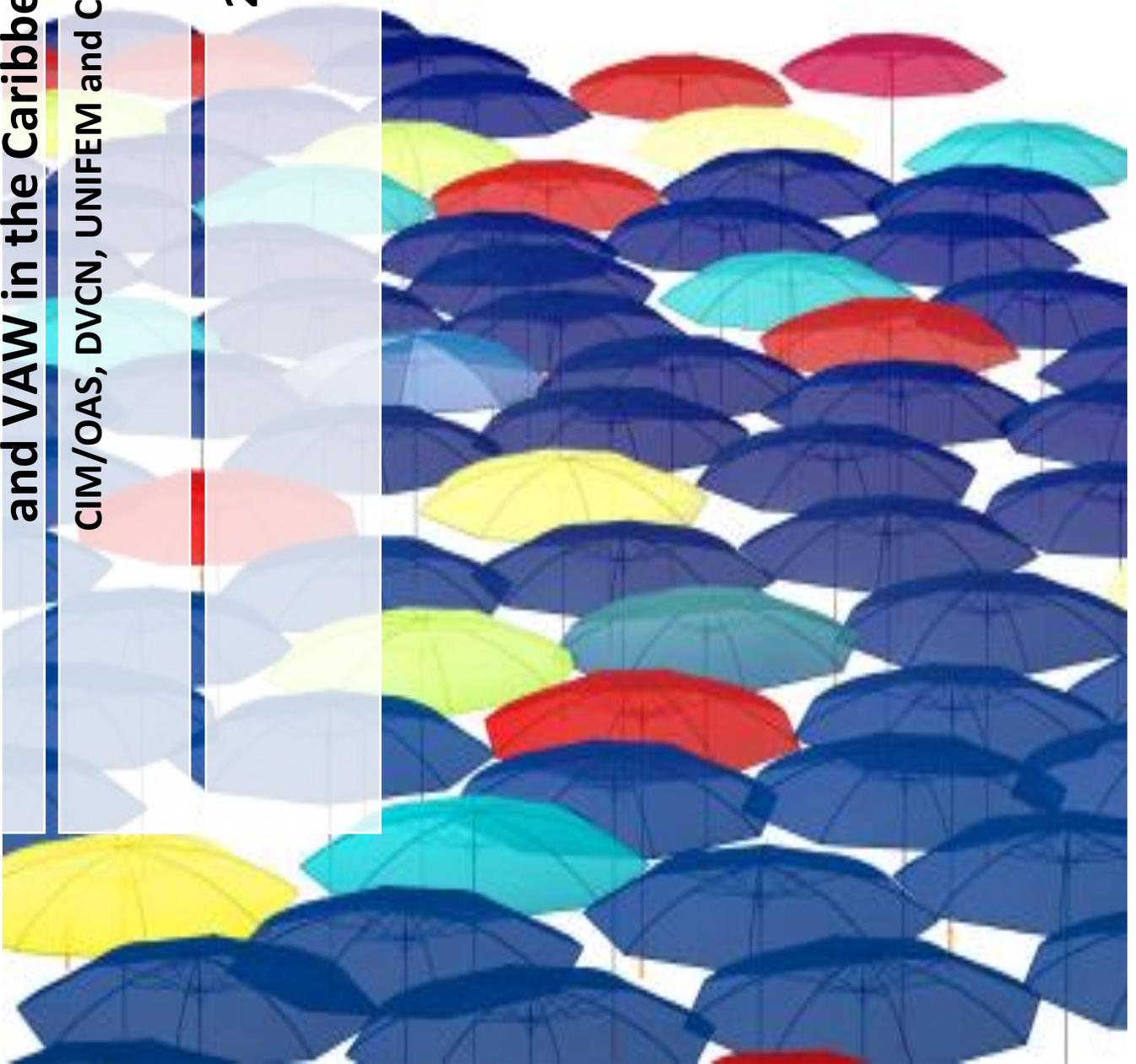


Virtual course on “Empowerment, HIV and VAW in the Caribbean”

CIM/OAS, DVCN, UNIFEM and CAFRA

2009



With the support from the Government of People’s of
China to the Inter-American Commission of Women.

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Introduction

VAW and HIV are serious development and public health problems in the Caribbean. There is a growing body of evidence that HIV and VAW are linked in different ways and those intersections take place through many direct and indirect ways. Gender inequalities are at the base of both epidemics and their relations create specific outcomes in terms of health situation, access to services, education, employment, social participation, and human development as a whole. But the risks and vulnerabilities are not the same for all women and specific conditions and contexts define specific outcomes and needs for different groups.

Development Connections (DVCN), the Inter-American Commission of Women (CIM/OAS), CAFRA and UNIFEM have combined their efforts to implement a proposal to train human resources in the empowerment approach enabling them to develop individual abilities and institutional capacities to deal with the multiple intersections between HIV and VAW. The course was funded with resources provided by the Government of People's of China to the CIM/OAS.

In this edition of the course, a diversity of students from the English speaking Caribbean participated; people employed at NGO's, government agencies, community groups, and citizens of countries varying from Antigua to Trinidad and Tobago. The report will focus mainly on the input from our participants, combining their experiences to a document with new in-dept information about the current practices surrounding HIV and VAW prevention, care and treatment.

