



# **Development Connections**

## **Global Virtual Course on Empowerment, HIV and Violence against Women - Moving Toward a Global Perspective, Locally Grounded**



**Final report**

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**Development  
Connections**

# **“Global Virtual Course on Empowerment, HIV and Violence against Women - Moving Toward a Global Perspective, Locally Grounded”**

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## Abbreviations and Acronyms

<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ANC</b>	Antenatal care
<b>ART</b>	Antiretroviral therapy
<b>DVCN</b>	Development Connections
<b>FCI</b>	Family Care International
<b>FGM</b>	Female genital mutilation
<b>FSW</b>	Female sex worker
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICW</b>	International Community of Women Living with HIV
<b>IDU</b>	Injected Drug User
<b>IPV</b>	Intimate partner violence
<b>M &amp; E</b>	Monitoring and Evaluation
<b>MSM</b>	Men who have sex with men
<b>NGO</b>	Non-Governmental Organization
<b>PICT</b>	Provider Initiated Counseling and Testing
<b>PLWH</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>STI</b>	Sexually Transmitted Infections
<b>SV</b>	Survivor of violence
<b>VAW</b>	Violence against Women
<b>CT</b>	Counseling and Testing
<b>UNAIDS</b>	United Nations Joint Program on HIV/AIDS
<b>WHO</b>	World Health Organization
<b>WLH</b>	Women Living with HIV
<b>UNFPA</b>	United Nations Fund for Population Activities

## Background

Violence against Women (VAW) and HIV are two global challenges to women's health and development which affect millions worldwide. Currently, a growing body of evidence is revealing the linkages between these two pandemics and demonstrating the advantages to be gained through integrated policies and programs. HIV and VAW share a complex network of structural and intermediary factors as well as outcomes at the individual, family and community levels, with a common basis in gender inequalities, intersected with other sources of discrimination such as ethnicity, age, level of education, socio-economic status, area of residence, disability, and sexual orientation.

The "Global Virtual Course on Empowerment, HIV and Violence against Women" is a component of the "Capacity building strategy for integrating HIV and VAW policies and programs" coordinated by Development Connections since 2006. This was the fifth edition of this training course which aims to develop competences of human resources to integrate HIV and VAW in interventions and to respond to the problems engendered by these two issues in emerging public policies. The Global Virtual Course took place from July to November 2009, and included 36 participants from 23 countries:

- **Africa:** Botswana, Burundi, Egypt, Ethiopia, Ghana, Kenya, Lesotho, Nigeria, Rwanda, South Africa, Tanzania, and Zimbabwe;
- **The Americas:** Jamaica, Mexico, Saint Lucia, and USA;
- **Asia:** India, Kazakhstan, Kyrgyzstan, Pakistan, and Vietnam;
- **Australia** and the **Fiji Islands**.

Besides the training curriculum, the course also emphasized creating more knowledge to build-up capacities, to stimulate, create and disseminate solid experiences and fresh ideas. As a result, fourteen learning resources were produced during the course by facilitators and students.

This report summarizes the key issues discussed in each module of the course, integrating the inputs and reflections of both facilitators and participants, the learning resources produced, and the results of the participant's' evaluation.

## I. General description

The main objective of this training course was to develop competences of human resources working in governmental agencies and NGOs to integrate HIV and violence against women (VAW) in interventions related to prevention, care, and treatment, as well as to respond to problems related to HIV and VAW in emerging public policies. The specific objectives were:

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

### ➤ Competences and audience

The course aims to increase knowledge, and develop skills and attitudes regarding HIV and VAW that will facilitate the adequate and appropriate performance of course participants when integrating interventions on both issues within diverse social and institutional contexts. The selected competences are classified in two groups: cross-sectional, and core. The former are incorporated in each module and include team work, ethics, intersectionality, and gender and empowerment approach. Ethical aspects include issues such as recognition of the rights of people affected by HIV and VAW, and the consequences of these rights for human development. They also include the responsibilities and limits of human resources involved in policy and program development, and the need for ongoing review of personal values regarding both issues.

There were three core competences, as follows:

- a. Capacity to analyze the links between HIV and VAW and the application of empowerment principles to programmatic and public policy interventions (laws, national plans, etc.).
- b. Knowledge and analysis of best practices in prevention, care, and treatment of HIV and VAW, and capacity to develop integration proposals, based on lessons learned from said practices, adapted to their social and institutional contexts.
- c. Knowledge and analysis of the specific needs of different population groups related to HIV and VAW intersections, and capacity to develop public programs and policies that meet said needs.

The participants' backgrounds included: medical coordinators of health services, advisors of international organizations (ActionAid, Oxfam, UNFPA, UNIFEM, UNDP, Catholic Relief Service), coordinators of HIV or VAW programs in government agencies (Ministry of Health, Women's Affairs Department), civil society networks/associations, VAW program managers, coordinators

of centers/services for women and children, women’s groups, Human Rights Commission representative, trainers, and Disabled People Association of Tanzania.

### ➤ Educational Approach

The design of the course emphasized five components to ensure achievement of the defined competences:

- a) Contents adapted to the different training needs and interests of the participants.
- b) Personalized tutoring.
- c) Diverse support resources from which students can select those that best match their training needs.
- d) Interactivity through means such as fora and working groups.
- e) Technological support system that allows interactivity and use of learning resources.

The planned activities were developed to address, to the extent possible, the individual needs of participants. Likewise, each participant's experiences and knowledge were a learning resource for the rest of the group. Each student is responsible for his/her own learning curve. Fora, working guides and group discussions aim to facilitate the development of creative thought, the ability to solve problems, conceptual comprehension, and synchronization between theory and practice.

The individual is an active knowledge agent; he/she develops meanings and defines the sense and representation of reality, based on his/her experiences and exchanges in different contexts. The individual's representations of reality are subject to change and comprise the base for developing new knowledge.

**María Alice Roschke, PAHO/WHO, 2002.**

The course comprised a total of 100 hours, approximately 7 hours per week. The modules, contents, and facilitators are summarized in the following table.

Module	Content	Facilitator(s)
<b>1. Conceptual framework</b>	a. Intersections between HIV and VAW	Dinys Luciano (DVCN) and Anda Samson (DVCN)
	b. International commitments and national legislation on HIV and	Roberta Clarke (UNIFEM)

Module	Content	Facilitator(s)
	<p>VAW</p> <p>c. Ethical and methodological issues on researching HIV and VAW</p>	<p>Dinys Luciano (DVCN) and Nazneen Damji (UNIFEM)</p> <p><b>Recorded sessions by:</b></p> <p>a. Mary Ellsberg, International Center for Research on Women (ICRW)</p> <p>b. Charlotte Watts, University of London, London School of Hygiene and Tropical Medicine, UK.</p>
<b>2. Prevention</b>	<p>a. Prevention strategies from the public health approach</p> <p>b. Best practices in prevention of HIV and VAW</p>	<p>Jacqueline Patterson, public health expert and founder of Women of Color United (USA).</p> <p>Lori Michau, Raising Voices (Uganda) and international consultant on VAW prevention.</p> <p><b>Recorded session by:</b></p> <p>Charlotte Watts, University of London, London School of Hygiene and Tropical Medicine, UK.</p>
<b>3. Care and Treatment</b>	<p>a. Test and counseling</p> <p>b. VAW, care and treatment (Women Living with HIV)</p> <p>c. Perinatal transmission and VAW</p>	<p>Deborah Billings (University of North Carolina, USA)</p> <p>Fiona Hale and Belinda Atim (Salamander Trust, UK)</p> <p>Mabel Bianco (FEIM, Argentina)</p>
<b>4. Considerations on key populations</b>	<p>a. Adolescents/Youth</p>	<p>Marilyn Thomson, consultant on gender and development in Asia,</p>

Module	Content	Facilitator(s)
and specific settings/ contexts	b. Sex workers	Africa and Latin America (UK).  Caroline Allen, consultant on HIV in the Caribbean and Africa and ex-professor of the University of the West Indies (Barbados).
	c. Migrants	Jenny Lopez, consultant on migration and ex-professor of CCI School of Counseling in the State of Florida (USA).

## 2. Modules: contents and key issues

### 2.1. Module 1: Conceptual framework on empowerment, HIV and VAW

#### 2.1.1. Exploring intersections between HIV and VAW and the link with empowerment - Facilitators: Dinys Luciano (DVCN) and Anda Samson (DVCN)

VAW and HIV are serious development and public health problems. The evidence from different cultures points to links between these two problems. Suzane Maman et al (2000) presented four possible ways of analyzing the links between VAW and HIV: i) coerced sex; ii) VAW as a limiting factor in negotiating safe sex; iii) sexual abuse during childhood associated with high-risk behaviors in adolescence and adulthood; and iv) HIV as a VAW triggering factor.<sup>1,2</sup> Other authors also have considered the links between VAW and adherence to antiretroviral

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<sup>1</sup> Maman, Suzane, et al. The Intersections of HIV and Violence: Directions for Future Research and Interventions. *Social Science and Medicine* 50 (2000) 459-478.

<sup>2</sup> Jewkes, Rachel. 2010. *Transforming theory into practice: the Stepping Stones experience*. Presented at: Technical consultation, “Scaling Up the Response to Gender-Based Violence in PEPFAR” in Washington, DC. USAID. May 2010.

treatment.<sup>3</sup> VAW's contribution to women's vulnerability to HIV has also been studied focusing on: a) lack of decision-making power regarding sexual behavior and interactions; b) risk perception; c) use of prevention and health care services; d) pregnant women's disinclination to use HIV test services and counseling due to fear of violence; and finally, e) sexual behavior of men who exert violence on their partners.<sup>4</sup>

### ➤ What information is available on HIV and VAW at country level?

There are ample pointers to linkages between HIV and VAW, and most participants agree that the link between the two epidemics has been proven; although more research is needed from different regions worldwide. Still, most countries face barriers accessing data due mostly to the lack of research on the intersections between both issues or a lack of clarity about the real incidence of VAW or HIV in the first place.

Evidence of HIV rates and VAW in the **Pacific** is scarce, therefore specific policies and laws are rare. In **Jamaica**, recent data showed that 16/1000 pregnant women were HIV+ and most of these women were economically dependent leaving them more vulnerable and less empowered over their own sexual decisions. In **Egypt** and the Middle East, not much research has been done on the linkage between HIV and VAW. The prevalence of HIV is regarded as low (0.01%) and the vast majority of the cases reported are men (around 90%). According to our Egyptian participant, numbers of HIV infections among vulnerable groups like MSM, FSW and refugees are significantly higher, ranging from 3% to 6,2%.

**Swaziland** has one of the highest HIV prevalence rate in the world, 26% (31% women and 20% men) SDHS, 2007 and a high estimated HIV incidence rate of 2.9% compared to other countries in the region (MOT, 2009)<sup>5</sup>. However prevalence among women 15-24 stands at 22.6% and that of men 5.8% (UNAIDS 2008). Extremely high levels of sexual violence, nearly 2 in 3 women aged 18-24, having experienced sexual violence, adds to the existing risk for contracting HIV (2009 multi-sectoral NSF from 2008 data). In **India** approximately 1 in 450 women (0.22%) tested positive for HIV. According to the Indian National Family Health Survey conducted across all Indian states in 2007 and 2008, 35.5% of married women as per sample size reported experiencing physical IPV with or without sexual violence from their husbands; 7.68% reported

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<sup>3</sup> Power, Rachel. 2003. Social Support, Substance Use, and Denial in Relationship to Antiretroviral Treatment Adherence among HIV-Infected Persons. *Journal of AIDS Patient Care and STDs*. May 2003, Vol. 17, No. 5: 245 - 252.

<sup>4</sup> Luciano, Diny. 2009. A manual for integrating the programs and services of HIV and violence against women. Development Connections. Washington D.C.

<sup>5</sup> UNAIDS, NERCHA. MONITORING THE DECLARATION OF THE COMMITMENT ON HIV and AIDS. (UNGASS). SWAZILAND COUNTRY REPORT. MARCH 2010

both physical and sexual IPV, and 27.80% reported experiencing physical IPV in the absence of sexual violence.

In **Vietnam**, there is an absence of strong data to make the linkage. 21% of married couples said that they had experienced domestic violence. Unfortunately, this data is not disaggregated by sex, so we do not know the prevalence of VAW. About 85% of all HIV cases reported in 2007 were men. The majority of HIV-positive women were infected by their partners rather than through sex work or injection drug use; these women had no other risk factor than having sex within marriage.

There are no available data on the **Somali** refugee population in regards to HIV or VAW. In **Ghana** over 50% of PLWH are women and according to one of the participants, there are signs that many women, especially in Northern Ghana, trace their situation to various forms of violence.

In the **Mexican** context the statistical information regarding violence and HIV are separated and do not consider links between the two issues. In a national survey conducted in 2002, it was revealed that 1 in 5 women suffers violence perpetrated by their partner at the time, 1 in 3 has suffered violence by a partner at some occasion in their life and 2 in 3 have suffered violence at some occasion in their life.<sup>6</sup>

In rural provinces of **Burundi**, contrary to common belief, rape by local residents, not soldiers or ex-rebels, is frequent. In these areas, legal and medical help are scarce. For a country like **Lesotho** with an HIV prevalence of 23.2%, the patterns, levels and extent of HIV transmission will be higher than in areas where HIV prevalence is low. Proving links between HIV and VAW is subsequently more difficult in low prevalence countries.

In **Ecuador** the data collection and analysis situation is striking. HIV is still seen and analyzed as a simple health issue that you can only analyze from an epidemiological viewpoint and using only epidemiological tools.

In **India**, HIV-positive women are blamed for their husband's death and are often evicted from their houses. One research study by NACO shows that the numbers are as high as 91%. In **Nigeria** too, widows of HIV positive husbands are chased out of the families and divested of their property.

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<sup>6</sup> Data from the survey available at: [www.inegi.org.mx/.../Violencia/Violencia-Análisis-Enc\\_Violencia-México.pdf](http://www.inegi.org.mx/.../Violencia/Violencia-Análisis-Enc_Violencia-México.pdf) -

## ➤ Structural and intermediate factors connecting HIV and VAW

- **Legal framework:** In many countries, legal obstacles constitute a determinant for both epidemics.

