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## Child Sexual Abuse and HIV Transmission in Sub-Saharan Africa

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## **Child sexual abuse and HIV transmission in sub-Saharan Africa**

### INTRODUCTION

There is growing recognition that children in sub-Saharan Africa (SSA) are vulnerable to HIV-transmission through sexual abuse and exploitation including incest, child rape, early (coerced) coitus, 'sugar daddies' and transactional sex. However, this awareness is relatively recent. For example, an early analysis of sexual behaviour in sub-Saharan Africa was Standing & Kisekka's annotated bibliography that was "intended as a contribution to basic research on AIDS transmission and to the formulation of appropriate prevention programmes" (1989: i). What is most remarkable about this review of hundreds of medical and anthropological papers on sexual behaviour in SSA is the dearth of material on child sexual abuse. There is very little data on the risks to children of HIV infection due to sexual abuse. The purpose of this paper is to examine the risks of HIV transmission to children through sexual abuse and exploitation in sub-Saharan Africa. The aim is to review the existing literature, identify gaps in knowledge, and suggest future directions for research. Firstly, definitional issues are addressed. What, exactly, constitutes 'child sexual abuse' in sub-Saharan Africa? Secondly, the high HIV prevalence in SSA is described. Thirdly, although this is a topic where very little direct empirical work has been conducted, the research which explores the link between child sexual abuse and HIV transmission is examined. Finally, future research directions are indicated.

## CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA: INCIDENCE AND DEFINITIONAL ISSUES

Sub-Saharan Africa (SSA) is the poorest region in the world. Epidemiological research on child abuse comparable to that in richer regions has not been conducted. However, available research suggests that child sexual abuse in sub-Saharan Africa is at least as prevalent as it is elsewhere. There are some indications that the prevalence may be increasing. For example, the 1998 Demographic and Health Survey for South Africa (Department of Health, 1999) examined 11,735 women's experiences of child sexual abuse. Results showed a higher proportion of younger women compared to older women reporting having been raped before the age of 15. For instance, 2.9% of 15-19 year olds report being raped before age 15, compared to 1.3% of 20 to 24 year olds and 0.6% of 45-49 year olds (Department of Health, 1999). There has been speculation that the perceived increase in child sexual abuse in sub-Saharan Africa is linked to the spread of HIV. That is, younger children are targeted by sexual predators as they are thought to be less likely to have HIV. Also, there is a widespread myth in the region that sex with a virgin/child/daughter may cure HIV and other diseases. These, and other issues relating to the nature and incidence of child sexual abuse in sub-Saharan Africa, have been reviewed in Lalor (2004).

### *Some definitional issues*

In the context of sub-Saharan Africa, perhaps more so than elsewhere, the commonly accepted definitions of child sexual abuse require expansion to encompass

coercion/violence in early sexual relations and the practice of exchange sex or transactional sex, including the ‘sugar daddy’ phenomenon.

#### Coercion/violence in early sexual relations

A number of studies from SSA have reported high levels of force/violence at first coitus for females, often in their early adolescent years. The African Medical and Research Foundation (1993) surveyed over 10,000 Kenyan adolescent females regarding health and sexuality. Of these, 3400 had had intercourse and almost a quarter (23.8%; n=809) of these reported being ‘forced’ at their first coitus. Erulkar, Karueru, Kaggwa, King’ola & Nyagah (1998) also examined early adolescent sexual experiences in Kenya amongst a sample of 1525 respondents aged 10-24 years. Respondents were asked about the degree of pressure involved during their last experience of being propositioned for sex:

**Table 1: Proportion of adolescents experiencing pressure during recent proposition, by type of pressure and gender (multiple responses allowed)**

	<b>Males % (n=215)</b>	<b>Females % (n=361)</b>
<b>Was sweet talked</b>	90	84
<b>Was touched</b>	59	40
<b>Was subjected to attempted force</b>	28	22
<b>Was threatened</b>	9	16
<b>Was offered money or gifts</b>	16	37

Source: Erulkar et al., (1998).