The course was coordinated with the following representatives of the participant organizations:

- CIM/OAS: Yasmin Odlum and Martha Beltran-Martinez
- DVCN: Dinys Luciano and Anda Samson
- CAFRA: Nzinga Barkley-Waite
- UNIFEM: Roberta Clarke

This report was written by Anda Samson and technically revised by Dinys Luciano and Yasmin Odlum.

1. General description of the course

The course was designed by Development Connections in 2007 and its first edition (April 2007) was implemented in the Dominican Republic in coordination with UNFPA, Margaret Sanger Center, COPRESIDA, ICW, and Colectiva Mujer y Salud, and included both on-site and virtual sessions. The second edition (September-December 2007) was virtual only, with 30 participants from 14 countries in Latin America, the Caribbean, USA and Canada, and was implemented in collaboration with UNIFEM, Inter-American Commission on Women (CIM/OAS), ICW, Isis International, and Red de Salud de las Mujeres Latinoamericanas y del Caribe. The third edition (June 2008) focused on indigenous women and was implemented on-site in Bolivia, in collaboration with Diakonia and Family Care International, with participants from Bolivia, Colombia, Paraguay and Peru. This report presents the results of the fourth edition, implemented in the English-speaking Caribbean (August –December, 2008).

The specific objectives of the course are:

- a. Analyze intersections between HIV and VAW and the application of an empowerment approach when addressing both issues.
- b. Examine strategic and practical implications in the integration of interventions in HIV and VAW prevention, care, and treatment.
- c. Use of tools to carry out integration of HIV and VAW intervention processes at the institutional and intersectoral levels.

The educational design of the course emphasizes five components to ensure achievement of the defined competences: a) contents adapted to the different training needs and interests, b) personalized tutoring, c) diverse support resources from which students will select those that best match their training needs, d) interactivity through means such as fora and working groups, and e) technological support system that allows interactivity and use of learning resources.

The contents of the four modules of the course are described in the following table.

Module	Content
1. Conceptual framework	<ul style="list-style-type: none"> . Intersections between HIV and VAW . Principles of the empowerment approach applied to HIV and VAW . International commitments and national legislation on HIV and VAW
2. Prevention	<ul style="list-style-type: none"> . Prevention strategies from the public health approach . Best practices in prevention of HIV and VAW . Key components of HIV and VAW prevention programs
3. Care and Treatment	<ul style="list-style-type: none"> . Comprehensive HIV and VAW care components . Voluntary test and counselling . Perinatal transmission and VAW . Integration of HIV in VAW services: case identification, care, treatment, referral systems and support groups.
4. Considerations on key populations	Youth and adolescents, migrants (including victims of human trafficking), and sex workers.

The course comprises a total of 93 hours, 7 hours per week. The participation was evaluated and certified by weighting the performance of the work guides, participation in fora and the final project.

In this edition 40 participants from Antigua, the Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St Lucia, St Kitts and Nevis, St Vincent and the Grenadines and Trinidad and Tobago were selected, working in the following areas:

Field Officer, Liasion Officer, Youth officer, Line Ministry CBO, FBO, National AIDS Programme, Youth Officer, Project Coordinator National Women's Organization, Senior Assistant Youth Coordinator, Senior Gender Development Officer, Assistant Youth Officer, Regional Technical Advisor CRS, HIV/AIDS Programme Manager, HBC/OVC Coordinator, Pre-school Teacher, Paliative Care Manager, Consultant -Women in leadership positions, Research Coordinator, Social Worker, Acting Rural Sociologist, Junior Clerk Social Services Department, Director Gender Relations at the Ministry of Health, Field Officer at a Drop in Center, Counselor, Coordinator Gender Affairs Division, Community Development Officer, Social Assistance Officer, Project Coordinator of Reproductive Health, Clerk for CARICOM Youth Ambassadors, Assistant Secretary, Research Assistant, Research Analyst, Outreach and Research Officer, Field officer HIV AIDS alliance, Outreach Programme Coordinator, Prevention Advisor,

PAHO/WHO Representative Executive Director, Programme Officer Antigua, Directorate of Gender Affairs, Program & Research Officer, Programme Officer, Communications Officer, Programme Officer WIN Belize, Technical Advisor, HIV/STI/TB, Women Development Officer, and Women's Development Officer.

2. Modules: key issues for the Caribbean

2.1. Module # 1: Conceptual framework on empowerment, HIV and Violence against women (VAW)

2.1.1. Dimensions of HIV and VAW and institutional responses

Facilitator: Dinys Luciano, general coordinator of the course and director of DVCN.

Addressing both issues separately will be a key barrier to development and sectoral goals such as the MDGs, UNGASS, and CEDAW. Both pandemics have proven to be crucial determinants of health and wellbeing of women, families, communities and societies.

- **Situation of HIV and VAW in the Caribbean:** The proportion of women living with HIV (WLWHA) is increasing in almost all regions and in some sub-populations is higher than their male counterparts. The Caribbean is no exception to this rule according to the testimonies of our participants: "The National AIDS secretariat from *Antigua/Barbuda* published data from 1985 to 2008 stating that the male: female ratio is 1:1." "According to the *St. Vincent and the Grenadines* UNGASS report 2008 the male female ratio stands at 1.6: 1 compared to the previous ratio of 2: 1." Available data indicate that between 25 and 69 percent of women are suffering from violence from their intimate partner. (Luciano, Dinys 2005)
- **Policies regarding HIV and VAW:** Maintaining the same policies focused on "at –risk populations" seems not to be working for all women and poses ethical questions about what are the scientific bases for keeping women (not only pregnant and sex workers) in the margins of the national and local priorities.