In **Burundi**, for example, widows are not able to inherit property; for economic survival many turn to prostitution as a solution.

**Kenya's** constitution still gives prominence to traditional practices even though Kenya is a signatory to CEDAW. For example, women whose husbands have died are forcefully taken through wife inheritance where they are “cleansed” through sexual intercourse or raped.

In **Egypt**, although under Islamic law a woman is entitled to inherit half of her brother’s part of the inheritance, many are cheated out of their share by their male relatives as women often don't have an ID card.

Marital rape is not a crime in **Nigeria**. Discriminatory laws such as section 55 of the Nigerian Penal Code encourage violence against women in the family and women’s total submission to men; and therefore undermine women’s ability to control their sexual and reproductive health. The section endorses assault on a wife for the purpose of correcting her.

Impunity is a problem worldwide. In **Mozambique**, for example, a family law went into effect raising the legal age for marriage to 18 for both males and females. However, few people know this, including government employees, and customary norms and practices continue to prevail. Participants from **Ghana, Lesotho** and **Ecuador** report a similar pattern, mentioning that despite signing many laws and ratifications including CEDAW, the institutions that are supposed to see to the execution of such legislations are ineffective and inadequately resourced. Furthermore, many secondary laws exist but they are not applied.

- **Poverty and migration:** In **Egypt**, this leads to an increasing number of female sex workers as well as to the forced marriage of under-age girls from rural areas. In **Swaziland** and **Zimbabwe**, the majority of the population lives by subsistence agriculture, a context which provides little opportunity for the economic independence that enables women to walk out on violent relationships. The trafficking of Vietnamese women to **Cambodia, China, Taiwan, South Korea** and other countries places them at great risk for VAW and HIV. For example, women who return from working as sex workers in Cambodia state they had difficulty negotiating condom use with clients and also suffered from violence. Migration is a commonly found risk factor for HIV transmission putting women and men in vulnerable positions. **Egypt** is a country that has nearly 2 million street children many of whom have been trafficked for forced

labor/sexual exploitation. In **Mexico** and Central America, many women are victims of trafficking for sexual exploitation or other forms of labor exploitation in which they are more vulnerable to violence.

- **Harmful practices:** Around 94% of women in **Egypt** have undergone FGM, another physical risk to contracting HIV. In the **Somali** population too, the majority of women have undergone the most severe form of FGM. Another common factor that increases the biological risk of contracting HIV for women is men's preference for dry sex in a number of contexts – increasing the likelihood of vaginal tears.
- **Gender norms related to women's roles within the family and men's sexuality:** A participant from **Saint Lucia** mentioned: "we have been socialized like many other societies that the man is the head of the household. A good Christian woman is a woman who obeys her husband and does as she is told. Women actually raise their children in the same way. Because of all these different ways that we are socialized in Saint Lucia as children (young girls) we are inviting, almost begging, for men to ill treat and mistreat us." In **Thailand** for example there is the practice of no sex during pregnancy, coupled with the belief that men have pronounced sexual desire that need fulfillment. This partly explains that while younger pregnant women (age 15 to 24) show declining HIV prevalence in Thailand, the trend is that of increasing HIV prevalence in ANC women at 2nd and 3rd pregnancies: age 25-29 remained the group with the highest HIV prevalence over the past six years. In the **Pacific**, similar beliefs have been reported.
- **Cultural beliefs:** In **Southern Sudan** HIV/AIDS is considered a serious health problem; however, belief in witchcraft interferes with the functioning of programs and services.
- **Violence and HIV status:** **Botswana** is characterized by a very strong family support system which in most cases works against the interests of women. For example, in most cases women are the first to know their HIV status because of pregnancy. This has exposed HIV positive women to abuse because men tend to feel that these women brought HIV into their households.

Despite the worldwide nature of VAW and HIV, patterns of HIV transmission and prevalence vary widely among countries and population groups within the countries. Factors such as multiple concurrent partnerships, polygamous marriage, lack of legal and social protection systems, denial of education, and male circumcision contribute to variations in HIV transmission in different countries. Several course participants mentioned the idea that although VAW is present worldwide, the economic advantages enjoyed by women in "first world countries" gives them more independence, consequently reducing their risk or vulnerability to HIV.

## ➤ Empowerment, HIV and VAW

Naila Kabeer defines empowerment as: "the process of gaining more power over one's life in the widest scope thinkable as well as the outcome of that process compared to the starting position."<sup>7</sup>

- The core concept of women's empowerment is the ability of a woman to control her own destiny through social, economic, and political independence. These aspects can be organized into four levels of empowerment, according to a model developed by Lori Heise<sup>8</sup>: the norms in society at large, community characteristics, relationship dynamics, and individual characteristics of victim and perpetrator. On all levels of this model women lack empowerment, eventually leading to a lack of decision-making ability regarding sexual and health-related choices.
- Intervention programs aiming at the prevention of HIV and VAW should be designed to address the specific gaps in empowerment that exist for women in the situation and region for which the program is intended.
- Enabling environment and empowerment: Has the country signed the many international conventions (including CEDAW) condemning VAW? Are there any laws to be implemented and what are the means to implement the law? Are there any traditions or religious beliefs that interfere with the implementation of laws, and/or any traditions like FGM that put women at specific risk, and how does the official legal system compare to traditional power relations within the household? Are there job opportunities for men and women alike, and is there extensive poverty? Similar questions could be asked about challenges and gaps in empowerment programs within specific communities. There exists a mutual influence between these factors and the interactions between men and women within a partner relationship. Lastly, previous sexual violence experiences, educational level and character traits are factors that may be targeted in intervention and prevention programs.
- Most points of intervention are not within the unique domain of women's groups; rather, they pertain to men and women in equal share. Laws do not apply only to women, and traditional views on women's duties are not only held by men. Therefore, women's empowerment is not a matter of women, but a matter of society as a whole.

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<sup>7</sup> Kabeer, Naila Dr. Institute of Development Studies, Sussex." Resources, agency, achievement: reflections on the measurement of women's empowerment." 27pp. A paper presented at the conference "Power, Resources and Culture in a Gender Perspective: Towards a Dialogue Between Gender Research and Development Practice" in Uppsala 26-27 October, 2000.

<sup>8</sup> Heise, Lori. 1998. Violence against Women: An Integrated, Ecological Framework. In Violence against Women, Vol. 4, No. 3, June 1998. 262-290. Sage Publications, Inc. USA.

### 2.1.2. International Commitments - Facilitator: Roberta Clarke, Regional Program Director, UNIFEM/Caribbean Regional Office.

- When we say gender, we are really condensing the concept of gender relations, the word relations adding the notion of how we treat each other because of our expectations and even demands of certain conduct because of that biology. So gender relations are the ways in which a culture or society defines rights, roles, responsibilities, and the identities of men and women in relation to one another.
- When we speak about gender roles we are referring to how we all expect, and in fact demand, each other to behave and act because of the biological differences. Gender roles are changeable because we all participate in constructing, reconstructing, defining and redefining our expectations across the sex divide, or some would say continuum.
- We come to an understanding of how we ought to behave very early in life – in fact, from the womb, differing expectations start to express themselves and this continues throughout our lives.
- Gender identities – masculinity and femininity – are fundamentally given meaning through sexual activity. Importantly, the sanctions for boys who do not conform to dominant notions of masculinity can be severe and perhaps much more so than for women now, who because of decades of redefinition of femininity appear to have a greater range of choices in some societies, in their lives. Additionally, the gender script tells boys that hardness and machismo are valued to the point that boys who are gentle, thoughtful or who want to abstain from sex, can be bullied. (Plummer and Simpson) These gender codes are policed not only by the peer group but also reinforced by schooling and parenting.

In **Mozambique**, a workshop including a values clarification activity revealed similar attitudes and beliefs on gender inequality; over half of the male participants argued that it is ok to use violence against their wives if they suspected the wife had cheated on them, and that payment of “lobolo” (dowry) justified marital rape. Almost all men in the workshop also admitted that they are often shunned from communities if they do not have multiple girlfriends.

The girl child has traditionally been denied education and forced to stay home taking care of farming activities or other household chores. This has increased as productive members of the workforce have died of AIDS, as HIV has taken its toll on many communities.

#### ➤ National and international commitments

Most countries have signed one or more conventions or treaties condemning VAW, and many have adopted national laws and plans to combat violence and gender inequality.

- **South Africa** ratified the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and, unlike **Swaziland**, is a State participant of its Optional Protocol. In both countries, the National Strategic Plan identifies women, people in prison, men who have sex with men, and commercial sex workers as among the most at-risk populations in the country. There is a Gender Equality Commission which aims at reducing vulnerability to HIV and violence since it tackles the causes and consequences of gender inequalities and the links to HIV and AIDS.
- The Government of **Botswana** is signatory to a number of conventions and declarations that demonstrate commitment to gender and development, including CEDAW and the SADC Declaration on Gender and Development and its addendum on Prevention and Eradication of VAW and Children in 1997. Botswana also endorsed the Beijing Platform for Action (BPFA), and adopted the Women in Development policy in 1996, as well as a National Gender Program Framework.
- Although **Egypt** has ratified a number of human rights conventions and instruments, including the CEDAW and the 1951 Refugee Convention, not many have been put in practice. Domestic laws to implement them are lacking. Furthermore, Egypt has put a number of reservations on these instruments, practically rendering them void. For example, refugee women cannot work, access education or health care, or gain citizenship.
- **Mozambique** too, has ratified a number of human rights instruments including the CEDAW. The country has a number of laws that exist to protect women and girls from SGBV and HIV vulnerability, including the Family Law passed in 2003. However, commitment to and knowledge of these rights at local levels is weak.
- Protection of human rights since **Ghana's** return to constitutional rule in 1992 has been successful; however, the women's human rights agenda has not attained the level of success achieved by other areas of human rights. Ghana has ratified the CEDAW, and has also endorsed the Beijing Declaration and Platform for Action, as well as the Millennium Development Goals and African Union declarations on gender equality.
- In **Ethiopia** there are some laws in place to protect women and girls. Sexual assault (excluding partner rape), female-genital mutilation, and forced marriage are all criminal offences in Ethiopia. In addition, Ethiopia has ratified the Convention on the Rights of the Child, which should protect girls from the practices listed above.
- **Jamaica** is also a signatory to the CEDAW, and the Belen do Para Convention. It has been trying to address the issues of violence against women, including human trafficking and sexual abuse. The Property (Rights of spouses) Act of 2004, introduced new rules to provide for the equal distribution of assets between spouses upon the breakdown of a marriage or relationship. The Offences Against the Person Act includes marital rape as

well as a provision for a husband being charged if he knows himself to be infected with an STI. There is a National Gender Advisory Committee.

- **Vietnam** is a signatory to CEDAW, but has not signed the Optional Protocol. It has passed the Gender Equality Law (2007) and the Law on Domestic Violence.
- International instruments ratified by the **Solomon Islands** addressing gender inequality include: Revised Pacific Platform for Action on the Advancement of Women and Gender Equality 2005-2015, the Beijing Platform for Action 1995, CEDAW, Commonwealth Plan of Action for Gender Equality, and the International Covenant on Economic, Social and Cultural Rights.
- **Mexico** has signed all international conventions on human rights in general and also on women's human rights and has in recent years started to develop a national legal framework on women's human rights: there is a General Law on Equality between Women and Men from 2006, and in 2007 the General Law on Women's Access to a Life Free of Violence was promulgated and is currently going through a process of harmonization in the 32 Mexican states.

## ➤ **Laws and HIV**

National and international policies can be important in reducing gender-based HIV transmission.

- There are some policies on VAW and HIV that hinder survivors from getting post-exposure prophylaxis in time. In **Ethiopia**, there are national guidelines on the clinical management of sexual assault. However, these guidelines state that survivors must be tested for HIV before being administered PEP. In resource-poor settings this is often not feasible.
- Within the South African National AIDS Council there are various civil society sectors on the Inter-Ministerial Committee responsible for ensuring that the national HIV and AIDS response is in line with the Constitution and the HR instruments and principles. Furthermore, **South Africa** has developed important work regarding gender-sensitive security reform, for example the National Policy Guidelines for Victims of Sexual Offences. The revision of the rape law and the provision of post-exposure ARV (at state expense) to sexual violence survivors were also considered.
- The **Solomon Islands** has no national legislation to address HIV/AIDS. The Ministry of Health has a new 'HIV/AIDS and STI unit' and a National AIDS Council, and therefore policies around HIV/AIDS are beginning to be designed.

- The Government of **Botswana** recognizes that gender is intricately linked to HIV and AIDS. Furthermore, there is acknowledgement that addressing each issue in isolation is not conducive to success in achieving the National Multi-Sectoral Response to HIV and AIDS, advocated for in the HIV/AIDS National Strategic Framework (NSF) 2003-2009. Therefore, the government continues to give priority to addressing HIV and AIDS and gender issues in all government policies, programs and projects. *But the major challenge is still separate programming in the two fields.*
- The establishment of the Nairobi Women's Hospital in 2001 was an important step in **Kenya** for dealing with specific needs of women related to HIV and AIDS. It provides free services such as pregnancy or HIV tests and medication like the HIV-post exposure prophylaxis.
- In **Egypt and the Middle East**, governments and policy makers have not embraced the idea that gender inequality may facilitate HIV and AIDS transmission. Although gender jargon is included in their national plans and policies, various human rights instruments are being ratified without follow-through. Egypt has a poor Human Rights record for torture in prisons, for criminalizing PLHIV, imprisonment of homosexuals and Sex Workers and migrants on a regular basis, and for deportation of HIV positive refugees.
- In **Kyrgyzstan**, as a result of persistent efforts by human rights advocates and women's groups, the law on HIV/AIDS has included some of the recommendations in line with international commitments (mainly CEDAW and BPFA) related to combating stigma and discrimination against PLWH.

### ➤ **Women's representation**

In 2005, a report submitted by NGOs at the Beijing +10 Review pointed out that despite progress made in some areas, there was still widespread VAW, a majority of poor people are women and there are few women in decision-making positions. **The Pacific**, as a region, fares among the worst in the world in terms of women's representation and participation in parliaments. The **Solomons Islands** currently have no women in national parliament, although there are 5 women in provincial parliaments. In **India**, most people (men and women) who are at the level of policy or program development do not embrace gender-sensitive thinking, affecting current programming development.