Over a quarter (28%) of males and over a fifth (22%) of females were subjected to 'attempted force' during a recent proposition for sexual relations. Wood, Maforah & Jewkes (1998) described the early sexual experience of a sample of 24 pregnant adolescents (aged 14 to 18 years) in a peri-urban township outside Cape Town, South Africa. First sexual encounters usually occurred around age 13 or 14 years, typically with men five years older. Many respondents described female peer pressure to commence sexual relations, which most did in ignorance of the biological mechanics of intercourse, often in a context of force, intimidation or violence. The authors note that "the term 'forced' emerged repeatedly and lay on a continuum of coercion which started with male 'pleading' and 'persuading' and escalated to assault by hitting, in some cases with belts, shoes and sticks" (Wood et al., 1998, pp. 237-238). Manzini (2001) found that the majority (66%) of a sample of 796 sexually active 15-19 year old females in KwaZulu Natal were willing at their sexual initiation. However, the remainder reported being persuaded (20%), tricked (4%), or forced/raped (10%) at first sex. We should note the possibility of social desirability bias amongst respondents to such surveys. Rarely do these studies (the majority of which are quantitative) define 'forced' or 'tricked.' In regions where early sexual relationships are not approved, it is possible an element of cognitive dissonance may occur so that early sexual experiences are rationalised by girls as being coerced. Having said that, we need to be extremely cautious in not taking such descriptions of violent/coerced sex at face value. This is an issue that warrants more detailed, qualitative, research work.

The extent to which sexual violence appears to be normalised amongst youth in South Africa is indicated in the results of a survey of 269,705 adolescents (Andersson et al.,

2004). Respondents were asked a range of questions regarding their beliefs on sexual violence. Amongst 10-14 year olds, 27.7% of males and 27.4% of females believed that 'girls enjoy rape'. Amongst 15-19 year olds, 28.9% of males and 21.1% of females held the same belief. Overall, 8.6% of all respondents said they had been forced to have sex in the last year. Among 19 year old females, 15% had been forced to have sex in the last year.

'Exchange sex,' including the 'sugar daddy' phenomenon

It is not unusual for some sexual relations in SSA to involve an element of financial, or other, exchange. Anthropologists have noted this for many decades and such historic behaviour frequently occurred in the context of cultures where marriage involved an explicit bride price (Armstrong, 1998). More recently, widespread poverty has required women and girls (particularly in urban areas) to exchange sex for necessities such as food or shelter. Some such relationships are purely commercial and take the form of prostitution. For many others, however, the relationship is more complex and may be supportive over long periods of time and may appear more akin to 'benefactor' type relationships. Thus, a spectrum of 'exchange sex behaviour' exists.

The 1998 Kenya Demographic and Health Survey (National Council for Population and Development (NCPD), Central Bureau of Statistics (CBS) (Office of the Vice President and Ministry of Planning and National Development) [Kenya], and Macro International (MI), 1999) asked 2,972 respondents who had had sexual intercourse if they have given (men) or received (women) any money, gifts or favours in exchange

for sex in the last 12 months. Fifteen percent of adolescent girls who have *ever* had sexual intercourse have done so in exchange for money, gifts or favours in the previous 12 months (16.8% of teenage males have given money or gifts in exchange for sex in the previous 12 months). The proportion is higher amongst 15-19 year old females who are unmarried, compared to those who are married (20.9% vs. 4.2%). Dunkle et al. (2004) reported that 21% of a sample of 1395 pregnant women in Soweto, South Africa aged 16-44 years reported ever engaging in transactional sex.

“Among women reporting any transactional sex, 43.2% reported receiving food, 36.7% clothing, 30.1% transport, 33% cosmetics, 13.9% items for their children or families, 11.9% somewhere to sleep, 8.2% school fees and 94.6% cash” (p. 1584).