According with the participants in some countries the situation is as follows:

- "In *Barbados*, the National Plan on HIV states that 20% of females with HIV reported being sexually abused, 18% were physically assaulted and 13% lived in abusive homes. The plan did not state whether or not this was because of their HIV status."
- In *Trinidad/Tobago* for example no studies exist linking both issues.
- *Grenada's* national plan for HIV does not address VAW and vice versa.

- *Antigua and Barbuda's* Nation Plan for HIV does not address the issue of VAW. However, The Nation Plan for VAW do addresses the issues of HIV and Sexual and Reproductive Health.
 - The National Plan for HIV in *the Bahamas* is spearheaded by the Ministry of Health, and while it is proud of its accomplishments of scaling up toward universal access to HIV prevention, treatment, care and support services, has not addressed VAW. Similarly the crises centre of The Bahamas has not addressed HIV in its plans for VAW prevention.
 - *Belize* over the past months has been conducting a study linking gender based violence and HIV. Preliminary data reveal that HIV positive women have been living in abusive situations for years, and further suffer abuse after they disclose their information. Information from the vertical transmission program has furthermore revealed that women due to fear of violence by their partner, families members, and fear of discrimination have risked the life of their new born by putting them to the breast as a way of showing their spouse or partner among others that they are not HIV positive.
- ➔ **What works:** Some alternatives for integrating HIV and VAW programs have shown their effectiveness for changing risk factors and vulnerabilities regarding both issues based on criteria such as: efficacy of the gender approach as underlying theory, intervention fidelity, process evaluation, sampling strategy and implementation, and outcome measures.

Some countries in the region are already implementing such programs:

- *Jamaica* has implemented a national gender policy, national HIV strategic plan, national behaviour communication and health education programmes, HIV workplace policies and prevention/control programmes.
- In *St Kitts/Nevis*, the 2008-2010 HIV/AIDS operational plan focuses on behaviour change, youth intervention, general population, mother-to-child-transmission, voluntary counseling and testing, and condom programming.

However, efficacy measurement is still a problem since outcomes are not always clear and best practices may differ from country to country.

2.1.2. Empowerment approach to address the links between HIV and VAW

Facilitator: Anda Samson, Medical doctor and academic coordinator of the course. Master's thesis "Connections between HIV and violence against women in Kenya. A broader view of empowerment issues." *Leiden University/PAHO*.

Many links between HIV and VAW have been studied so far, amongst others: lack of decision-making power regarding sexual behavior and interactions; risk perception; use of prevention and health care services; fear of pregnant women to use HIV test services and counseling due to fear of violence; and finally, sexual behavior of men who exert violence on their partners. The common denominator of all these links between HIV and VAW is a lack of decision-making power of women regarding their own lives, health, and sexuality.

- **Women's empowerment at country level:** As one of our students remarked: "In *Grenada*, There is a high level of gender inequality in that men take control of every aspect of the relationship except the point of bearing the children. They (men) often feel threatened when there is a form of equality or women liberating themselves in society. Many Grenadian men don't like to use condoms because they think if you use (them) sex feels 'bare'. Women feel intimidated to ask their spouse to use a condom because it would stimulate the thought of unfaithfulness and this would also lessen their bargaining power on insisting this condom use or even refusing unwanted sex." A participant from *Antigua and Barbuda* stated: "As it relates to sexual and reproductive rights and practice, women did not have any rights over her body. It was a practice (not written in law) that a married woman had to seek the consent from her husband if she was in need of a Tuba ligation to be done. However, with the intervention and advocating by the Executive Director of Gender Affairs, this practice was removed from the books two or three years ago. Women are now free to make decision for our own bodies without the consent of a husband."
- **Access to information and empowerment:** Many people have emphasized the importance of information. In *Suriname*, 50%-80% of women have heard of HIV and within this group, 50% know of 3 specific ways to prevent HIV. In *Grenada* this number is the same however 97% knows where to test and receive aid for HIV. On the *Turks and Caicos* islands, 66% have heard of the infection and of those women 66% know where to obtain aid. In *Guyana*, 30% of the out-of-school youths believe that mosquitoes can transmit HIV and 25% thought that HIV could be transmitted through the sharing of a meal with an infected person. The survey showed that a number of perceptions that may contribute to stigma and discrimination. For example, 25% of the respondents reported that they would not purchase from an HIV+ shopkeeper and more than 33% would want to keep it a secret if a family member were to become infected. Even though these numbers are discomfoting at times, the discussion was broadened using Lori Heise's work.

Other than the above-mentioned examples, the following topics were identified by the participants:

- a) Lack of a good legal framework. There is a reluctance to outlaw sexual violence against women within marriages in many countries.
- b) Economic power: many women are unemployed or underemployed and are therefore depending on their partners.
- c) The involvement of men: in most countries, involving men into the process of empowering women has proven to be challenging.

Being empowered on one level does not automatically imply empowerment on another level. An example of this was given by one of our participants: “in Mexico and Central America, the advent of factories established under free trade agreements (“maquilas”), caused these factories to hire women who had previously not worked outside their homes. The women's new economic status, combined with a change in the power structure due to the men's high unemployment rate resulted in an increase in domestic violence in those communities.”