### ➤ **Common vs. Customary law**

International agreements sometimes collide with local cultural norms and traditional rules. The reality is that, at the local level, customary practices and judicial systems often take precedence. **Egypt**, for example, has many other laws that override human rights instruments

and conventions. Before 2000, women who sought divorce in Egypt had to rely on the fault-based divorce (Talaak). A woman had to prove to the court that it was impossible for her to continue living with her husband. Since 2000, there is the possibility of No-Fault divorce (khula), the right to file for divorce on the basis of “incompatibility,” without having to provide evidence of harm. Women not providing grounds for filing the divorce request must agree to forfeit their rights to alimony and their deferred dowry as well as to repay their advanced dowry.

In **Mozambique**, despite existing laws, there is no agreement within society about the legal definition of crimes such as rape, sexual assault, etc. Some people argue, for example, that “estupro” = rape, meaning having forced sexual intercourse with a virgin. In **Zimbabwe** many members of the judiciary and chiefs do not support the criminalization of marital rape and to date there have been no successful prosecutions of marital rape.

In **Ghana** under the chieftaincy act, the national house of chiefs has been mandated to periodically review cultural practices to ensure that they are in line with modernism; however, there is little evidence that this is indeed being enforced. **Botswana** operates under the dual legal system of the common law based on the Roman Dutch and Statutory law and the Customary law of the peoples of Botswana. Under customary law women are subject to male guardianship all their lives while men are released from guardianship when they marry. In most instances women are treated as minors subjecting them to a subordinate position. The issue of gender inequality is compounded by societal and cultural norms.

### ➤ Education, endorsement, and enforcement are different challenges

The solution to ending VAW lies just as much with behavior change as with international instruments. The international normative framework can be meaningful when it is incorporated into domestic legislation and policy. One of the most central values of the human rights system is accountability. The key, however, is use and enforcement and most importantly, ending impunity.

For example, the Abolition of Marital Power Act (2004), and the Domestic Violence Act (2008) in **Botswana** were constructed to replace the common law principle of marital power with equal powers of spouses married in community of property. However, the infrastructure for enforcement of these acts is lacking. In **Vietnam** too, monitoring frameworks for domestic violence and gender equality laws are still lacking.

Another challenge is the creation of knowledge regarding the existing infrastructure, in government employees as well as citizens. As one of our participants remarked, “The constitution of **Botswana** makes provision for the fundamental rights of each individual regardless of their sex. The gap is the delay in implementation of these revised laws and in taking these laws to the people. The community, particularly women, still do not know much about most of the legislation that protects their rights.”

The state has obligations to respect, protect and fulfill rights. This also means providing support, treatment and care services and facilities.

### ➤ Gaps in legislation

In a country like **South Africa**, stronger emphasis should be made toward enhancement of the capacities of the criminal justice system.

Most participants remarked on the urgency of not only de-stigmatization, but also de-criminalization of sex work. As a participant working in South Africa and Swaziland remarked, “in SA we can find a comprehensive legal framework that protects the Rights of all persons in the country, however sex work activities are criminalized in **South Africa** as well as in **Swaziland**. Advocacy is very much needed to reform legislation. But this would mean that international obligations should be binding to public decision makers to promote effectively gender equality and protection of Human Rights.” The participants from **Saint Lucia** and **Zimbabwe** added that the same applies for homosexuality. Also, an important focus of women’s rights advocacy should be the participation of women themselves.

In **Vietnam**, sex workers can be sent to “Administrative Detention Centers” where they are locked up and “rehabilitated” over 2-3 years. Upon entering a detention center there is mandatory screening for HIV, but very few centers are equipped to offer the appropriate care for HIV+ women.

In **Zimbabwe**, issues of security of the person are not recognized in the Constitution. As a result the current Constitution offers very limited protection for women and women’s rights. The lack of sexual and reproductive health rights and gender equality indicates limited reduction in vulnerability to violence and HIV/AIDS.

A sex crimes unit has been established within the **Kenya** Police. Also, a family division has been established in the High Court of Kenya, to handle matters related to this kind of violence. However, the new legislation still excludes marital rape as a punishable offence. Furthermore, it provides that any person who falsely alleges a sexual offence against another person is guilty and liable to punishment equal to that of the offence complained of.

Human rights instruments can be powerful tools to help protect and reduce vulnerability to HIV among society, especially for marginalized groups – but the signing of HR instruments alone is ineffective in combating gender inequality without the support of appropriate domestic laws and decrees and complementary programming that ensures access to rights and implementation of conventions and HR instruments at all levels of society. The central challenge posed by the HIV epidemic is reduction of vulnerability. The course participants’ responses suggest powerfully that such reduction will not come without the transformation of unequal gender relations and transformation of stereotypical and harmful or restrictive gender

roles – both masculine and feminine. This transformation must occur at many levels and must be community-driven, connecting the personal to the political.

In the context of this course and of human rights work, the question here is “what is the role of the state”. The state has a three-pronged obligation – to respect, to protect and to fulfill rights. It must adhere to the common principles of universality, non-discrimination, inter-dependence of rights, participation, inclusion and accountability.

### **2.1.3. Methodological and Ethical Considerations - Facilitators: Nazneen Damji, Program Specialist on HIV and AIDS, UNIFEM and Dinys Luciano (DVCN).**

**Recorded presentation - Charlotte Watts. University of London, London School of Hygiene and Tropical Medicine, UK.**

Recently, key methodological and ethical questions have arisen from the increased interest in researching HIV and VAW. Methodological limitations of the current evidence on the links between HIV and VAW have been identified, and can be overcome with future studies (Maman, S, Campbell, J., Sweat, M., and Gielen, A. 2000):<sup>9</sup>

- a) *Additional prospective studies are needed to describe the ways in which violence victimization may increase women’s risk for HIV and how being HIV positive may affect violence risk;*
- b) *Future studies are needed to describe men’s perspectives on both HIV risk and violence in order to develop effective interventions targeting men and women;*
- c) *The definitions and tools for measurement of concepts such as physical violence, forced sex, HIV risk, and serostatus disclosure need to be harmonized;*
- d) *Combining qualitative and quantitative research methods will help to describe the context and scope of the problem.*

Steadily, we are witnessing a transition from a science that identifies individual risk factors for HIV to one that analyzes the cultural, social, economic and political gendered systems that generate patterns of HIV and VAW in populations. There is a considerable heterogeneity in the proportion of women among PLWH worldwide. The emphasis on looking beyond gender as a simple risk category and seeking structural explanations for gender differentials in HIV is crucial to research the linkages between HIV and VAW. As Anda Samson pointed out (2008), empowerment is the common underlying problem feeding into these two public health issues. It is a continuum of factors related to women’s empowerment so intertwined that they cannot

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<sup>9</sup> Maman, Suzanne, et al. The Intersections of HIV and Violence: Directions for Future Research and Interventions. *Social Science and Medicine* 50 (2000) 459-478.

be assessed as separate risk factors when addressing the issue of HIV.<sup>10</sup> Therefore, there is a need not only for better definitions of *physical violence, forced sex, HIV risk, and serostatus disclosure*, but also for establishing the indicators of women's empowerment/gender equality that better explain their intersections.

- **Harmonization of definitions**

The currently main definition of VAW, extracted from the Declaration on the Elimination of Violence against Women (1993), is *“any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”*

This concept of VAW links different types of violence but at the same time implies a need for operational definitions of each of these typologies. Research into VAW should be specific as to the type of violence involved. A woman may be emotionally or sexually abused by her partner but will not recognize this as such because of the culture in which she has been socialized. Therefore harmonizing terminology and definitions is important. Furthermore, the lack of harmony between the various definitions for VAW and scales currently in use prevents us from being able to make comparisons across sites and cultural and social contexts. In this process we should realize that harmonization is not static but a dynamic process that must be informed by realities from different contexts.

- **Local sensitivity to needs and culture**

- In **Jamaica's** 2008 national AIDS Program KAPB, answers to sensitive questions were not told to the interviewer but answered by the respondents on separate cards provided for the purpose. In some cases, this resulted in a 20 point change over the 2004 baseline which was asked face to face. This is a result that is similar to results that were shown in the WHO multi-country study.
- In the **Somali** context, sexual assault is so stigmatized that even a close friend of a woman who is raped will abandon her to avoid stigma – meaning that she will be stigmatized and isolated solely for being her friend.
- In the **Middle East** and **Egypt** the problem of VAW is very much swept under the carpet, ignored or labeled as Western concepts or definitions of rape and violence that are not relevant to this context. The role of religious leaders is one to take into account when researching in these countries.

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<sup>10</sup> Samson, Anda. Lack of Empowerment: A Driving Force Behind the HIV and Violence Against Women Epidemics. En: Las múltiples caras de las intersecciones entre el VIH y la violencia contra las mujeres. Development Connections, UNIFEM, Organización Panamericana de la Salud y la Red de Salud de las Mujeres Latinoamericanas y del Caribe. Washington D.C. 2008.

These examples show that awareness of culturally sensitive subjects is of crucial value to the success of the project.

- **Data availability**

Even in the early stage of research on VAW, descriptive statistics have been used alongside qualitative methods. Descriptive and inferential statistics have helped to establish VAW and HIV as serious health and development problems – as well as widespread social problems. But the sources of information on both issues usually work separately and use different tools of data collection. On the other hand, in many countries Demographic and Health Surveys (DHS) include standardized questions on VAW and HIV that can be cross-analyzed. And recently a few DHS include HIV test but only those in Kenya, Haiti and the Dominican Republic (2003, 2007) allow for the link between the survey database and the test database and therefore make it possible to explore connections between HIV prevalence and VAW experiences.

- **Quantitative vs. qualitative methods?**

The false dilemma of quantitative vs. qualitative methods is no longer valid. The research on VAW began with qualitative descriptions usually obtained by interviews, but descriptive statistics have also been used to summarize findings that are not intended to be generalizable, but that can tell us something about the dimensions of VAW, for example. Neither the quantitative nor the qualitative method is inherently superior. Our voyage of research on HIV and VAW aims to use a pragmatic approach of mixed methodologies. The research question determines which method is a better fit for a specific study.

- **Sampling**

When developing quantitative methods within research, the "quality" of the samples used is a key aspect to bear in mind. The sample needs to be representative, as the variables that we are using in order to find a clear representative result or conclusion will depend on the representability of that sample in relation to reality within our main area of study. Errors in sampling can have a significant impact on study power and lead to biased results. Attention also should be paid to the need of the benefits from "alternative approaches, including established *value of information* methods, simple choices based on cost or feasibility that have recently been justified, sensitivity analyses that examine a meaningful array of possible findings, and following previous analogous studies."<sup>11</sup>

- **Ethical considerations**

- ✓ Ethical considerations regarding rights, consent, power, gatekeepers (in the case of children and youth), safety, referral to services, role of restrictive laws when researching HIV and VAW, among others, pose key questions on how to carry out

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<sup>11</sup> Bacchetti, Peter. Current sample size conventions: Flaws, harms, and alternatives. *BMC Medicine* 2010, 8:17

studies integrating epistemology, theory and reflections on the validity, ethics and accountability of the knowledge that is produced.

- ✓ Clearly, individuals who enter into research are becoming involved in a relationship not unlike the usual structures of interaction, and risk placing themselves in the hands of a researcher whom they are confident will respect their welfare. Therefore, acknowledging this power dynamic is critical in undertaking research. It is more effective when researchers maintain more of a partnership with their research participants, sharing common norms and values with them that limit the conditions of usage of that power.
- ✓ Research participants should have some kind of recourse such as courts and ethics committees – through which they can question or complain about the way in which the research is conducted.

- **Privacy**

It is very important to involve media in advocacy and dissemination of results, but during the research process, there should be strong confidentiality. In the **Vietnam** research project on HIV and VAW, there is a significant chance of failure if the local media will spread the word that researchers will enter an area and interview women on the subjects, for research purposes (women will speak less freely) as well as safety matters.

- **Safety**

The course participants suggest that research should be done as much as possible by local women's groups, communities, organizations, etc. that understand the religion and cultural context and can design the research in a sensitive and appropriate way to avoid harm/stigmatization to the participants. A testimony from a participant working in Somali refugee camps shows how important this is: *"The researchers were able to collect quantitative data, however, during follow-up research 4 weeks after the original research, it was found that 20% of the women who participated experienced violence due to their participation in the research. This was both violence by the neighbors and their husbands. This could have been reduced by providing people with responses to give neighbors and family members when asked about why they were speaking to the researchers."*

- **After-care**

The **Jamaican** participant remarked that the vulnerable populations have come to recognize that they are continually being researched and are becoming a bit frustrated, since their participation in a research project does not always lead to assistance or direct profit for these women. A participant from **Somalia** remarked that *"...we should be prepared to refer (interviewees) to services if available. If there are no services available then it is important to tell women before starting the interview about the possible consequences of participating in the study and try to find ways to help them minimize these consequences."*

Ethical principles such as beneficence, autonomy and justice are important in all research projects conducted with people; however, when dealing with sensitive subjects like HIV and VAW, there are additional ethical restraints to keep in mind. Both research processes and services should: **a)** provide prevention means for HIV and VAW (primary, secondary or tertiary levels), **b)** provide information on the services/research they are participating in, **c)** not impede or place any barriers on access to known preventive/care methods, and **d)** actively promote the use of known and safe preventive/care services. It is our duty to minimize risks for the users/the "researched".<sup>12</sup>

## **2.2. Prevention of HIV and VAW. Facilitators: Jacqueline Patterson (Women of Color United (USA) and Lori Michau (Raising Voices, Uganda).**

The body of knowledge on the intersection of VAW and HIV is beginning to grow. As the understanding of the linkages between the two increases, so too do the combined efforts to prevent them. Given the large number of common underpinnings, many of the prevention strategies for either subject are almost the same. However, others are specific to the unique characteristics of each pandemic. Combining prevention efforts requires specialists in each field to think outside of their traditional framework. One of our participants rightly remarked “we need to think like public health specialists, not like doctors.” In short, national planners and policymakers, and all others working in prevention must: i) know their epidemic; and ii) set priorities accordingly.