Many of these sexual relationships consist of adolescent girls receiving financial and other gifts from older boys and men, in return for sex. García-Moreno & Watts (2000) refer to this kind of relationship as “economically coerced sex” (p. 261). Older boys/men who provide financial/economic support to young girls are widely known as ‘sugar daddies.’ Whilst most likely to occur in conditions of poverty and deprivation, such relationships have also been noted amongst the middle and privileged classes, where additional funds may be used for fashionable clothes/hair-dos, mobile phones and other luxury items. Silberschmidt (2001) argues that the patterns of sexual behaviour evident in parts of SSA today are not the result of some traditional “permissiveness”, but the result of the breakdown of traditional norms and regulations surrounding sexual behaviour, aggravated by widespread poverty.

Thus, any conception of child sexual abuse in sub-Saharan Africa must be cognisant of the economic vulnerability of young girls, and their sexual exploitation by older men. 'Prostitution' is an inadequate term to describe the spectrum of exchange sex behaviour and is, moreover, inappropriate to refer to the behaviour of adolescents.

*Gender differential in HIV infection rates: what does it tell us?*

Female adolescents in many parts of SSA have considerably higher infection rates of HIV relative to their male counterparts. For example, Delius & Walker (2002) note that in the 15-24 years age group, the risk of HIV infection for young women outnumbers that for young men by a ratio of 2:1. Gregson et al. (2002) explain that the greater incidence of HIV in adolescent females is due to (a) higher probability of infection in male-to-female sexual intercourse than female-to-male intercourse, for a variety of physiological reasons and (b) adolescent females' greater exposure to previously infected partners. It is this aspect of HIV transmission that they examine in rural Zimbabwe, finding that "young women form partnerships with men 5-10 years older than themselves, whereas young men have relationships with women of a similar age or slightly younger" (p. 1896), thus increasing their risk of contracting HIV.

As in other regions, child sexual abuse has many manifestations in sub-Saharan Africa; incest, commercial sexual exploitation (ranging across the spectrum of 'exchange sex') and rape. However, perhaps more so than other regions, understandings of child sexual abuse in sub-Saharan Africa must be cognisant of



economic factors, cultural norms governing sexual relationships and the generally low social status of women and children.

## HIGH HIV PREVALENCE IN SUB-SAHARAN AFRICA

Sub-Saharan Africa has extremely high levels of HIV. Of the estimated 39.5 million people worldwide living with HIV, 24.7 million are in SSA (UNAIDS, 2006).

Containing only 10% of the world's population, SSA has almost two thirds of all people living with HIV. The epidemic is concentrated in the southern part of the continent – all seven countries there have adult prevalence rates over 17% (with Botswana and Swaziland having prevalence rates of over 35%). HIV incidence figures are often based on screening of pregnant women in antenatal clinics. Such estimates are potentially inaccurate in that they sample from a limited part of the general population: those pregnant women who present for antenatal care. Recently, research has been conducted in South Africa to try and gain a fuller understanding of HIV prevalence across a sample (n=8,428) of the general population, the *Nelson Mandela/HSRC Study of HIV/AIDS: South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey, 2002* (Shisana and Simbayi, 2002). A prevalence rate of 11.4% amongst persons aged 2 and older is reported. UNAIDS typically report prevalence amongst 'adults', 15-49 years. Amongst this age group in South Africa, a prevalence of 15.6% was reported (17.7% amongst females and 12.8% amongst males).