2.1.3. International commitments and national laws on HIV and VAW

Facilitator: Mercedes Kremenetzky (CIM/OAS.) Senior Specialist of the Inter- American Commission on Women and coordinator of the Mechanism to Follow Up on Implementation of the Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, “Convention of Belém do Pará” – MESECVI

For most participants the existence of the international commitments, for example the convention of Belem do Para, was not new. The department of gender affairs in *St Kitts/Nevis* was the driving force behind the act against domestic violence.

Marital rape is outlawed in *Grenada*, the *Turks and Caicois islands*, *Belize*, *Trinidad and Tobago* and *Antigua and Barbuda*. In contrast, *Guyana* has no laws condemning marital rape, as well as *St Kitts/Nevis* and *Jamaica*.

In *Grenada* there is legal protection for women who fall victim to violence. In *Antigua and Barbuda* in regards to legislation, out of the Conventions The Domestic Violence Summary Proceeding Act was passed. Where an Order of Protection can be taken out against the perpetrator. The Order of Protection comes with the Power of Arrest to the Order and imprisonment if the order is breach. Some Police Officers and frontline workers were also trained to be more sensitive when responding to incidences of VAW and there is a zero tolerance by the police as in regard to VAW.

In almost all cases, lack of funding and lack of human resources is noted as an important limitation to not only the development of legal frameworks for HIV and VAW, but also as a limitation to the implementation of these frameworks. Human resources are costly and since the countries are often small there is no budget. Funding from sources like UNAIDS or PEPFAR are named as important measures to improve prevention programmes

2.2. Module # 2: HIV and VAW prevention

2.2.1. HIV prevention - Facilitator: Paulo Lyra, Regional Advisor on HIV Education and Communication. Pan American Health Organization, Washington D.C.

According to the UNAIDS Global Report on AIDS (2006), rather than being a consequence of deficient prevention strategies, the constant spread of the AIDS epidemic is due to the inability of implementing the available and highly efficient means to contain HIV propagation. About 25 years ago, HIV prevention was admitted to be out of reach of the majority of people highly exposed to HIV because many of those responsible for formulating policies refused to implement proven efficient measures. This forum analyzed successful HIV prevention strategies in Latin America and the Caribbean as well as the principles behind these effective prevention programs, and will identify necessary programmatic actions and public policies.

- **Progress and gaps on HIV/VAW prevention in the Caribbean:** Many community-centered prevention programmes exist throughout the region.
 - In *Grenada* for example, there is a programme with the media are promoting a series of workshops in many locations, there is an island wide campaign with the distribution of Pamphlets, condoms and other relevant information. In *Jamaica* programmes exist focusing on medical reduction (blood safety, etc) and education and counselling is cross-cutting. These policies include awareness sessions as a prevention strategy and promote voluntary testing.
 - *Antigua and Barbuda* engagement is based on a behavioural communication change initiative which emphasis is placed on empowerment of women to take control of their own sexual practices by building the confidence to negotiate with their partners and to have the ability to make choices as of the use of his condom or hers. The initiative is designed to suit any target audience and involves discussions, about VAW and HIV, the demonstration and distribution of Female Condoms.
- **Mother – to child – prevention:** While the PMTCT program is seen to be impacting, the prevention of transmission to babies is undermined by partners who refuse to be tested, women who are fearful to be tested because of the perceived violence by their partner.
 - Notable is the culture in *Belize* for women who know their HIV status to put their babies to the breast so as to send a message to their partners, families and the rest of the society, that they are not HIV positive, and the repeated pregnancies.
 - A lot of emphasis is placed on knowing your HIV status in Barbados. All pregnant women are offered the test and are encouraged to have the test done. This test is offered as part of their antenatal care visit. Their partners are also encouraged to take the test. Hardly any of the pregnant women refuse to have the test done, however how many of the partners are taking the test is not reported.

- In *Grenada*, parenting and pregnant women sessions exist, aimed at bridging the gap between parents and children through various awareness and educational programmes and sessions.
 - In *Jamaica*, there has been considerable reduction in Mother to Child Transmission because of mandatory testing.
- **Stigma and discrimination:** To date, the *Barbados* HIV response has emphasised medical treatment and the care of PLHIV, the reduction of stigma and discrimination, and prevention including education and communication (IEC) programmes. With the advent of antiretroviral drugs, there has been a significant reduction in morbidity and mortality associated with the disease. However, *unsafe sexual attitudes and practices persist and there continues to be only limited support for condom distribution and use*. In the new plan 2008-2013 it has been recognized that the emphasis needs to be on communication and advocacy for behaviour change within the society at large to reduce the incidence of HIV and to encourage respect and tolerance towards PLHIV and persons at risk. With the addition of partners such as PEPFAR, World Bank and Global Fund, a dramatic improvement in access to VCT has occurred in *Guyana*. However, it appears that although general knowledge about HIV is relatively high, so is the level of stigma and discrimination. When asked in a Behavioral Surveillance Survey in 2004/2005, 48% of respondents replied that they would keep their HIV status from their family if they found out they were HIV+; 23.7% reported they would not buy goods from an HIV-positive shop owner, 65.3% were of the opinion that an HIV-positive teacher should not be allowed to teach.
- **The ABC strategy (Abstinence, Be faithful, use Condoms):** It is mentioned many times as a method used in prevention programmes. However, the modern trend is to depart from this model, for a number of reasons. First because ABC is a contradictory behavior message. It does not serve to all people. Second because there is no evidence that programs seeking to promote abstinence have resulted, so its use as a public health intervention is questionable. Abstinence will always be choice for the individuals who want to practice it, but abstinence driven programs seems not to affect – or even increase – the occurrence of STI's. Furthermore, being faithful does not work for married women, when their husbands are unfaithful. The message can even put them at risk. Another topic brought up several times is the fact that sex between men plays an important role in HIV transmission worldwide, even in countries with generalized epidemics. Unfortunately, there is a great denial about that, and few prevention programs. The criminalization of homosexual behavior is one addition problem: how can we develop prevention programs if the target population is at risk or arrest and prosecution.
- **Female condoms:** Despite the negative thoughts surrounding the possibilities of behaviour change, an experience from Suriname shows that through careful planning and implementation changes in population behaviour are possible; the promotion of female condoms was deemed a failure in Surinam. However this programme chose to

