth profile of women with assault histories is also necessary to the development of culturally competent treatment for East African women who have been assaulted, in order to thwart a path to adversity.

Acknowledgements

The empirical research reported here was funded by the National Institute of Health (NICHD), RO1 HD 41202 to Ulla Larsen. Research was performed with IRB approval from the Harvard School of Public Health (HSC Protocol # 0108ACOM) from the Kilimanjaro Christian Medical Centre Research and Ethical Clearance Committee, and from the National Institute for Medical Research, the United Republic

of Tanzania. Informed consent was obtained from each woman interviewed. We also thank Dr. Saidi Kapiga for his intellectual and practical support and advice, especially at the early stages of the research. The authors would like to thank Said Aboud, Mlemba Abassy, Emillian Karugendo, Fred Matola, and Marianne Massawe for their valuable collaboration in data collection. Tina Jiwatram helped to edit the manuscript. Correspondence can be sent to: Laura McCloskey, School of Social Policy & Practice, 3701 Locust Walk, University of Pennsylvania, Philadelphia PA 19104 email: lmcclosk@sp2.upenn.edu

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