An unexpected finding of this study was the high prevalence of HIV in children aged 2 to 14 years (5.6%). Vertical transmission alone cannot explain this prevalence. The

researchers recommend that “a detailed study be undertaken to explore the finding, examining the role of sexual abuse and nosocomial infection (health service acquired infections)” (Shisana and Simbayi, 2002, p. 101). In response to the issues raised in the 2002 study, a further study focussing on HIV prevalence in children in South Africa was conducted, the ‘*National Household HIV Prevalence and Risk Survey of South African Children*’ (Brookes, Shisana and Richter, 2004). This report was published because of the lack of information about HIV prevalence in children “despite high levels of vertically transmitted infection of infants as well as high levels of sexual abuse of children (p. 1). A total of 3,988 children aged 2 to 18 years were studied. Of these, 3,294 (82.6%) provided a saliva specimen for HIV testing. This was the first national HIV prevalence study of children in South Africa. HIV prevalence was found to be 5.4% (the authors note that this is higher than expected and that further studies are necessary to verify this finding). HIV prevalence in 2-18 year old girls is slightly higher than among 2-18 year old boys (5.7% v’s 5.1%), but the difference is not significant. A larger discrepancy exists between 10-14 year old girls compared to 10-14 year old boys (5.9% v’s 3.5%). Vertical transmission from mother to infant should occur equally between boys and girls, suggesting additional risk factors for young adolescent females. The researchers noted the high refusal to participate rate among Indian and White South Africans and make repeated cautions about interpreting the data due to high refusal rates and relatively low numbers once division by age and sex takes place:

“If the prevalence levels reported in the HSRC study are correct, additional research is necessary to explain these findings. In particular, research will need to focus on the role of sexual abuse, on the incubation period for children

and on nosocomial infections (health services acquired infections)” (Brookes, Shisana and Richter, 2004, p. 19).

Children under 12 were not asked about sexual debut and experience. No participants were asked about sexual abuse, “for ethical and legal reasons.” Therefore this study is not able to comment on whether sexual abuse is a HIV risk factor for children. The authors conclude, “more work is needed to establish the proportion of HIV infection due to vertical transmission, nosocomial factors [health services acquired infections], sexual abuse and sexual behaviour in children” (p. xvii).

“One of the main limitations of this study was that, for ethical reason, types and levels of child abuse could not be measured. This prevented determining the extent to which it contributed to the transmission of HIV, particularly in relation to vertical and nosocomial transmission. Further research on how to access and measure this kind of information in relation to the spread of HIV and the levels of infection in children is urgently needed” (p. 38).

## RESEARCH EVIDENCE SHOWING THE LINK BETWEEN CHILD SEXUAL ABUSE AND HIV TRANSMISSION

### *Studies which have made a specific link between child sexual abuse and HIV*

While no quantitative or epidemiological data from the region exist, a number of studies have explored the extent to which child sexual abuse may transmit HIV in sub-Saharan Africa. Human Rights Watch (2002) interviewed “approximately” 100

girls under 18 years in Zambia in May/June 2002. The focus of the study was the sexual abuse of girls, leading to heightened risk of HIV transmission. A main concern is that the cultural expectations of obedience and subservience makes “it extremely difficult to negotiate safe sex and to control their sexual lives” (p. 20). This has been noted by many other authors in the region (for example, Armstrong, 1998; Kaboberi-Macharia, 1998; UNHCR and SC-UK, 2002).

The Human Rights Watch report (2002) detailed a number of case studies where adolescent girls report being sexually abused by family members, some of whom were HIV positive. They highlight the powerlessness of girls to report such abuse, particularly where they are economically dependent on relatives (their own parents having died) (Human Rights Watch, 2002, p. 25). As in many other studies in the region (Lalor, 2004; Jewkes, 2004), the authors note the apparent targeting of young girls for sex as they are believed to be more likely to be free of STDs and the myth that sex with a virgin will cure AIDS. However, it is difficult to know to what extent such beliefs contribute to the sexual exploitation of children. The phenomenon of “sugar daddies” is also highlighted as a risk factor for HIV infection for girls, that is, “the HIV epidemic seems to be pushing these men to seek increasingly young girls on the assumption that, other things being equal, younger girls are less likely to be HIV-infected” (Human Rights Watch, 2002, p. 34). The role of increasing poverty in Zambia is also noted as a factor in forcing young girls towards survival sex, and the associated risks of HIV transmission.