promote the use of these condoms, aiming at a female-controlled way of HIV prevention. The design of the intervention started with a formative assessment to document the knowledge, attitudes, and practices prior to the intervention, through key informant interviews. In the second phase the procurement of female condoms was regularized, and the distribution network was gradually expanded, and is now more than 140 outlets. In the past year around 100,000 female condoms were distributed through this network. This example shows there is an urgent need to increase the capacity for effective planning, implementation and evaluation of prevention interventions, otherwise we will continue to fail.

2.2.2. VAW and HIV prevention in the Caribbean: The experience from UNIFEM

Facilitator: Roberta Clarke, Regional Programme Director, UNIFEM/Caribbean Regional Office

Everyone can contract HIV, and as we know there is also greater biological vulnerability to contracting HIV for young women (to do with epithelial lining). The question however, is whether there are some who are more vulnerable or at greater risk than others due to life circumstances or life style. There is a connection between HIV and violence, but we need to be careful not to collapse the two. Many persons have contracted HIV without violence being a factor. Rather routine gendered sexual behaviour helps us understand vulnerability. That said, we not know enough about the connections between HIV and violence. But it would be reasonable to conclude that in intimate partnerships characterised by domination and inequality, women's vulnerabilities are very high. Indeed, the national aids programmes have anecdotally reported that women who test positive often speak to the experience of sexual violence. So we need to think through how violence is a cause and a consequence of HIV.

- **Sexuality, HIV and VAW:** A practical challenge is the need to speak positively about sex and sexuality as a key strategy in halting and reversing the spread of HIV. We use the language of sex to denote something which we have understood as unchangeable. Sex is about the body parts, the chemistry of hormones. There is no doubt however that *sexual expression* is informed strongly by dominant gender norms. The language of gender is used to bring into relief the notion that behaviour is in some large measure determined by societal expectations, demands and compulsions.

In the Caribbean, research shows that people express sexuality in patterns related to gender. Young men around the Caribbean have earlier sexual initiation as well as stronger histories of multiple partnerships. Research from *Jamaica* suggests a correlation between those experiences and expectations of hegemonic masculinity and homophobia on the other hand, and shows that the need to avoid the labelling is one strong reason for early sexual initiation. Alongside there is also a culture of 'deceit' or 'duplicity' which we can see has been a source of humour in Caribbean popular culture. And when men do not conform to that, they face the censure of being sissy, mampoule men (in the language of the expressive Trinis) or as batty men (the Jamaican narrative). In Jamaica, the term 'one burner man' is a derogative to

describe a man who is faithful to one partner. What however seems less well understood is what researchers refer to as hypersexuality amongst young women. So as gender and HIV programmers, we would need to take the cultural factors into consideration in crafting messages for men. Gender socialisation has also led many women into behaviours of sexual passivity. Many women, socialised to think that having a man is one important marker of femininity, may and do tolerate a host of behaviours of their partners which put them at risk.

The participants raised many pointers in respect to the abovementioned discussion topics, amongst which:

- political economy as the context within which choices are determined and made; many women are in a dependent position with regards to their partners.
- women's silence about domestic violence, the acceptance of violence as part of a relationship, and the thought that violence against them will be self-inflicted for most women.
- the sexual double standard; young men are expected, and almost encouraged to have multiple partners and start expressing their sexuality at a young age, whereas women are considered promiscuous when expressing their wishes in sexuality.
- the central position of power to explain many dimensions of relationships between women and men;
- mixed messages around sexuality- sexual conservatism co-existing with worst forms of sexual abuse of children and the silence that attends that.

Even while we have a growing awareness that gender inequality and stereotypes are the main drivers of the epidemic in the region, behaviour change strategies seem not to be responding to this reality. Therefore we need to evaluate critically the existing programmes. The widely used ABC strategies can be a powerful combination but these work best when individuals can express agency and they are less effective where the culture, the political economy constrain the range of choices which individuals can make.

2.2.3. VAW prevention strategies

Facilitator: Diny Luciano (DVCN).

The region has seen major advances in public policies and programs that seek to respond to, prevent and punish VAW, although implementation of these has been severely limited. In terms of prevention, in some countries the problem is seen more and more as a social problem and is becoming less and less acceptable; still, VAW is widespread. It is worth noting that acceptance of VAW is significantly higher in situations in which a woman transgresses her traditional gender role, in the obligation to have sex with her husband even when she does not want to, when she has been unfaithful and/or when she "fails to care for her children or spouse."