Prevention gets at the root of the problem. For us, that is the power imbalance between women and men. This cannot be simply messaged – it involves a whole set of deeply held beliefs and values. Prevention then involves a process by which we encourage, inspire and support community members to question these beliefs – to critically analyze the value and consequences of them in their own lives. Promoting and creating more equitable relationships will look different to every person. Injecting new ideas that help community members question the legitimacy of the status quo is at the heart of prevention work. One of the challenges for us in the field now is identifying the key milestones that help us know we are on the right track toward changing the imbalance of power.

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<sup>12</sup> With these ethical related issues in our midst, there are some initiatives that have been made, for example, A Manual on Research on VAW: A practical guide for research and activists, developed by WHO & PATH: [www.who.int/gender](http://www.who.int/gender) or [www.path.org](http://www.path.org)

Traditionally, prevention is divided into three levels (Leavell and Clark, 1965): primary, secondary and tertiary prevention. *Primary* prevention efforts are those directed towards preventing a disease from happening to healthy people, *secondary* prevention is directed towards people who are sick, aiming to avoid the disease's progress and to limit the damage or complications of the disease. *Tertiary* prevention corresponds to physical, mental and social rehabilitation.

The goal of most HIV and VAW prevention programs, however, includes all three kinds of efforts: preventing HIV and VAW wherever possible, diminishing the impact of either on people's lives, and integrating people affected back into society. This makes these prevention efforts particularly complex. Prevention programs enhance more than just prevention of the disease; they also include education, health, security, and state policies. Thus, in order for prevention to be effective, health systems must be strengthened, all necessary resources put in place, laws designed (and used). If medication or resources are not available or affordable the prevention program will be in vain. Each step in prevention programs faces specific barriers.

Troubles in prevention can be roughly divided into structural and process barriers:

#### **i) Structural barriers**

- Geographical barrier: the population that lives far from medical services has limited access to medical services because of geographical barriers.
- Communication barriers: Inability to communicate with people because of language differences.
- Infrastructure barriers: Human resources available but infrastructure for a clinic or hospital lacking.
- Human resource barriers: Infrastructure available but human resources lacking.
- Material resource barriers: clinic with doctors and nurses but lacking material for the attention of the patient, including promotion resources, medicines, paper supplies, formats, technological resources for attention, and others.

#### **ii) Process barriers**

- Attitude barrier: the barrier that the health provider promotes in the process of attention.
- Cultural barrier: the barrier that the patient promotes in the process of attention; acceptance and acknowledgement of the disease.
- Knowledge barrier: when the health provider is not familiar with the attention process, this could be from formation, lack of expertise, or unfamiliarity with the norms in the community.

- Political barrier: Local, state or national barriers (e.g., no support in laws) against the development of the projects in prevention.

### ➤ Pitfalls in prevention

Translated into programs for HIV and VAW, many of the above barriers have been mentioned by participants from a wide variety of countries; some specific to the locality of the programs, others more widely applicable, but all provide lessons about the sometimes unexpected traps in otherwise well-organized and carefully-designed prevention efforts.

- A participant from **Swaziland** mentioned that HIV positive women face stigmatization and discrimination from health care workers and do not receive protection from public institutions, such as the police or the judiciary. Sex workers face these problems to an even higher degree. In a context where sex work is illegal, this may cause additional problems.
- The role and influence of religion and religious leaders in the **Middle East** is very large and requires a unique approach. In **Egypt**, for example, a prevention organization was accused by religious leaders of encouraging prostitution because they opened up a day drop-in center for street girls and educated them about protecting themselves against violence and HIV. Finally the accusation resulted in a stop of most prevention activities.
- In **Kyrgyzstan**, despite women being engaged in all spheres of life, culture and traditional norms say that a man is the head of the family and men's interests, careers and personal lives take priority over women's.
- In **South Africa** and also little by little in **Swaziland**, the need for men's involvement is becoming more acknowledged, although this is also a great challenge in some areas, such as rural areas where men's will for involvement and some strong traditional practices are big hindrances for gender equality and elimination of violence against women.
- Participants in **Botswana** and **Jamaica** remarked that money for prevention programs is largely channeled through HIV funding. The Jamaican HIV prevention program is based on the Stages of Change Model of the Behavior Change Theory, and is doing quite well; HIV infection is not seen as a death sentence anymore. However, the evaluation of the campaign showed that many people were now in the assumption that "if he/she has HIV and is looking so healthy then nothing is wrong with me becoming infected".

## Prevention – the role of services and legal framework

- Well-informed referral systems are largely missing. And where they are in place, they are a clear testimony to the effectiveness of having system-wide protocols and training to provide a holistic continuum of services. As a participant from Tanzania remarked, service providers are often working in isolation, making it particularly difficult for clients with HIV/AIDS, who are either experiencing or at risk for VAW, to receive holistic treatment. As such it is important to develop both formal and informal networks.
- An interesting finding in **Kenya** revealed that closed cubicles and extreme privacy make women counselors and clients vulnerable to VAW and HIV infection. The potential for abuse in the VCT counseling rooms is emphatic that the violence is not unique to VCTs but is largely shaped by gender and power relations within the Kenyan cultural context.
- Many participants mentioned that enforcing laws condemning VAW is still difficult. Moreover, if they are enforced and perpetrators are punished, for example by imprisonment, without a proper facility for economically dependent women, there is no real solution.

### ➤ Actions that work

Despite the above-mentioned problems and challenges that remain to be overcome, many successful interventions have been developed throughout the years. Lessons have been learned from previous experiences and messages gradually adapted from a western-language based method to community-based and community-owned messages. When external sources try to impose something on a community, without giving the community ownership, they do not work. Giving them ownership will raise the success level of programs significantly.

For example, in a successful project in **Somali** camps, community members are given the tools to get a group of community members together to discuss safety and security issues. Even though the program focuses on GBV, the tools do not discuss GBV – but have community members lead other community members through the process of mapping out the communities.

Where previous methods focused on human rights, most of the current programs mainly work with the concept of power analysis. Everyone has experiences of power – when they felt that they had it within themselves, with others and when they felt oppressed by someone else's use of power over them. This framework of power seems to help bring people to the work in a more personal way because it connects their own experiences with violence against women.

Beyond the basics of food/shelter/clothing, people also need and crave acceptance, to feel useful, respect, health, happiness, fulfillment, and recognition. Perhaps these are even more

acute needs in resource-poor settings. Quality prevention efforts help community members feel these. In response to why people in communities do this work they answer “I am now respected in my community”, “now I am known to my community”, “people come to me for help now”, “people look at my wife and I and ask how come we are now happy”, “my family is now developing – see how bright my wife and children look!” They have truly next to nothing in terms of material things – but respect, a sense of usefulness and being known can be extremely powerful.

The following projects have implemented these lessons and proven effective:

- **Stepping Stones** addresses issues of gender inequality and unequal power relations by creating dialogue among community members. A number of participatory methods are used to get men and women to explore healthy relationships, communication, gender roles and expectations, and other factors that can prevent or trigger violence, gender discrimination and other harmful practices. Communities use role play, values clarification, daily activity charts, pair wise ranking and other participatory methods to generate discussions on problems and come up with solutions to those problems, often stemming from deeply rooted cultural and traditional attitudes and beliefs. Stepping Stones in particular has been evaluated and shown to be effective in reducing violence against women (MRC, South Africa).
- **STAR** is a project developed by the Pamoja Africa Reflect Network through combining the Stepping Stones and Reflect methods. It aims at reducing HIV infection and improving literacy and communication. The project is currently being piloted in a number of countries. A participant from Mozambique feels it might work better among facilitators who already have experience with SS or Reflect because of the focus on advocacy rather than guiding facilitators in detail through sessions.
- The **IMAGE** project has high success rates and achievements with up-scaling over many years. Economic empowerment of women is the most effective tool against so many vulnerabilities and inequalities that women suffer.
- The **MUTAPOLA** framework addresses the issue of HIV transmission within the context of VAW. It uses a multi-sector approach to address the issue. Community structures are also made an integral part of this structure. It is a framework of training used to build the capacity of Women Living with HIV and other stakeholders in identifying and addressing VAW and HIV in any setting.
- The **SASA!** approach, developed in East Africa, is a new methodology for addressing the link between violence against women and HIV/AIDS. It is designed to inspire, enable and structure effective community mobilization for prevention of VAW and HIV/AIDS. SASA! is about mobilizing the community to challenge patriarchal norms, because they lead to violence and HIV.

- In **Mexico**, civil society has created a response group for the prevention of HIV in women, named *Grupo Latinoamericano de Trabajo en Mujer y SIDA*. In the last three years, the group has developed 12 HIV prevention projects in vulnerable groups.

These are all big projects, showing that prevention work is multi-layered – rooted in the community level, but also looking at policy level change. Within this, there need to be efforts from individual change to changes within social norms, from changes within community structures to changes in policy. There are many layers, and no single effort is sufficient to create long-lasting change. Changes are necessary on all levels in order to have an impact. However, smaller positive efforts that may contribute have been named:

- In **Zambia**, PEP is implemented at police stations. The efficacy of this move is still to be determined, but it sends a clear and positive message.
- In some regions in **Swaziland**, sex workers try to organize to support each other and fight for their rights. Groups like SANGRAM in India (<http://www.genderhealth.org/pubs/SANGRAMdesc.pdf>) and HIPS in the USA ([www.hips.org](http://www.hips.org)) set good examples as well.
- In **Nigeria**, during the 16 days of activism, multisectoral HIV and VAW prevention efforts were made to reach out to as broad a public as possible, using all communication methods available.
- A participant from **Africa** mentioned the importance of involving traditional rulers and community gate keepers as opinion leaders in public enlightenment campaigns and community dialogues, to guarantee male involvement in VAW programming.
- In summary, despite the great amount of work yet to be done, many successful and proven interventions against HIV and VAW exist. Equal in importance to resources for addressing the HIV epidemic and VAW, are community involvement and dialogue.

## 2.3. Module 3: VAW, CT and perinatal transmission

### 2.3.1. Counseling and testing and VAW - Facilitator: Deborah L. Billings (University of South Carolina)

In recent years, counseling and testing is being used increasingly; the goal is to make HIV testing more widely available. Many factors and new issues connected to counseling and testing slow the process of integration in health services: some universal, some country- or culture-specific.

#### ➤ Factors that influence women's and men's decisions to seek HIV CT

VCT plays a key part in HIV-related prevention and care, particularly as a starting point for accessing other HIV-related services. The goal of counseling and testing is not only to provide people with information about their serostatus. The meaning of test results for people's lives, whether positive or negative, needs to be "negotiated" within themselves. Sometimes that conversation is an internal one; often times other important people enter and take part in that conversation and negotiation. The various incentives for people to test or refrain from testing are unraveled using Lori Heise's ecological framework.

Some participants mentioned that not all testing is voluntary; sex workers, if arrested and accused of a crime, may sometimes be given a test without their consent. Street children are also tested without their consent or knowledge by shelters that are established to house and protect them. Refugees and migrants are often tested without their knowledge or consent by private hospitals that then refuse to treat them.

- **Individual level**

In some cases, personal medical reasons can persuade people to consent to HIV testing. In **Egypt** for example, renal patients must take an HIV test before receiving dialysis, and those who require a certificate of "clean health" have to test to confirm a negative serostatus in order to enter neighboring Gulf countries. A negative incentive for people might be their legal status; if found seropositive for HIV, undocumented refugees/migrants will be deported within 72 hours.

Men and women in **Egypt and other countries in the Middle East**, if found HIV positive, will face extreme social, religious, and economic marginalization as well as violence. For women, it could even lead to death (honor killings). A positive serostatus would not lead to death for men. Many participants report that married women fear that their husbands will beat them and leave them if they test HIV positive.

Low levels of knowledge about HIV, low risk perception, and not knowing where to get tested also influences the decision regarding testing, among men and women (although in women the level of comprehensive knowledge and knowledge about where to take a test is lower than

men – only 7% of women have comprehensive knowledge about HIV and only 12% know where to test).

In **Mozambique**, a woman often will access CT services from a referral from other sexual and reproductive health services. In **Jamaica** too, CT is offered through referral from other services; it is offered at all antenatal clinics. 95% of females attending these clinics will accept the test after counseling. Men typically access clinics less frequently than women; moreover, men are more likely to seek treatment from a local drug peddler or traditional healer, or just go to the pharmacy and purchase their own antibiotics. Sometimes they will find a nurse that they know and ask them to administer an injection in private - without ever going to the clinic. It is therefore important to develop more male-friendly SRH services at clinic level, so that they also will receive proper referrals and access CT.

The result of the test and what happens after may be a reason not to test; will people receive care and treatment if they test positive? Marginalized groups such as victims of trafficking and undocumented refugees are not always included in the national plans for treatment and care and thus opt out of testing. In the case of sex workers, the decision to seek CT depends on the age and competency. There are many cases in which sex workers 13-16 years old are lacking life experience and are more likely to be violated by clients and job providers. At the same time they may not know the local language in which some materials are distributed.

Participants from **Egypt** and **Kyrgyzstan** report that, for rural people, proximity and accessibility of care or even counseling services are a reason to refrain from testing. Since poor rural women are not sufficiently empowered to travel without their husband's permission or the permission of male relatives, this impacts women more than men.

- **Relationship level**

In **Jamaica**, people who suspect that their partners may be having affairs may want to know their status and do a test. Also, if a partner died from unexplained circumstances, this is a reason that people will go for testing.

There is no barrier for women in **Kyrgyzstan** to visit a doctor without prior negotiation with husband or other relatives; however the problem is in economic dependence. If earning little, medical treatment or support is not prioritized by migrant families and women are the first to neglect their own health. In many rural areas in Kyrgyzstan, men will seek an animal doctor's advice and counseling for STI's as they feel ashamed to attend female medical personnel. Therefore, it is of great importance to train male urologists.

In **Egypt**, according to several studies men normally decide to test without consultation with their partner. According to the study of Women Living with HIV in Egypt (2006), all 12 women who took part in the study contracted the virus from their husbands and only found out about their status when they were contacted by the MOHP and made to take the test after their husbands tested positive. Some of the men did inform their wife of their status and all the wives in this study stood by their husbands.