Keke (2002) examined the relationship between child sexual abuse and HIV transmission amongst 21 South African children who were sexually assaulted. She

suggests, “It has not been possible to know exactly how prevalent HIV transmission is in children who have been sexually assaulted. This is an area that has not been studied in South Africa, and there is no literature available” (p. 5). The core of this study was the administration of post-assault HIV tests to children. A number of difficulties in completing the testing were encountered. These included lack of finance in the family to present for follow-up tests, ignorance in the family about HIV, fear that preliminary results will change, pressure on family by perpetrator to withdraw the case (and all related medical/counselling processes). Of the 21 children in the sample, 17 were tested for HIV. Keke (2002) reports that four of the 17 children (23.5%) were found to have HIV. However, there is no suggestion that 23.5% of children who are sexually assaulted became HIV+ due to the assault, as the pre-assault HIV status of these children is unknown. That is, HIV infection cannot be attributed to the assault. Future research design would have to address the question as to whether the HIV infection pre-existed the sexual assault. Suggestions for future research directions are considered at the end of this paper.

*What is the HIV transmission risk for children who have been sexually abused?*

Although it is a matter of extreme concern to victims, particularly in regions with high HIV prevalence, no data exist as to the risk of HIV transmission due to a single, or multiple, experience of rape or child sexual abuse. HIV infection in children who have been sexually abused has been studied by the paediatric profession in the US. Of course, HIV levels there are considerably lower than in sub-Saharan Africa but the research is illuminating. Atabaki & Paradise (1999) review the primary findings. They note, “no case of HIV transmission was identified either in 126 abused children

tested by Yordan & Yordan [1992], or in 140 abused children tested by Siegal and colleagues [1995]” (p. 183).

Working from a different perspective (with HIV infected children as the starting point of their research, as opposed to sexually abused children), Gutman et al. (1991) reported that sexual abuse was a ‘certain’ or ‘possible’ source of infection in ten (10.4%) of 96 HIV-infected 2 to 15 year old children. More startlingly, Gellert et al. (1993) found that sexual abuse was the most likely source of infection in 28 (68%) of 41 HIV-positive children.

However, a considerably larger study, a retrospective review of 9136 HIV-positive children younger than 13 years, found that only 26 (0.3%) had been sexually abused (Lindegren et al. 1998). They reviewed all cases of HIV (n=1507) and AIDS (n=7629) in children younger than 13 years in the United States up to December 1996. Of these 9136 children, 26 (0.3%) had a history of sexual abuse and 23 of these had been exposed to no other known HIV risk factor. Whilst this proportion is small, the authors advise that

“in communities with high HIV prevalence, public health departments and clinical centres should encourage provider awareness of the risk for HIV transmission among children evaluated for sexual assault.”

Van As, Withers, du Toit, Millar & Rode (2001) detail the injuries in 200 sexually assaulted children (age range 8 months to 13 years; mean 6.3 years) seen at the Red Cross War Memorial Children’s Hospital, Capetown, South Africa between 1991 and

1999. Ninety-six (48%) children had perineal injuries. Of these, sixty-nine (34.5%) had first-degree injuries (abrasions or superficial lacerations of the vulva, anal margin or perineal skin); 23 (11.5%) had second-degree injuries (tears of the peri-vaginal or transverse perineal muscle); and 4 (2%) had third degree injuries (compound lacerations involving the anal margin and sphincters). In total, 31% of the perineal lacerations required surgical repair. The medical consequences included “HIV seroconversion in 2 children, symptomatic or asymptomatic gonococcal infection (19), bacterial vaginosis (3), trichomonas (2), and genital warts (1)” (p. 1036). The two children who tested positive for HIV were negative immediately after the assault. That is, their positive HIV status occurred after (and, presumably, because of) the sexual assault.