VAW prevention strategies play a fundamental role in the change of culture and of regulations that perpetuate the problem and increase women's vulnerability to HIV. From a public health point of view, a HIV and VAW integrated strategy deals with related factors at the macro, sectoral, community, family, and individual levels. It also applies three types of preventive interventions: primary, secondary, and tertiary. Primary prevention focuses in

increasing knowledge about the link between HIV and VAW, promoting protection against both problems, reducing stigmatization and discrimination, and promoting non violent and egalitarian social relations between men and women.

Secondary prevention includes interventions to provide care for HIV and VAW cases as soon as they are identified in health centers, schools, and other facilities, to prevent repetition of VAW and/or re-exposition to HIV. Tertiary prevention focuses on damage reduction for women living with HIV and VAW survivors through support interventions to face physical, social, and psychological consequences. This forum will analyze the strategies used in VAW prevention, particularly those related to violence from the sexual partner (domestic violence), sexual abuse of children and date rape (against teenagers). The best practices in communications programs to promote behavior change at the individual and community levels

The available evidence indicates that comprehensive interventions that address the **determining factors** of VAW have been more effective, reducing social acceptance of this problem while developing the social responses needed to prevent, respond to and punish VAW. In other words: providing information is not enough in itself to generate a positive behavioral change that is sustained over time, and that “changing attitudes and raising awareness seem to be much easier than changing violent behavior.”

a. Comprehensive framework: VAW cannot be eradicated without changing attitudes and practices at all levels in our societies. VAW is justified in a society not only when individuals and the community as a whole consider rape, physical and emotional violence, trafficking in women, etc., as acceptable under certain circumstances, but also when the absence of an institutional response makes it invisible and natural. Institutional negligence is another form of violence.

b. Need for changing attitudes and behaviors in men, women, and children since both men and women share the values of the society in which they live.

c. Working with men is crucial since they can have an influence on the culture and environment that allows other men to be perpetrators. Some researchers have pointed out that asking men to make a shift may not be as difficult as it may seem for several reasons: a) they already feel uncomfortable with their socialization, b) men overestimate the extent to which their peers endorse gender stereotypes about sexual attitudes and behavior, and c) violence, including rape, is strongly associated with hypermasculinity or the tendency to overconform to perceived male gender role expectations.

d. Public investment in preventing violence: public allocation for VAW prevention is scarce across the countries and in some of them international funds are the main source for sustaining VAW programs.

e. Documentation and evaluation of VAW prevention strategies: although enormous effort has been put into programs to prevent VAW in the Caribbean, still the research regarding their efficacy lags far behind the practice of providing these interventions. Some researchers are trying to develop innovative measures to assess changes at different levels –and their

sustainability in the long term- but the lack of reliable and valid indicators of effectiveness has hampered the usefulness of the already scarce research on violence prevention. Ideally, more experimental investigations will use control groups, because most prevention studies thus far have been quasi-experimental..

f. The mother-to-child transmission (PMTCT) prevention programs must include detection strategies, first aid, and care and counseling for violence survivors. Studies carried out in Africa and Asia show that women who have been victims of violence are in higher risk of being infected with HIV. Studies indicate that some women refuse telling their partners about the test because of the fear of violence. In many countries, if the pregnant woman is diagnosed HIV positive, even if the partner was not tested or did not inform her about his own positive result, women are treated violently and accused of infidelity and/or of transmitting AIDS to their partners and family.

2.3. Module #3: VAW, Voluntary Counseling and Testing, and Perinatal Transmission

Facilitator: Robert Carr, Senior Lecturer/Head Graduate Programmes Unit. The University of the West Indies, Jamaica.

In many ways VCT is the cornerstone of HIV prevention programming in the Caribbean. There are workshops and health fairs and even national testing days promoting VCT. If we step back, we can see that there is an assumption that the person being tested is able to do a number of things:

- a. Act on the information that they are HIV-negative by addressing risk behaviours and changing how and with whom they have sex to reduce their risk;
- b. Act on the information they are HIV-positive to reduce the risk of infecting their partners including disclosing their HIV-positive status to their partners, enter treatment when it is necessary to manage their health status, and
- c. Enter into Perinatal Mother To Child Transmission prevention programmes if they are pregnant.

However, not all populations may be adequately catered when using these assumptions. According to UNAIDS (2006), resources allocated to HIV prevention, treatment, and care for some target populations are not proportional to the HIV prevalence, or the specific risks to which they are exposed. Among the factors associated with this situation are deficient administration of resources and violation of fundamental human rights. In this forum the specific concerns were analyzed that should be dealt with in integrated interventions with teenagers, migrants (including victims of human trafficking) and imprisoned women.

- **Social vulnerabilities and HIV:** In the case of young women, in some countries the probability of living with HIV is higher than that of young men. In the Dominican Republic, women between 15-24 years of age have twice as much probability of living with HIV than men of the same age (Alba, Wendy, 2007); and in Trinidad and Tobago, HIV prevalence is as much as five times higher for girls than for boys 15 to 19 years

old (PAHO, 2005). At the same time, in the United States HIV rates are 8 to 10 times higher among prisoners than in the general population (Center for AIDS Prevention Studies, 2000). Female victims of human trafficking are specially vulnerable to STIs because when they arrive to the specific country (or geographical area) they may face a community with a higher incidence of STI/HIV than their place of origin, which, added to a lower perception of the risk to catch the virus compared with the resident population, it impacts the vulnerability to the epidemic. Likewise, in some cases, the human trafficking experience involves sexual violence from the dealers.