- **Community Level**

In **Jamaica**, outreach testing is done in rural communities. With the introduction of the Ora Quick (oral swab), persons can now be tested in the privacy of their homes. Males also have a tendency to have their partners seek treatment and share it with them rather than to access services themselves. This strategy is fairly new and has not been evaluated as yet.

Most participants mention stigma and discrimination as a reason to refrain from testing. A participant from **Somalia** remarks “I have worked in a number of countries and have never seen a community that stigmatizes HIV more. There is not even a conversation about HIV or acknowledgement that it exists.” In some countries, growing fundamental religious groups lead to a pervasive intolerance in the society towards everything that is deemed immoral, including HIV positive serostatus, and have a big impact on whether or not a person will test. The belief in a link between HIV and inappropriate behavior, particularly sexual behavior, has made people reluctant to test for HIV, fearing that if they test HIV positive they might be associated with some of those behaviors. To address this, many sectors have been working hard to promote CT.

Campaigns and behavior change communication strategies help to encourage women and men to get tested. For example, during World AIDS Day, two districts in Manica province promoted “know your status” campaigns, offering t-shirts to those who attended CT. This type of campaign at community level has more chances of reaching men in **Mozambique**, who often do not go to clinics for common medical issues.

- **Society level**

In **Jamaica**, CT has been endorsed by the Prime Minister and his wife who publicly tested as a part of the World AIDS Day activities. This has also encouraged persons to know their status. However, despite these efforts, more females are being tested than males while more males are infected than females. Males tend to use their female partners’ status to judge their own. Since 16/1000 pregnant women in **Jamaica** are HIV+, it is quite clear that the females are not disclosing their status to their partners.

In a number of countries, much work has been done on HIV awareness, but this has not been the case in **Somalia** which may be a part of the lack of willingness to talk about it.

Commercial sex work was outlawed in **Egypt** in 1948. Current penalties range from one month to 7 years. By ministerial decree, all HIV positive non-nationals must be deported from Egypt within 48 hours. In 2008, “confidential” voluntary testing was made available at public and private testing centers; but positive results including the name of the HIV positive individuals must by law be reported. In addition, those who test positive must bring their spouse for HIV testing. Those failing to bring their spouses are notified to comply then visited at home to ensure tests are conducted. These measures understandably discourage people from seeking CT. In 2007, Egypt police launched a series of arrests of people they suspected of being HIV positive during which people were coerced into testing and imprisoned. After this incident, testing at newly established CT centers went down significantly.

Wife battering in Egypt is only dealt with as a crime if it exceeds the accepted limits of disciplining or if it results in certain injuries. The law also makes it illegal for any institution to separate a wife from her husband without his consent, making the provision of shelters problematic. Thus women do not want to test for HIV or report violence.

In rural areas of **Mozambique**, the national association of traditional healers (AMETRAMO) has joined the HIV network. Traditional healers have been trained as trainers in HIV, STI prevention and referral mechanisms (i.e. referrals to CT and SGBV services). They have also been trained in GBV screening procedures and how to handle such cases. This may lower cultural barriers and encourage people to agree to be tested.

### ➤ **Factors that influence women's and men's decision to disclose their serostatus to sexual partners.**

Connected to CT, but not the same, is disclosure of serostatus. Some participants rightly remarked that disclosure is a complex event, and is a process that develops over time. People may disclose to their partners, to some close relatives, be open about their serostatus to the whole village or decide not to disclose their serostatus at all. During the process they need ongoing counseling.

- **Individual and Relationship**

A negative result is always met with relief and people will be less reluctant to disclose it. However, fear of stigma and discrimination and fear of the reactions of their partners are two of the main reasons why HIV positive people are not willing to share their result with partners and relatives.

Most participants, regardless of their geographical location, report that HIV status disclosure to sexual partners has a number of potential risks for women (even more so women in abusive relationships), including: loss of economic support, blame, abandonment, physical and emotional abuse, discrimination, and disruption of family relationship. Disclosure may lead to physical harm and even death in some cases; “honor crimes” refers to the murder of a woman by her male family members (sometimes female) for a perceived violation of the social norms of sexuality, or a suspicion of women having transgressed the limits of social behavior imposed by traditions, including HIV seropositivity.

In some countries where more information is available, however, women in a stable relationship who test positive are more willing to tell their partners because they are sure that they were infected by them. People are more willing to disclose if they feel that they will receive support.

In **Mozambique**, an HIV positive woman is usually blamed as being the source of infection, even if it is likely she was infected by her partner. When the country starts operating the Provider

Initiated Counseling and Testing, this could result in increased cases of violence against women since more women will be tested due to their access to clinics.

According to the study of Women Living with HIV in **Egypt** conducted in 2006, all interviewees reported being harassed, mistreated and subject to violence by their families and in-laws when it became known they were HIV positive despite the fact they were all infected by the virus from their husbands most of whom had already died from AIDS. Some were even thrown out of the family house, abandoned and disinherited. This reaction of course discourages disclosure.

In **Somalia**, every problem is dealt with on a clan basis and not between individuals, so there would be a great risk that disclosing to a partner would expose you to the whole clan. Since HIV is so stigmatized, people would most likely not disclose to sexual partners. Also, if a woman has an illness in the beginning of the marriage, the man can ask for his dowry back, lowering the probability of disclosing.

- **Community level**

In the 2008 EDHS (**Somalia**), women and men aged 15-59 who had heard of AIDS were asked questions to assess the extent of stigma associated with HIV/AIDS. The accepting attitudes towards people living with AIDS were expressed by only 1% on four indicators collectively. Only 38% of women and 34% of men said that they would be open about having an HIV-positive family member. This indicates that stigma is almost universally associated with HIV/AIDS within the society. In this setting, cultural barriers are compounded by lack of VCT in some Somali camps, but even in the camps with VCT, testing for HIV is rare.

Health care personnel in **Egypt** have tested many people, mainly marginalized groups, without their consent. This was done to collect evidence for the state to prosecute them for homosexuality or prostitution. Doctors also test refugees and migrants without their consent and then refuse to treat them. Domestic violence is widespread in Egypt. Moreover, marital rape is not considered illegal, which may contribute to the spread of HIV.

Lack of knowledge about the disease may also play a role in testing and disclosure; in the study of Women Living with HIV in Egypt, most respondents indicated that women were not aware of the seriousness of the condition before they saw their husbands going through the last stages of the disease.

- **Society Level**

In many **African** countries, women tend to access health facilities more than men, for antenatal care services, for example. This gives women an opportunity to interact with the health workers and be referred for testing accordingly. This results in most cases with women knowing their HIV status before men. The knowledge and understanding of the availability of ARV therapy has also encouraged some individuals to test for HIV, particularly pregnant women who realize that they can save their children by testing and enrolling in the PMTCT program.

On the issue of disclosing serostatus, in countries where information and education is available, both women and men are starting to see the benefits of disclosing their results.

In **Egypt**, accepted sexual relations are those between a male and a female within the confines of marriage. Other sexual relations are considered immoral and often illegal. There is a general reluctance on the part of the government and civil society to discuss issues related to sexuality and to discuss and raise issues that impact high risk groups. Thus, the virus is driven underground and these populations do not test out of fear of stigma and discrimination, legal action, and alienation from family and society.

#### **2.4. HIV Support, Care and Treatment and VAW - Facilitators: Belinda Atim and Fiona Hale (Associates of the Salamander Trust)**

VAW can hinder HIV positive women's access to HIV care, treatment and support. The intersections are different, according to the circumstances. The 2007 Human Rights Watch report 'Hidden in the Mealie Meal', analyzes the impact of gender-based abuses on women's HIV treatment. Many of the quotes taken up in the report indicate that accessing and adhering to ARVs is a trigger for further violence and abuse.

- **Refugees and migrants**

The vulnerability of migrants to HIV transmission is widely recognized in available research, highlighting both the increased engagement in risky behavior of migrants, and the severe social conditions and human right abuses that migrants experience as a cause of this vulnerability.

According to a survey in the Mexican-US border zone, (Martinez-Donate et al, 2001) the prevalence of unprotected sex is high: 60.4% of migrants travelling from Mexico to the US (crossing the South to North border) reported having unprotected sex, 52.9% of migrants travelling from one border area to another, 44.5% of migrants voluntarily travelling back to Mexico from the US and 46% of deported migrants. Surprisingly enough, however, none of the surveyed migrants was HIV positive.

According to another survey carried out among 1500 people in the **States of Jalisco, Oaxaca, Michoacan, Estado de Mexico and Zacatecas** (communities of migrant origin) the average rate of HIV/ AIDS prevalence was 1.1%. Although the result may not seem high, it is worth highlighting that the rate is three times higher than in the rest of the general population in Mexico. According to a study carried out in a Mexican rural community (Salgado de Snyder VN, Diaz Perez Maldonado) two thirds of women in a relationship reported not using a condom with their partners, even when they suspected that their partners' behavior in the US could result in a risk to HIV infection to them.

In refugee camp settings in **Somalia**, with people displaced by war, even if testing and treatment were available, the lack of privacy and the stigmatization of HIV positive people would cause additional hindrances.

Knowing where to intervene in the group of migrants is a challenge. As a participant rightly remarked, refugees are often described as a homogeneous group living in refugee camps or a community; however, the reality can be different. In **Sudan** for example, a great number of refugee and migrant women live in urban settings in the South as well as in rural and urban settings. This heterogeneity makes targeted interventions difficult.

In **Egypt**, PLWH are excluded from VAW/HIV national strategies, policies and programs, resulting in piecemeal parallel health systems being set up for them that do not feed into national systems. Unrecognized refugees or migrants are deported within 72 hours, if found to be HIV positive, and do not have access to CT or other services. They are often victims of violence by employers, police officers and others because of their illegal status.

Refugee women in **Cairo** are particularly vulnerable to HIV and VAW due to their poor social and economic status – they are often are subjected to violence and mistreatment including rape; some have had to resort to brewing of illegal alcohol or prostitution for economic reasons and because of this they are subjected to SGBV and physical violence from clients and police.

Another concern for refugee women is the lack of treatment once tested positive; sometimes women get the possibility to test for HIV through NGO's, however the treatment following cannot always be guaranteed. Furthermore, although much work still remains in terms of guaranteeing treatment, support and care for those already living with the virus, prevention among migrants is another issue. An important program is being launched in **Mexico** by the Clinica Condesa. The objective of the program is to support migrant women who have experienced sexual violence and to distribute PEP and emergency contraception pills to them upon evaluation and HIV/AIDS testing.

- **Institutional violence**

In **Mexico**, occurrence of institutional violence at health facilities through negligence, stigma and discrimination is documented through focal group studies and statements from PLWH. A consequence of pursuing adequate treatment can in some cases mean separation from their families crossing the US border. US laws consider HIV as a no admission factor for tourists and residents, which is a clear human rights' violation. Only in case of political asylum or refugee status PLWH can receive a waiver to enter US territory based of family reunification, humanitarian purposes or public interest.

**Kenyans** witnessed firsthand that HIV positive women could not access treatment. Some of them belonged to one ethnic tribe and could not be treated by a doctor from another ethnic tribe. Displacement is another barrier to treatment in Kenya; doctors could not trace some patients even if the ARV was available. Therefore, the impact of war or conflict on care and treatment is huge. Once someone finds out their status and begins counseling, follow-up

mechanisms become a nightmare and such people fall through the cracks because they cannot access care and treatment later, especially when they become critically ill.

In the **Egyptian context** – (EDHS 2008) – the level of awareness of pregnancy, delivery and breast feeding as modes of mother-to-child-transmission increased with educational attainment and wealth among men and women. The percentage of women aged 15-59 who have knowledge of PMTCT is 57% compared to 71% of their male counterparts. This explains the low prevalence of HIV infection from mother-to-child (1%). In addition to a high level of awareness, the percentage of antenatal care coverage for PMTCT is 70% (UNAIDS/WHO/UNICEF 2008 Update – Epidemiological fact sheet on HIV/AIDS in Egypt).

In **Kyrgyzstan** the lack of knowledge among health workers on HIV is a key issue. Family doctors and primary health care facilities do not know much about this infection. In Kyrgyzstan the TB clinic doctors and nurses receive an additional bonus for treating patients with dual infection TB/HIV.

In **Ecuador**, there is a lack of knowledge even dealing with simple aspects of HIV/AIDS and the counseling is often suboptimal. As a result, WLH's were made facilitators themselves. The idea consists in capacity building among WLWH, geared towards gender, women and HIV, women's vulnerabilities to HIV, how to live with HIV as women, etc.

Another challenge deals with the research: barely anything has been done to develop women-oriented research. ARV are studied in men and not in women.

- **Sex Workers**

Sex workers do not have the privilege and freedom to access health services like other people do. They are not free to talk about their sex life with health workers as sex work is illegal in most countries, which causes a barrier to speak out. This in itself limits the kind of services they can receive, including ARVs. Sex workers have also indicated that they are not free to collect condoms from clinics because if you are seen collecting condoms frequently you are victimized. The sex workers have also indicated violence at the hands of the police, which often goes unnoticed.

Sex work goes with a sentence of up to 7 years in **Egypt**, for example. Also, SWs in society are subjected to extreme stigma and discrimination and violence and sometime death (by relatives in the name of honor). Hence this group of women is "underground" in the society and is too afraid to take part in research, studies, access to CT and services or to complain about violence.

In **Jamaica** too, sex work is illegal. However with a prevalence rate of 9% in 2005, and 24% of men testing positive for HIV reporting sex with prostitutes, the National AIDS program has made special effort in working with this population. For those testing positive there is access to treatment and care however this is sometimes hindered by the behavior of the health care workers themselves to PLHV and sex workers. There have been many anecdotal reports of VAW against sex workers, and there have even been cases of abuse from the police as well.

- **Married Women**

Heterosexual intercourse is currently the primary mode of transmission in **Egypt** (50% of cases). Egypt is also experiencing an increase in the number of HIV infected women and the majority of women are infected at an earlier age than men. In addition, the target groups practicing risk behaviors have links with the general population; a considerable proportion of them, even the MSM, are married or have multiple sex partners.