The risk of HIV transmission by a forced sexual act against a child depends on the type of intercourse (anal, vaginal, oral), the presence of other STDs, the degree of force used and the exposure to sexual secretions and/or blood. Whilst no definitive data exist, US studies suggest that the risk of STI transmission to *adult* victims of sexual assault is “between approximately 5 and 15 percent depending on the disease screened for and the type of test used” (National Research Council, 1996, cited in García-Moreno and Watts, 2000, p. 257). However, comparable research work has not been done in regions such as sub-Saharan Africa where the incidence of HIV in the general population is substantially higher than it is in the United States. The study by Van As et al. (2001) in South Africa suggests 1% of sexually assaulted children below age 14 contracted HIV from the sexual abuse. Further studies are required to replicate these findings.

### *Indirect links between child abuse and HIV*

Child sexual abuse is a risk factor for HIV transmission because the child is exposed to the bodily fluids of the perpetrator. However, in addition to direct infection, sexually abused children may be at increased risk of future HIV infection because of the association between child sexual abuse and other high-risk behaviours. It is a moot point whether research findings from the US are relevant to the African setting. However, a significant literature in the US has demonstrated that children who experience sexual abuse may later in their adolescent and adult lives become involved in high-risk behaviour such as early onset sexual behaviour, drug use, prostitution, multiple sexual partners and exposure to repeat victimisation (Finkelhor and Browne, 1985). For example, Zierler, Feingold, Laufer, Velentgas, Kantrowitz-Gordon and Mayer (1991) studied a sample of 186 adults in New England, US, of whom 41 reported being raped or forced to have sex as a child or teenager. They found that “sexually abused women and men were more likely to engage in sex work, to change sexual partners frequently, and to engage in sexual activities with casual acquaintances than individuals who had never been assaulted” (Zierler et al., 1991, p. 575). Specifically, survivors of child sexual abuse were “four times more likely to report having worked as a prostitute ... two times more likely to have multiple sexual partners on an average yearly basis” (p. 574) and 2.6 times more likely to become pregnant as a teenager. Wingood and DiClemente (1997) examined a sample of 165 female African Americans in a socioeconomically deprived area of San Francisco. Of these, 13.3% had experienced forced sex before the age of 16. This group were 1.4 times more likely to report having a STD, 2.4 times more likely to report having more



than two lifetime STDs, 3.8 times as likely to report a history of anal sex and 5.1 times as likely to have a partner who had been physically abusive in the previous three months. More recently, Klein, Elifson and Sterk (2007) studied 250 'at risk' women in Atlanta, Georgia (US) regarding their experiences of childhood neglect and found that "being neglected led to diminished self-esteem, adhering to more negative attitudes toward condom use, and involvement in a greater number of HIV-related risk behaviors" (p. 48). The authors suggest, "one of the uniquely harmful aspects of being neglected is the implied message that one does not matter, that one's needs – like oneself – are insufficiently important to be attended to" (Klein, Elifson and Sterk, 2007, p. 49).

This increased risk of revictimisation amongst those who have been abused at a young age is often explained by intervening variables such as low self-esteem, learned helplessness and poorly developed 'refusal skills'. Does early sexual abuse have similar sequelae in sub-Saharan Africa? There is little empirical work available to answer this question definitively for the sub-Saharan Africa region. In one study, Dunkle et al. (2004) examined 1,366 women presenting for antenatal care in Soweto, South Africa, to assess gender-based violence as a risk factor for HIV. They examined women's experiences of intimate partner violence, child sexual assault, forced first intercourse, adult sexual assault by non-partners and current involvement with a controlling partner. Of the 1,366 sample, 33.5% (n=458) tested HIV positive. The rate of HIV infection was considerably higher in those women who reported high frequency of physical and sexual 'intimate partner' violence (41.2%). However, there was *not* a statistically significant greater incidence of HIV amongst those women who

reported child sexual assault before the age of 15 (34.7%, compared to 33.5% in the total sample).