- **Pregnant women:** Another vulnerable group are pregnant women. In many cases there are health care facilities during pregnancy, ensuring the best possible prevention of HIV transmission from mother to child. However, in many instances post test – and maybe even more importantly, post pregnancy – care and services are lacking. Although transmission of the virus to the child is often prevented little attention is given to the HIV status of the woman tested, and even less to their sexuality. All these factors may result in women returning with multiple pregnancies after having been tested HIV positive. There is a tendency to frown upon these women as being irresponsible and insensible.
- **Parenting, stigma and HIV:** There are a series of issues that are often overlooked in these discussions, including the rights of HIV positive women to becoming a mother, the secrecy and shame surrounding the HIV status, children facing the possibility of becoming orphaned and sometimes a genuine but unfounded belief in modern medicine to treat the infection.
- **Coercion within couples.** Some women who test positive for example state that they can't tell their partner for fear of his response, and that their HIV status has been shocking news because they have been faithful, and so for them it is also news of a betrayal. NGOs and others providing counselling and support, especially support groups of HIV+ women, have played an important role in their lives. Hence, the issues around PMTCT and safeguarding women's established the need for new approaches to HIV+ women having children. As one of our participants stated: *“Women having repeated pregnancies I think is a failure to provide proper family planning services, and perhaps proper ongoing post test counseling which often times because of human resources constraints is a major gap in national responses for HIV”*

2.4. Module #4: Considerations on special populations

2.4.1. Addressing the needs of key populations

Facilitator: Glendene Lemard - Research Assistant Professor, School of Public Health and Health Sciences, University of Massachusetts – Amherst

The main underlying issue all populations are facing is that they tend to be underserved in any given setting, placing them at increased risk for contracting HIV. The first part of this forum was dedicated to framing reasons for the increased risk factors, using amongst others:

- The effects of violence victimization on the key populations and on the society at large
- The underlying factors impacting the key populations and why they are underserved
- The barriers that exist that make intervention strategies inadequate
- Key points to consider in creating long-term interventions for reducing the rate of violence and HIV infection in the key populations.
- The ecological model of violence

The participants outlined the factors that they felt made the key populations particularly vulnerable which included:

- Cultural stigmas attached to various groups e.g. migrants and sex workers
- Lack of power and capacity to protect themselves
- Lack of money, job opportunities and financing for healthcare
- Unfamiliarity with settings and illegal status (as in the case of migrants)
- Secrecy of work (as in the case of sex workers)
- Social environment in which child is raised and lack of protective factors
- Social factors such as inequality and lack of economic safety networks
- Coercion into sexual activity especially at an early age
- Cultural values, norms and folklore (for example, encouragement of rape of child to cure disease).
- The key effects of abuse and the impact of violence in the key populations and the wider society included:
 - Consumption and extra burden added to families
 - Costs to production, incomes and savings
 - Engaging in illicit activity if stigmatization prevents useful and legal employment
 - Negative sexual and reproductive health effects especially in the case of sex workers.
- The barriers to effective violence and HIV prevention strategies as discussed by the students, included:
 - Insufficient policies, programs and services
 - Stigma attached to key populations and unwillingness to serve them
 - Lack of involvement of key populations in creating strategies aimed at helping them
 - Lack of collaborative effort among key stakeholders in different countries.

Some students sketched the policies in their countries that exist to protect against violence as well as the factors that they felt would be very useful in preventing violence and the risk of HIV infection in the key populations. These included:

- Education and the need to empower persons in the key populations
- Increase awareness of issues, especially of violence against women and children
- Amend laws on sexual offences
- Amend immigration policies to increase protection for immigrants (including those that may be illegal)

- Workshops for adolescents as well as family members to promote more positive behavior among youth
- Build and sustain peer educators and peer communicator networks to strengthen interventions
- Increase access to healthcare
- Increase awareness of cultural factors and reduce level of machismo in society
- Need for a comprehensive approach to promote health and well being and reduce risk of violence and HIV infection.

In some instances cultural beliefs were highlighted as different students responded to different recommendations promoted by the WHO, for example, the suggestion of providing condoms to prisoners – this was difficult for some students to accept while others found it at odds with their religious beliefs but accepted that protection against HIV infection was nevertheless very necessary.

Other issues were those relating to gender and what it means to be masculine in the LAC region as well as the growing trend of early sexual activity among adolescents. The suggestions all linked to the same underlying concept of empowering the youth and ensuring that they have an active voice in creating the strategies that are aimed to protect them. A key theme throughout was the need to empower individuals which was reinforced in the other forums as well.

2.4.2. Youth and adolescents

Facilitator: Amaia Pérez -Casa Africa/UNIFEM

Around 2 million people between the ages of 15 and 49 are living with HIV/AIDS in Latin America and the Caribbean, with 36 per cent women in Latin America, and virtually half (49 per cent) in the Caribbean. Young women are 2.5 times more likely to be infected than young men in the Caribbean. HIV prevalence has reached rates of 1 per cent or higher in the general population in at least 12 Caribbean and Central American countries

According to George Alleyne, Special Envoy for HIV/AIDS in the Caribbean, the gender pattern of HIV/AIDS in the Caribbean has been well documented. The mode of transmission was now firmly heterosexual in all countries. AIDS is predominantly a killer of young adults in their most productive years and was disproportionately affecting young women.