Several studies indicate a fairly high STI prevalence among women (4% of women attending anti-natal clinics, 8% attending family planning clinics and 36% of FSWs). Male partners rarely bring their wives, thus precluding partner treatment. Family planning services are lauded as a national success but are not yet integrated with STI or CT services. Increasing prevalence among young women, high instances of STIs among women, and lack of tracing and treatment shows that women's vulnerability to infection is increasing.

According to a small study, only 7% of women in **Egypt** were classified as having comprehensive correct knowledge about HIV transmission. Added to this are high levels of domestic violence (almost half of ever married women had experienced violence by their partner, including sexual violence), increasing sexual harassment in the public domain, the 96% female genital mutilation rate, the early marriage of girls in rural areas as well as the trafficking of underage girls to the Gulf states for sexual exploitation under the auspices of marriage, and discrepancies in the legal system that undermine the rights of women to protect themselves against HIV; for example, marital rape not being considered a crime, polygamy, FGM, etc.

In **Jamaica** everyone has access to treatment and care of all chronic diseases including HIV/AIDS. The number of persons in need of ARVs is approximately 6,000. However, the number of persons currently on ARV is 3,300. The issue here is not unavailability of the drugs, but rather people's reluctance to be seen taking the medication.

#### **Antenatal service attendees**

In **Jamaica** the PMTCT program which started in 2002 is integrated in the MCH services. Although mothers may opt out, up to 95% of them access the CT. Those who test positive are incorporated in the high risk clinic and are placed on ARVs. No research has been done looking at the level of disclosure; however, anecdotally this seems to be very low. Multiple partnerships are a big issue in Jamaica for both males and females and therefore females will not want to disclose to the wrong partner. Delivery and post partum care is available; however, again because of stigma persons will breastfeed on their return to their communities from the hospital.

In **Mozambique**, PMTCT is technically supposed to be integrated with MCH services, but human resource capacity is lacking, as are national frameworks to support integration of services at local levels. Also, PMTCT does not target men or partners, which means lost opportunities in terms of partner decision-making and preventing blame of women as the source of infection. Many women reported domestic violence during pregnancy; this suggests the HIV pandemic

will worsen this problem. Involving men in ANC and MHC services could take the focus off women and help to address HIV as a family issue.

Pregnant women in **Ecuador** are accustomed to receiving treatment since they are nearly always tested, but there is some desertion from treatment. In Ecuador, the Carta Magna states that women who are in charge of sick, disabled or old people and who do not have paid employment should be given the right to social insurance, considering that domestic work is as useful to society as paid work.

### **2.3.2. VAW and Perinatal transmission of HIV - Facilitator: Mabel Bianco (FEIM, Argentina)**

Women are often tested for HIV during pregnancy. In many instances, this happens without their consent or using methods such as PICT – provider initiated testing. This has an impact on their lives once they inform their partners and families, and may sometimes lead to the beginning or reactivation of VAW. What is usually referred to as “vertical transmission” or “mother to child transmission” leads to the underlying assumption that women are solely responsible for infecting their child with HIV, adding another cause of discrimination, stigma and blame for women living with the epidemic.

HIV positive women are rarely offered advice and support on their sexual and reproductive health as it is commonly assumed that a positive diagnosis results in an end to their sexuality or their desire to become mothers. Using the appropriate terminology and referring to this issue as “parent to child transmission” or “perinatal transmission” is therefore a small but necessary and important step towards moving away from the discrimination and stigma of HIV positive women.

#### ***Provider-Initiated Testing and Counseling and its consequences for violence against women***

- Provider-initiated testing and counseling face the same issues as counseling and testing in other circumstances; for example, the follow-up of patients after they test positive, providing adequate treatment and care. In addition, there are a few specific issues that are to be overcome.
- Careful attention must be placed on the power dynamics between health service providers and women attending antenatal clinics. *“women may not feel empowered to make a truly informed and voluntary choice, or may prefer that the provider make a decision on her behalf.”* Often, not much attention or time is dedicated to counseling and the implications or consequences of being tested are often not appropriately communicated, leading women to feel obliged or forced to undergo testing against their will. This not only has important ethical and human rights implications but can also result in many women refusing to attend antenatal clinics to avoid the ordeal.

- With high levels of illiteracy and poor educational and counseling programs, many women really are not always making informed choices. The counseling and testing beforehand has not always been sufficient to prepare them for the results of the test and the consequences.
- Also, since PITC does not necessarily include testing of partners, women are the first to be aware of their status in a relationship. In confronting their partners about their status, men will often refuse testing and place full blame on the woman, accusing her of bringing HIV into the home or being with other men and refusing the possibility that he could be HIV positive and refuse to be tested.

In **Sierra Leone**, many people were afraid to get tested because there was talk about nurses and VCT counselors disclosing a person's status to family members or friends. Therefore, it is crucial that in order for PITC to work, all health workers who are testing for HIV receive training about ethics (confidentiality, informed consent, privacy), counseling, and also are equipped to screen for violence against women and make appropriate referrals. They need to be able to address the implications of a pregnant woman disclosing a positive (or negative) test result and refer to legal and policy frameworks.

In **Mexico** and **Jamaica** PITC is offered to all women attending antenatal clinics. They do have the opportunity to opt out of being tested. For those receiving a positive result no follow up is done to find out if she has disclosed to her partner, therefore we are unable to say how many cases of IPV are due to females disclosing their status. For the past two years, 15/1000 women tested positive.

In **Kyrgyzstan** too, all women attending prenatal care services pass through the process of PICT. However, women living in rural areas and coming to the hospital for delivery are not included in the process, increasing the risk of maternal mortality and perinatal transmission of infectious diseases.

In **South Africa** PITC is also offered to women attending antenatal clinics. The HIV prevalence among women attending antenatal clinics was 29% in 2006 and 30.2% in 2005. Although in many cases data/indicators on pregnant women who have disclosed their status is not available, it has been documented that pregnant women suffer more violence. Extrapolating from this knowledge, combined with the fact that many women face violence after disclosure of their sero-status, it seems reasonable to assume PITC may, if not properly counseled, lead to increased violence.

In **Egypt** there is mandatory testing for pregnant women, which has led to violence and discrimination of women who have tested HIV-positive.

Not much is known about the additional number of women being tested through PITC programs. In **Jamaica**, due to the workload at times the provider does not offer PITC. It is

difficult to analyze the number of women tested through PITC versus through VCT programs. In **Kyrgyzstan** almost 100% of pregnant women attend prenatal care, but very few attend VCT services.

Seen from a human rights perspective, women's physical autonomy and their right to make decisions about their own bodies must always lie at the heart of all sexual and reproductive health policies and programs. Even though prevention of child transmission is important, HIV testing and counseling should always be done with an individual's consent. Even when testing is provider initiated, voluntary counseling and testing is always necessary. People use the pre and post test counseling as an opportunity to assess their risk and will try to come up with a risk reduction plan.

In addition, many people do not access clinics for general health problems. Having VCT sites available and targeted to the most at-risk and marginalized populations can succeed in getting more women tested, and consequently their partners, as well as in preventing secondary transmission, particularly for those who have reasons for not attending a clinic. Programs should explore training first points of contact (TBAs, traditional healers) in rapid voluntary testing and counseling, as well as addressing the implications of disclosure, including violence.

## **2.5. Key populations**

### **2.5.1. Migrants, HIV and VAW - Facilitator: Jenny Lopez (Consultant on migration and ex-professor of CCI School of Counseling in the State of Florida, USA).**

International migration is a dynamic and expanding phenomenon. Today it is regarded as a decisive global factor of the 21st century. At no other time in history have there been so many migrants, as it is estimated that approximately 200 million people (3% of the world's population) currently live outside their country of origin.<sup>13</sup> For the purpose of this forum we will focus our discussion on the feminization of migration and explore four groups: migrant workers, refugees and internally displaced, victims of human trafficking, and migrant fiancées/brides.

In general, migration contributes to the increase of risk factors of HIV and VAW. Migrants are vulnerable to the multiple manifestations of the intersections between HIV and VAW: the promotion of forced sex, the lack of empowerment of women to demand protection during

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<sup>13</sup> López, Jenny. Migración, VIH y violencia contra las mujeres. In: Las múltiples caras de las intersecciones entre el VIH y la violencia contra las mujeres. Development Connections, UNIFEM, Organización Panamericana de la Salud y la Red de Salud de las Mujeres Latinoamericanas y del Caribe. Washington D.C. 2008

sexual relations, the high-risk of sexual behaviors in childhood and adolescence, the little or no access to prevention and care centers, and the fear of migrants living with HIV to use the health services for fear of violence and discrimination. In this forum we will explore some generalities of the migration phenomenon; the dynamics of female migration from a life cycle perspective, from the time they decide to leave to the time they come back to their country of origin; the multiple factors that make them vulnerable to VAW and HIV and their difficulties to access prevention and treatment services.

International migration affects countries at every level of economic development and of every ideological and cultural persuasion. The main push factors for people who emigrate are associated with circumstances of poverty, gender inequality, unemployment, political instability, and deterioration of the environment.

Even though migration could be seen as an empowering experience, it is often marked by the violation of the migrant's rights, including discrimination, racism and xenophobia. Social exclusion of migrants in receiving countries, violations against women migrants, disintegration of family units, poor social and economic reintegration and deteriorating health outcomes of migrants, are some of the negatives of migration. Migrants, especially irregular migrants, feel "invisible" and at heightened risk of exploitation and abuse by employers, traffickers or smugglers. Their lack of legal status or documentation makes it extremely difficult for many to claim their rights.

Almost half of all migrants are women. Migrant women are doubly disadvantaged, both as migrants and as women. They face disproportionate risks of physical abuse and sexual violence. Many of them work in the service sector, with unregulated jobs, like domestic workers, and others emigrate as part of the growing phenomenon of internet dating ("mail order brides"). Unaware of their vulnerabilities to being trafficked and abused, their perception of the risks to VAW and HIV are very low.

Violence against women constitutes both a push factor for migration and a consequence of it. Migrant women would often say, "I thought that anywhere would be better than here," or, "What could happen to me that would be worse?"

On the other hand, there is a complex relation between mobility and HIV/AIDS. As the information on HIV and population mobility refers: "Because of their mobility and their status as non-nationals, migrants may fall through the cracks in HIV responses in countries of origin, transit, destination and return".

### ➤ **Scope of the problem**

In **Lesotho**, the Demographic Health Survey shows that Labor migration to South Africa is predominantly undertaken by the uneducated male workers. The return of laid-off mine workers from South Africa is a cause of a rise in GBV, since in many households women have

become the sole breadwinners. Women in the households who suffer higher levels of violence from their husbands when they return back home, are also more vulnerable to HIV since they are also considered a “risk behavior” group.

Women are mainly involved in internal migration for reasons of marriage and employment. In this regard, migration in Lesotho is age, education, skill and sex selective. Migration of women is dominated by young ones between 15-29 years of age, who usually are better educated and often absorbed in the local labor market.

In **Malawi** there are high levels of trafficking in girls and young women for forced labor and prostitution at local bars and rest houses in the country. Malawi is not only a country where trafficking is originated but also a transit and destination country for women and children (and also men) trafficked for the purposes of forced labor and sexual exploitation. This is one of the drivers of the HIV epidemic in the country.

**Botswana** has refugees, illegal entries (mostly from **Zimbabwe**) and numerous migrant workers, especially from other African countries. The police station in the area where the refugee camps are located has recorded many cases of rape of refugee women and girls, and this increases their vulnerability to HIV. However, since most refugees are illegal, there is reluctance to report violence because of fear of deportation. This has made most Zimbabwean women in Botswana vulnerable to rape and other forms of abuse.

A study of victims of human trafficking in **Moldova** (Eastern Europe) showed that over 70% of victims were rejected by the community. “Many migrant workers also think that there is little hope for the future, which suggests that workers may have little incentive to act in a manner which will safeguard their health in the long term, or seek help when their health and well being is threatened”. (JICA/IOM, 2004)

Mark Lurie in the KwaZulu Natal province of **South Africa** compared ‘migrant couples’, in which one of the partners migrates for work, with ‘non-migrant couples’. Migrant couples were more likely than non-migrant couples to have one or both partners infected with HIV (35% versus 19%) and to be HIV discordant (27% versus 15%). Among the HIV discordant migrant couples, 30% of the time it is the woman who is HIV-positive and her migrant partner who is negative.” (HIV and People on the move. Risk and vulnerabilities of migrants. IOM and Multiagency. 2006) These findings highlight the importance of working not only with migrants at their place of work, but also with their rural partners who stay home.

In **Jamaica** there is a lot of *internal* migration from the rural to the urban communities. HIV infection is high for these vulnerable women and girls who are exchanging sex for money and are powerless to negotiate safer sex. As this is all illegal, occasions of violent behavior would not be reported to the police.

Migration is a pressing issue in **Mexico** with the border between Mexico and the US being one of the most transited in the world. The real dimension of the problem therefore remains unknown and prevention, treatment, care and support services are still limited and inadequate.

Although some organizations such as the “Asociación de Salud Fronteriza México – Estados Unidos” are carrying out important work, public policies in both the US and Mexico are lagging behind in recognizing and addressing the increased vulnerability of migrant women to both HIV and VAW. According to an investigation presented by Martha Caballero Garcia during the XVII International Conference on AIDS, at least 30% of undocumented women migrants have suffered sexual violence. Sex therefore is often a means of survival for many migrant women, making them increasingly vulnerable to HIV.

A participant working with refugees in the **Somali region of Ethiopia** reports: “the refugees are Somali from Southern Somalia where they have fled from the current conflict near Mogadishu. In all stages of the migration cycle, there are a few cultural practices that put women and girls at greater risk. In Mogadishu, women and girls were at great risk for sexual violence due to the conflict. Women report that they were at risk of rape even if they wanted to go to the market. There is no access to treatment. Social isolation and stress in the Somali context often lead to domestic violence. Mogadishu is basically cut off from the rest of the world, so it is difficult to provide access to information and services. In the refugee camp, women and girls are at risk for sexual exploitation and survival sex – both of these lead to risky sexual behavior.”