The issue is more directly addressed in a recent paper by Slonim-Nevo and Mukuka (2007), who surveyed 3,360 10-19 year olds in Zambia regarding their experiences of physical and sexual abuse by family members and Aids related knowledge, attitudes and behaviour. They found that

“abuse by family members was a significant predictor of engagement in high-risk behaviours ... Specifically, the higher the level of sexual and physical abuse in the family, the higher the probability of engagement in any kind of high-risk behavior, controlling for various socio-demographic factors. For example, each unit of increase in the family abuse scale is about 1.5 in the likelihood of trading sex for food, money, gifts or a place to stay, of having sex with an unknown person, and of having sex while high on drugs” (p. 152).

The authors note certain limitations to their study; ‘family abuse’ included physical and sexual abuse; extra-familial abuse (such as at school) was not studied. The issue of child sexual abuse and later high-risk behaviour and exposure to HIV needs greater attention.

#### FUTURE RESEARCH DIRECTIONS

The role of child sexual abuse as a form of HIV transmission in sub-Saharan Africa requires further empirical investigation. Arising from this review, a number of areas for future research are suggested.

The authors note certain limitations to their study; ‘family abuse’ included physical and sexual abuse; extra-familial abuse (such as at school) was not studied. The issue of child sexual abuse and later high-risk behaviour and exposure to HIV needs greater attention.

Firstly, a large-scale empirical study of HIV infection resulting from child sexual abuse is required. Such a study presents considerable methodological and ethical difficulties. Keke (2002) noted the practical difficulties in administering post-assault HIV tests to children. A number of the difficulties encountered by Keke were related to the protracted nature of follow-up testing required. Future research designs should employ HIV tests that require less follow-up or that provide immediate results.

It is necessary to have a control group against which to compare the HIV levels of children who have been sexually assaulted – that is, data on the HIV levels in a sample of children from the general population. Previously, this data was not available but the recent ‘*National Household HIV Prevalence and Risk Survey of South African Children*’ (Brookes, Shisana and Richter, 2004) provides a useful opportunity for comparisons with the general population of children to be made. In order to exclude other HIV risk-factors (such as transactional sex, heterosexual relationships), investigations should include a focus on children below the age of sexual maturity.

Secondly, child sexual abuse as an *indirect* predisposing factor to HIV exposure, through high-risk behaviours such as transactional sex, should be explored. Given the

extent of violence/coercion in early sexual relationships and the extent of exchange sex in sub-Saharan Africa, it is important to know whether such early sexual experiences increase the likelihood of girls and women engaging in high risk behaviours such as multiple partners, exchange sex, prostitution and repeat sexual assaults and rape.

Thirdly, high levels of coercion and violence in first/early sexual relation have been reported in numerous studies conducted in sub-Saharan Africa. These studies are primarily quantitative, and are often based on very large sample sizes. There is a need for qualitative studies to complement these studies and further explore the extent of violence associated with early sexual relations and to decipher respondents' understanding of terms such as 'rape', 'force' and 'trickery'. Wood et al. (1998) conducted such a qualitative study with 24 pregnant adolescents in Cape Town, South Africa. They described widespread gender violence and coercion in adolescent sexual relations. Further qualitative work with a wider sample of adolescents in a variety of contexts is required to determine if such experiences are normal throughout various populations in the region. Clearly, if such exploitative gender relations are widespread there are profound implications for societies struggling to deal with the ongoing spread of HIV.

Each of these suggested research directions centre on the sexual exploitation of girls and women in sub-Saharan Africa. Such exploitation frequently occurs in societies where patriarchal views regarding the satisfaction of male sexual urges are dominant, women's social status is generally low, and poverty is widespread. These conditions highlight the role of socio-cultural factors in the transmission of HIV.

It is surprising that child sexual abuse as a form of direct and indirect HIV transmission has not received greater empirical attention in SSA. Child protection and gender equality initiatives have considerable potential to limit the transmission of HIV. Future research endeavours should address this gap in our understanding of HIV transmission.

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