- Most HIV infection takes place in early to late teens in the Caribbean; available data show that girls 15 to 19 years old outnumbered boys of the same age group by five to one in new HIV infection. Since boys were more sexually active and had their first sexual experience much earlier than girls, one would expect that they would show higher incidence than girls.
- **Education of girls, HIV and VAW:** The Caribbean shows a remarkable paradox in terms of education and HIV. About 75 per cent of recent university graduates are women. However, for every level of education there were more women under therapy than men. It would, therefore, appear that the gender discrimination that made it difficult for women to negotiate sex was not overcome by education. That called into focus the need for education to provide very early certain life skills that

would enable the female to cope with pressures for unwanted or transactional sex as adolescents. The vulnerability of the young female was shown by a Pan American Health Organization (PAHO) study of adolescent behavior, which mentioned that about half of the girls had been forced into their first sexual encounter.

"...In my experience, social and cultural norms are much engrained in the Caribbean, hence in a region with predominantly female headed households where the educational system marginalizes life skills, it is not surprising that young females are not able to effectively negotiate safer sex. Although more educated women can be seen in our society, we still live in very strong machismo conditions where the effects of our educated women are rarely seen. In a community where the initial sexual experience for most females are forced and transactional sex has been the experience of one's sexual history at one point in their lives, the development of poor self esteem will have an adverse effect on negotiating for safer sex. Additionally violence and abuse is a common occurrence in most communities (..)" (student statement)

➔ **Risk and vulnerabilities of young people:** Statistics have shown that the 15 - 29 age group is the most vulnerable group in terms of HIV. It has also been shown that even though there is a lot of public education this knowledge has not been translated into behavioural change. Therefore it can be assumed that cultural norms, socialisation, peer pressure and economic situations are factors which contribute to the spread of HIV within this age group. In order to address this situation, it is necessary to target the under 15 age group in order to change their way of thinking. It is also important to use persons within the 15 - 29 age group as peer counsellors. The under 15 might be able to relate more to these persons and they would also provide a more vivid picture of what could happen if they adopt certain life styles. It would also enable them to make more informed sexual choices when they reach the 15-29 age group. Peer groups aid young individuals in gaining a sense of their own identity by providing a social identity usually for the first time in a young person's life. That is, by way of association with others, young people gain a firmer sense of who they are. This, in turn, leads to the development and practice of social skills that will stay with them throughout their lives. Peer education seeks to utilize the positive aspects of adolescent peer groups by helping them learn from each other something they do naturally anyway.

➔ **Men's involvement:** One of the recurrent themes in the course was the difficulty to involve men in the prevention processes of both HIV and VAW. *"Young men could be trained as Trainers for Peer Educators, to do public education on VAW, Adolescent Sexuality. I see mostly women doing so. In Jamaica the president of the Peer Educators Association (PEA) is a man and has been the same man for years and at meetings or workshops attended the representatives from the are mostly females. The high schools' challenge quiz teams are made up of mostly males. The debate teams are mostly males. Honestly I don't know where we lose them."*

"It is extremely important to involve (men) because we have been reshaping and broadeneing the definitions of femininity for decades, but so far, taditional notions of masculinity have been left almost untouched. The little changes that have been made

to the definitions of masculinity have been as side-effects to the feminist movement, not really as deliberate strategies to achieve equality". Despite the recognition of the importance of involving men, no clear solutions to this problem exist to date and the challenge remains.

3. Evaluation from participants

The students were overall very pleased with the contents of the course. Average punctuation they gave the course was 8.8 out 10.

"It is an excellent course and it provides the framework for people to develop an understanding of the linkages and intersections of HIV and VAW."

"it is an excellent course with lots of information to help women and girls and also men. It also provides health providers and caregivers with techniques as how to care and protect persons living with HIV and VAW."

"The facilitators were great and I felt good reading their comments that they made with my work as well as with other participants. There were very knowledgeable in the respective areas that they facilitated."

"The course is of a very high level and can be taken without leaving your family and job"

"I believe that the course was well put together and simple to understand, in addition the bibliography was a bit lengthy but yet informative and a good resource material in answering the questions. Giving grades personally motivated me to do better in the other assignments and inspired me to think harder and make meaningful contributions. Overall the course was a brilliant one that motivated me to become an HIV/AIDS facilitator with the Grenada Red Cross Society for that inspiration I thank you. All the best with future courses and hope it will be an inspirational one for other participants."

➤ Recommendations for future editions of the course

- The pace of the course is quite fast, and some people have discussed the large amount of compulsory reading and have stated that one week per forum is too short to read through the information thoroughly.
- Information to complete the work guides is not always available. It is one of the goals of the course to gather the available information hence we need to state more clearly that some information simply is not available.
- The working groups did not materialize very well. Despite the existence of forums to facilitate discussions outside of the general discussion forum, these were not heavily

used. Forming teams at the beginning of the course may help to reinforce collaboration and learning through other participants.

- We realized that for some participants the use of a virtual course was something completely new. However, after a few starting problems this seemed not to be a big issue anymore. One student suggested voice communication especially when a student urgently need something clarify, however none of our students that filled in the course evaluation described any technical difficulties.