“Military personnel tend to have two to five times higher rates of sexually transmitted infections – which can increase the risk of HIV – than the civilian population. In war, this difference can skyrocket to 50 times higher or more. These high rates of STI prevalence may be due to the fact that military personnel in the context of migration and mobility engage in unprotected sex with multiple partners, including sex-workers. Military camps also tend to attract the sex industry, bringing together two high-risk groups: sex workers and soldiers”. (UNAIDS 1998)

### ➤ Domestic workers

Under conditions of rising unemployment and severe competition in the labor market, for many citizens of poor Central Asian countries, labor migration is the only possibility for providing their families with means of survival. At the same time labor migration carries certain risks associated with lack of legal, social and economic protection for labor migrants, especially for those who are involved in the informal economy sector. Very often, the spheres of employment and labor migration are tightly interconnected which results in scaled seasonal movements of the workforce within the region from poorer counties (Kyrgyzstan, Tajikistan, Uzbekistan) to richer ones (Russia, Kazakhstan). The informal economy sector, which is represented mainly by women, has become an important part of the overall economy, and while it ensures income for millions of people, those working in this sector are significantly exposed to various forms of exploitation and violations of their human rights. By different estimates women make up to 30-40% of all labor migrants and are more exposed to risks related to personal and economic security, including violence and abuse.

To better understand the situation of women labor migrants in Central Asia, UNIFEM commissioned a study to assess the rights of women labor migrants in two groups of the CIS countries, the origin countries (Kyrgyzstan, Tajikistan and Uzbekistan) and the receiving countries (Kazakhstan and Russia). Among a number of challenges, various cases of violations were reported by respondents, including cases of violence and sexual abuse. It is hard to estimate the scope of violence, but these individual reports and references are depicting not a very pleasant picture of the situation of women labor migrants in the informal economy. HIV exposure is another complex dimension having direct connection with the migration in this sub-region.

Domestic workers are usually discriminated against, as they fall outside the ambit of local labor laws that protect the rights of workers in other sectors. Hence, legislation governing the scope of work, number of working hours, minimum wages, and leave and other entitlements of domestic workers are practically non-existent. It is a challenge to assist domestic workers who are illegal immigrants, because they are trying to hide so that they are not seen and arrested. In contrast, refugees can be assisted during the post arrival stage. They can be given information about their rights within the receiving country so that they are well informed to take action and seek help when violated.

### ➤ Efforts, ideas and existing programs

Six countries in Southeast Asia – Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam – signed a Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement.

One idea would be to train peace keepers – who are in Mogadishu and often themselves perpetrators of sexual assault – on HIV prevention and VAW. Women report repeatedly that they were raped during flight by military and other groups while traveling from Mogadishu to Ethiopia. If properly trained, military and police could even act as an entry points for women to seek services if they were harmed; for example, if there are hospitals in the area, they could give messages about services.

In **Mexico**, the *Clinica Condesa* has launched an initiative in order to address the high levels of sexual violence experienced by migrant women during transit. The objective of the program is to support migrant women who have experienced sexual violence and distribute PEP and emergency contraception pills to them upon evaluation and HIV/AIDS testing (to exclude that they are not already HIV/ AIDS carriers) in migration shelters.

In **Chinatown in NYC (USA)** a type of incense was distributed that women used and inside the incense was a small message on how to get help if they were being exploited. Similar messaging could be used about HIV.

In **Mozambique**, close to the Zimbabwean border, many refugee women would work as sex workers at night. Since the influx of Zimbabwean refugees, more cases of STIs were being reported. A program was developed aiming at the increase of access to HIV prevention information for migrants through outreach activities, such as guest houses, bars, markets, water collection and washing sites. In **Jamaica**, similar outreach efforts have been made.

In **Latin America** domestic workers have organized through the “*Confederación Latinoamericana y del Caribe de Trabajadoras del Hogar*” (CONLACTRAHO), since 1988. This is a crucial organization in terms of reaching out to domestic workers. CONLACTRAHO is now present with country representatives in **Brazil, Argentina, Uruguay, Paraguay, Bolivia, Dominican Republic, Venezuela, Colombia, Chile, Peru, México, Canada, Guatemala, Costa Rica** and **Ecuador**. In claiming their rights and influencing agendas at national and international levels they are unveiling the situation and the rights of domestic workers, which historically have been invisible.

In **San Jose, Costa Rica** a radio program called “*Mujeres sin Fronteras*” exists, aimed primarily at Nicaraguan migrant women, many of them undocumented and domestic workers. By addressing an issue of interest every day – for example: VAW, migration laws, ways to access legal residence, human rights, HIV/AIDS, etc. – the program is able to reach a wide audience. Radio is widely accessible and many women listen in as they are carrying out their domestic chores.

In **Vietnam**, IOM have developed self-help groups in areas where these women live and educated them on the Law on DV and provided them with negotiation skills. The women have been very successful in getting the local authorities to support them, where previously they were told that DV was a private matter. Future entry points for help would be, for example, assisting returned migrant women, legally registering themselves as residents of Vietnam, and getting citizenship for their children, access to credit, education and health services for themselves and their children.

Many of the girls (and some boys) are the source of income to impoverished parents living in deprived rural areas. Others make money for middlemen and traffickers who supply children and women to tourists looking for sex while on holiday. To avoid this we must create the economic and social conditions that prevent parents, relatives, middlemen and traffickers from condemning children to lives of sexual slavery, develop educational and skill-building opportunities for women and girls to enable them to earn an independent living.

### ➤ **HIV status and migration**

As of September 2008, 66 of the 186 countries in the world for which data were available placed special entry, stay, or residence restrictions on PLHIV. These restrictions take two general forms. The first is an absolute ban on entry for PLHIV, and the second involves restrictions on longer term (generally greater than three months) residence.

HIV-related restrictions exacerbate stigma and discrimination associated with HIV. When people with HIV are excluded and denied access to opportunities for improving their livelihoods and well being, they will also be denied access to health care and HIV prevention, care and treatment services which can prevent secondary infection including vertical transmission. With this 'illegal' status the likelihood of people disclosing their serostatus could eventually lead to unprotected sexual liaisons thus re-infecting themselves and infecting others.

Travel restrictions may also encourage nationals to consider HIV a "foreign problem" that has been dealt with by keeping foreigners outside their borders, leading to the false and dangerous assumption that they do not need to engage in safe behavior themselves. According to a study carried out by Victoria Ojeda, from the University of California, San Diego, as much as 80 to 90% of the population surveyed considered that HIV/AIDS came from the "outside and was brought to Mexico by migrants". The restrictions reinforce the prejudice that migrant people are the ones at risk and not the residents or nationals in a country.

### ➤ Trafficking in persons

Human trafficking is a modern form of slavery. Many victims are abducted or recruited with false job offers for purposes of sexual exploitation and forced labor. Human trafficking is also a form of gender-based violence; victims suffer extreme abuse and are at high risk for HIV infection. They are involved in risky sexual behavior, they have limited power in negotiating safe sex, they are exposed to the use of drugs and they usually don't have access to services or to information about HIV.

In **the Caribbean** the risk of being trafficked for sexual purposes is high. In the latest Trafficking in Persons Report by the US Department of State, Jamaica is mentioned as a "source, transit, and destination country for women and children trafficked for the purposes of sexual exploitation and forced labor. Victims are typically recruited by persons close to them or newspaper advertisements promoting work as spa attendants, masseuses, or dancers; after being recruited, victims are coerced into prostitution".

**Vietnam** is a source country for migration and trafficking, not usually a destination country. One of the first problems migrants encounter is the language barrier if they are from an ethnic minority group and do not speak Kinh language and therefore cannot understand HIV and VAW information and access services in their own language in the big cities. Many rural, female migrants do not have access to health (SRH, HIV, VAW) and education services for themselves and their children due to difficulties in changing family registration from rural to urban areas.

A participant from Kenya states that "Internal trafficking of women and children in particular is a growing problem in **Eastern Africa**. Citing some key findings, a study conducted by the Kenyan Institute of Policy Analysis and Research (IPAR) found that **Kenya** is a major source, transit and destination country for trafficked women, men and children from neighboring **Uganda** and increasingly from **Somalia** and **Sudan** who are forced into unpaid work or forced prostitution."

Kenyan victims are trafficked to other countries mostly through bogus employment agencies that deceive victims into going abroad for work. The most common forms of trafficking in children from and within Kenya are theft of toddlers, abduction of children for forced marriage, confinement of child domestic servants, abduction of children for use in occult practices, and illicit inter-country adoptions with child sex tourism being on the increase.

Trafficking in African women and children for forced prostitution or labor is exacerbated by war, poverty, and flawed or nonexistent birth registration systems. Because children who are not registered at birth never formally acquire a nationality, they are easily moved between countries.

**Egypt** is a transit country for women being trafficked from Eastern European and African countries to **Israel** for the purpose of sexual exploitation. Bedouins, who have detailed knowledge of desert routes and methods of avoiding detection, contribute to trafficking through the Sinai Desert. En route, many women are raped by their Bedouin captors. Egypt is also a country of origin for women who are trafficked to Arab countries such as Saudi Arabia, the United Arab states, Jordan, Kuwait, and Yemen for the purpose of transactional marriage. Street children are trafficked for labor, especially begging, distribution of drugs, and other illegal activities.

In **Ghana** human trafficking is not very popular, however there have been recent reports of child trafficking in the cocoa growing areas as well as fishing communities. It was realized that most of these children were sold out by parents because of poverty or as a form of loan repayment.

### **2.5.2. Youth and Adolescents - Facilitator: Marilyn Thomson (Consultant on gender and development in Asia, Africa and Latin America (UK)).**

Young people (aged 15-24 years) account for 45% of new HIV infections and in 2007, 2 million children under 15 years became infected with the virus. (UNAIDS Report 2008) Adolescence is a period that holds specific threats in terms of vulnerabilities to HIV infection and to violence. Statistics show that the HIV pandemic is increasingly affecting young people and young women and girls in particular are vulnerable because of their gender. In this forum we will examine what makes adolescent girls and boys vulnerable and what needs to be addressed to support them.

#### **➤ Vulnerability**

Adolescents are particularly vulnerable to HIV because they are in a critical development stage of their lives and may not have all of the information, skills and access to materials that they need to protect themselves from HIV. Girls who are married at a young age, forced to drop out

of school to care for family members or to work in order to provide for themselves and other family members, lack education and skills to make proper life choices that will protect them from HIV. Biologically, girls' bodies are underdeveloped which puts them at higher risk of cuts and tears during sexual intercourse, which can also put them at higher risk of contracting HIV through unprotected or forced sex. When adolescents are dependent on others for food, shelter, and clothing, they are less able to negotiate safe sex or to get out of an abusive relationship.

Young people are also less likely to access health services for fear of their parents or guardians finding out, or from being treated poorly, judged or denied certain services from health staff. In countries where young people need parental consent to receive certain SRH services, such as family planning, this is even more an issue.

Peer and cultural pressures for young boys to behave in certain ways (i.e. machismo) and to have multiple sex partners can also make adolescents vulnerable to STIs, HIV and unwanted pregnancy. Moreover, adolescence is a developmental stage often characterized by increased risk taking behavior characterized by a lack of full understanding about how their actions and risk taking today can have negative impacts in the future. Common risk seeking behaviors associated with adolescence are drug and sexual experimentation, multiple sexual partners, and failure to use condoms.

Adolescents are very much influenced by their peers and also the mass media (negatively or positively). Many youth feel pressured by peers and the media into engaging in risky behavior. In the context of **Botswana**, there is pressure for boys and men to be knowledgeable and in control on issues of sex and to have power over women. Boys do not want to show that they do not know how to use a condom properly; they would rather just do the wrong thing during sex. This makes a boy vulnerable to HIV infection because they avoid seeking help on sexual matters with the fear of being labeled by their peers as not being man enough.

Another factor is the information gap; adolescents don't always have access to appropriate information. This may partly be due to cultural factors that do not allow bringing clear messages at school. Teachers themselves are not always aware about HIV/AIDS. In **Swaziland** and **South Africa**, even though there is general knowledge on ways of preventing HIV, and in urban areas and educated adolescents the comprehensive knowledge on HIV is medium to high, there is still misunderstanding on real possibilities of putting such information in practice. Education is one of the most effective forms of preventing HIV. It can be classified to formal education: which takes place at schools, and non-formal education: this could be accomplished by the gate-keepers for the key population who have influential roles within the community. Those play a critical role in changing the attitudes of people surrounding them especially in traditional rural regions.

Young people often lack information about healthy relationships, communication and safer sex, especially if they do not have regular communication about it at home or in school. Both boys

and girls are vulnerable and require gender and age-sensitive SRH services and programs that address rights, relationships, and decision-making in relation to safer sex.

In Africa the vulnerability is very high especially due to high poverty level, parents who are sick are unable to either take care of their family or keep the young girls in school making the young girl become head of the family at a tender age and thus exposing her to sexual violence. Sexual advances are usually from older men, making it difficult for a girl to negotiate safe sex. Their young age also makes the adolescents vulnerable to HIV infection because they are not yet able to reason on issues and identify and understand implications of unsafe sex practices.

Because of the HIV/AIDS epidemic, in Africa many children are left as orphans. The state of orphan-hood also creates issues of poverty and makes girls in particular more vulnerable to infection as they try to find ways to fend for themselves and other siblings economically and are in the process taken advantage of by men.

In **Botswana**, teenage girls are also more vulnerable to HIV than boys because girls usually start their sexual activity before boys. In most cases sexual advances toward girls are from older men who have had many sexual partners and have an increased risk of having HIV. And when boys engage in sexual activity it is usually with girls of their ages who have not yet had many sexual partners.

Lack of access to sexual and reproductive health information and education, which is exacerbated by the stage of development that youth and adolescents are at, is characterized by anxiety and embarrassment about sex, and reluctance to present themselves for medical attention when they have sexually related problems. Youth often fear judgmental, moralizing advice and thus avoid accessing prevention and treatment programs.

### ➤ Essential conditions for effective protection strategies

Legal, social, cultural and religious systems and laws that discriminate against women need to be addressed in order for special targeted intervention strategies to work. War and conflict elimination are necessary preconditions as well.

Youth-friendly services and education programs are indispensable for prevention messages to stick. Adolescents are usually afraid to seek HIV prevention services for fear of being judged. Parents should also take up the role of communicating with their children on sexual matters to support the school-based programs.

Not only youth need education on HIV and VAW in order for prevention programs to function. As a participant from **Mozambique** reports: "A local church had set up a shelter. The church was forcing the young girls in the program to undergo virginity testing every two weeks. When asked how this was done, we were told that it was a 'woman's issue' that they knew about and it was done by the sisters in the church. They continued to inform us that if the girl's hymen

was not intact, they expelled her from the program. No investigation was done, and no support was provided. When we asked some of the girls about this, they said that they had had friends who were expelled from the program after getting ‘tested’ and ended up in the streets.”

### ➤ **Most effective strategies**

A key milestone of prevention mechanisms may be media. In **Southern Africa**, for example, the media is almost always sexist, discriminatory and stereotyped. Therefore, prevention and protection mechanisms should also target the media, since in order to protect youth we may need to consider educating the general population as well: through the media, through making health care available to the population regardless of area and sex, through church interventions that are coupled with entertainment (edutainment approach). Young people were seen not to be patient with formal programs that do not have a component of fun. The **Gambia** Family Planning Association, for example, used theatre and radio programming with input by young people.

One NGO in **Botswana** provides youth friendly centers where they offer youth-friendly services to boys and girls, and programs specific to their needs. The centers house a clinic where young people can get assisted on SRH issues, HIV information, etc.

Most participants report that the most effective approaches are those that are developed with, by and for young people themselves.

A peer education initiative, carried out by the **Kenya** Girl Guides Association with technical assistance from FHI/IMPACT, includes contests and a merit badge that Girl Guides can earn through work and study. The Centre for Study of Adolescents (CSA) runs programs aimed at lowering the dropout rate for girls by teaching them about sexual and reproductive health, including HIV. The initiative has been implemented in more than 100 schools in Kenya and has had positive results so far. Formal education in schools in the **Somali** context would not be appropriate and would make girls feel very uncomfortable. Here too, using peer-educator models could be key in programming for youth. If there are role models in the community, youth should also have access to these people in order to learn positive behaviors. For girls, an important aspect of programming is to provide a safe space where they can come together, share their thoughts and feelings on life, learn to negotiate and develop confidence, and have a place where they can be themselves.

**Kyrgyzstan** has been selected as one of the pilot countries for implementing the worldwide initiative Dance4life. It aims to share knowledge about HIV and AIDS in a participatory way. No matter what background, whether male or female, HIV positive or negative, all are invited. The strategy is very effective in mobilizing and educating adolescents and youth through informal education. Moreover, the program includes a strategy of eliminating stigma and discrimination towards HIV-infected youth and increasing their participation through the activities. In the

same program, more than 10,000 youths all over **Tanzania** were reached through media coverage. Each young person in the project was challenged to reach at least five others.

Lastly, there is something to be said for role models. Adults behaving responsibly and demonstrating respect for their partners, healthy communication in marriages and partnerships, can serve as positive examples to young people.

When boys constantly observe men using violence against women, for example, from a young age, this instills certain attitudes and beliefs about this sort of behavior being acceptable, and even expected by them as boys/men. It is not enough for influential men, for example, to speak to a class of young people telling them to abstain from sex, and turn around and exploit young girls, have sex with minors, multiple sex partners and unprotected sex. When girls witness their mothers and sisters being abused by men, they grow up thinking this is just "how it is" for them as women, and they do not understand that it is, in fact, a violation of their human rights.

### **2.5.3. Sex workers - Facilitator: Caroline Allen (Consultant on HIV in the Caribbean and Africa and ex-professor of the University of the West Indies, Barbados).**

Gender-based inequalities and norms supporting these inequalities promote sex work and are associated with risks of HIV and violence against women. Sex work is illegal in many, if not most, countries in the world. However, what defines illegal sex work and what is regarded as immoral, is not always clear. Sex exchange for money, clothes, or security is common, sometimes in shorter, sometimes in longer relationships, whereas sex workers in more formal sex work settings may be criminalized, discriminated against and violated.

As a participant from **Trinidad and Tobago** mentioned "At every class level, it is clear that many middle and working class women seek out sexual partners strictly for their middle or upper class. Along with material items, this also translates into networking with higher class people and having access to money to invest in furthering their educational and career goals, as well as money to help out their extended family. None of these people, society views what they are doing as "prostitution, or as "sexual-economic exchange" – even if they admit they chose their partners not for "love" or "intimacy." It seems that people and authorities consider sex work to be when a women or man has sex with a person in exchange for money and then goes on their way. To summarize the above, power relations between people of different classes seem to be a key factor that determines whether this society views a relationship to be based on sexual economic exchange or not".

Similar ideas are reported by African participants: "when exchanging sex for material goods, many girls did not feel like they were victims in these intergenerational relationships, but were using them as a means to aspire to a better life. They did not consider themselves prostitutes." It seems that women who are involved in more "organized" sex work, as a business or

profession and more full time, are more likely to identify themselves as “sex workers”. Importantly, those who do not identify themselves as “sex workers” can be harder to reach with prevention services.

People who are most vulnerable to VAW and HIV through engagement in sexual-economic exchange are often people who have not had opportunities to fulfill their education, people who are already marginalized in their communities or families due to sexual orientation or identity, or marginalized ethnicities who may face discrimination by other groups and, because of this, have less access to public services and opportunities, including social and legal protection services. Younger people, who may not understand the implications of this engagement, may be targets for exploitation by older people or people of power. Often these perpetrators of violence and exploitation are people who should be acting as mentors and sources of protection – but instead take advantage of their power positions.

A problem that is almost universally mentioned by the participants is the illegality of sex work. In **Egypt**, for example, nearly all sexual-economic exchange of unmarried women is regarded as prostitution, due to the extremely conservative Islamic culture and society. Sex outside of marriage for any reason even for economic reasons can result in honor killings or imprisonment. Thus, if sex workers know that reporting a case of rape or physical violence to the police may mean that they (sex workers) are the ones who end up behind bars, they will be less likely to report when they are violated. Moreover, the **Kenya** law penalizes women or men for selling sex, but not the client for buying. Sex work in Kenya is thus based on a legal double standard as well as a sexual double standard. **Swaziland** and other countries of the **Southern Africa Region** show the same double standard.

Male sex workers in Kenya who sell sex to men, in addition to being penalized under the solicitation laws, are also penalized under sodomy laws which have a 7-year jail sentence. These men thus suffer a double stigma as sex workers and as men who sell sex to men, often regarded as gay.

Abuse of sex workers often occurs by intimate partners who feel that they can do so because the woman is having sex with other people. In some ways not using condoms can be a way for the partner to assert his power by getting more favorable sexual treatment than the clients.

## ➤ Interventions

Empowering sex workers means helping to ensure they have access to health services, legal services, education and economic opportunities so that they are able to protect themselves from HIV and other STIs and unwanted pregnancy, as well as from VAW. They need to know and understand their rights, and how to utilize services. SRH services should also be designed in a way that addresses the needs of SWs. Also, restrictions on grants or programs that prevent interventions that target SWs, or force grant recipients to make pledges against supporting at-

risk populations (e.g. PEPFAR), or that promote the stigmatization of groups of people, must be reformed. The ultimate level of empowering sex workers remains its de-criminalization.

The situations sex workers face are not legally considered as real work, because this consideration of "work" would mean real rights, real access to treatment and prevention and real access to social rights and provision of social services, which most sex workers do not have. Legalizing sex work will give sex workers a platform to voice their situations, to ask for help, to easily access relevant health and other services and this will greatly lead to reduced violence on sex workers and reduction in their vulnerability to HIV infection. With the legalization of sex work, governments and other sectors can put in place programs to address the needs and vulnerabilities of sex workers. Their rights will also be respected and they will have support structures.

Empowering sex workers is also about giving them the skills to survive and the relevant information to know their rights and make informed decisions in relation to their sexuality. Sex workers can be given skills to negotiate for safe sex, can be educated on the laws that protect their rights, can be empowered on other ways to be economically independent.

Within one year of being organized into peer-led groups in **Kenya**, 80% of sex workers reported 100% condom use. In addition, they reduced the number of sexual partners and increased their treatment of Sexually Transmitted Infections (STI). Despite known over-presentation of positive responses in these self-reported changes, it is a big improvement. By empowering sex workers at the individual level, they regained their self-esteem, internal strength and confidence to face life, giving them power to control life within and outside their homes and the inspiration to protect themselves from STI/HIV infection.

Violence prevention strategies should be incorporated in the work with sex workers. Sex workers in one area in **Botswana** have organized themselves into peer-support groups in order to address issues of safety, to share experiences with one another, to discuss coping mechanisms, etc. This is a good intervention as it involves education of sex workers by other sex workers, and the group is lead by sex workers. This makes interaction easy as the sex workers can freely discuss issues without feeling stigmatized. One other intervention that has been used in Botswana is placing of condom dispensers at the popular sites where sex workers usually line the streets.

### **3. Participants' evaluation**

The students were overall very pleased with the contents, methodology, facilitators and coordination of the course. On average, they gave the course 8.7 out of 10 points.

#### **3.1. Course design**

Eighty-five percent of the participants indicated that the contents of the course did reflect the situation of the country in which they reside, and 15% reported that the contents more or less represented the situation. The same proportions also indicated that the course contents were adapted to their training needs and that the subjects were relevant to their work. Seventy-seven percent expressed that the bibliography (compulsory and recommended) was appropriate. The comments and recommendations on the course design were:

- The course was very well designed.
- Reduce the amount of required reading.
- More legal and policy documents should be given as reference materials.
- Extend the duration of the modules, to give more time to comply with the assignments and to read the documents provided.
- Disseminate the materials through hard and soft copies in areas with limited internet connectivity.
- Replace some documents with Powerpoint presentations. Those included in the course were extremely useful and informative. Videos were also really interesting.

#### **3.2. Fora**

Ninety-three percent considered that the dynamics of the facilitators was good and 85% indicated that facilitators were helpful in resolving/clarifying their problems and doubts regarding the subjects discussed. Some of the recommendations and comments regarding the fora were:

- The fora were great, especially the amount of feedback provided by the facilitators. The style used by some of the facilitators was particularly useful. This involved having a series of discussions about issues broken down, which allowed us to really look at the details of the issue.
- The fora were arranged in a way that you feel you are an active member of a community. Facilitators and participants responded to your ideas even when you might imagine they were not good.

- Tolerance was very much observed.
- It was my first online course and especially the fora attracted me to [continue] attending until the end of the program.
- Everything was organized well, the facilitators were fully involved in the discussions, and even gave good comments and advice.
- I like the course very much and especially the work on assignments.
- The only improvement would be to make the discussion a full 7 days in order to provide adequate time for responses back and forth. Sometimes the discussions would start Tuesday, and only give a few days for dialogue.
- More time needed to be allocated to each of the fora. Longer sessions could be useful.
- Some assignments were not responsive to the poor data and services conditions of African countries.
- More interaction among participants should be encouraged.
- The discussion in the fora should be contextualized within the reading materials and they should be able to take the debate to the next level and share ideas on how each problem can be tackled using various case studies which exist.

### 3.3. New learning

One hundred percent responded that the course provided them with new theoretical knowledge and 85% indicated that they developed/learned new skills or abilities to integrate HIV and VAW in their work. Seventy-seven percent said there was a good linkage between the work guides and their professional needs and 93% indicated that they will apply some of the new learning provided in the course to their routine work.

Some of the comments and recommendations on this matter were:

- My work involves working with the police officers, health workers, and psychosocial support service organizations on addressing the intersection. The knowledge acquired in this course will assist me in further explaining the intersection in a broader sense, my focus has always been around prevention, but with what I have learnt I can further show the above-mentioned stakeholders the intersection even on care and treatment. And this will strengthen my advocacy work towards establishing a referral system between the 3 above-mentioned stakeholders.
- I will apply the learning from the course in my routine work because the VAW component is at the starting point in our country program, at the same time we are implementing an

HIV program among youth so I can now elaborate some thoughts and ideas and even strategies in my work with my colleagues.

- I will use the references provided, as well as theories and models in planning and integrating programming. I have actually already used some of the course content in work – such as making recommendations for integrated SRH and HIV programming to address intersections of VAWG. Also, I found the forum on research ethics very important and will make sure to observe the considerations of conducting research on sensitive subjects like VAW.
- It demonstrated the need to have integrated programs globally, which helps me with work on a more macro-policy level.
- Currently we are doing a research looking at the human rights of PITC on women living with HIV/AIDS and the information I got will be very useful.
- Ongoing project work on VAW and HIV/AIDS enhanced with knowledge from this course and at a training workshop on strengthening legislative frameworks to address VAW.
- In Mexico we are working to develop research projects in public health linking HIV, VAW and migration so this course has been very useful.
- I will apply new learning to the UNFF project CIRDDOC is implementing on “Bridges to end VAW as a strategy for HIV prevention and stigma reduction”.

In terms of connectivity problems, some participants reported difficulties such as having a small bandwidth that affects connectivity in general, especially downloading videos and Elluminate recorded sessions. Others indicated that the major challenge was to find a balance between their high volume of work in their organizations and the time needed to fully participate in the course.

## **4. Materials/learning resources produced**

The facilitators, other experts and participants produced a substantive amount of materials/learning resources on HIV and VAW that are useful beyond the course. These materials were published through the e-bulletin *DVCN Critiques* in December 2009. A preliminary list of these materials is below.

### **I. Researching HIV and VAW**

#### **1. Mary Ellsberg - Ethical and Methodological considerations on Researching VAW.**

English: <https://sas.illuminate.com/p.jnlp?psid=2009-08-02.0956.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

Spanish: <https://sas.illuminate.com/p.jnlp?psid=2009-08-28.1529.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**2. Charlotte Watts** - Ethical and methodological considerations on researching HIV and VAW

<https://sas.illuminate.com/p.jnlp?psid=2009-07-27.1136.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**3. Marilyn Thomson** - HIV and Violence Against Women - Monitoring and Evaluation of Programs

<http://www.dvcn.org/Documents/MarilynThomsonVol2No3Dec09.pdf>

## II. Prevention

**1. Jacqueline Patterson** – HIV and VAW from a human rights and public health approach.

<https://sas.illuminate.com/site/external/jwsdetect/playback.jnlp?psid=2009-08-09.2250.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**2. Charlotte Watts** - The Image intervention: a successful empowerment intervention to address HIV and VAW in rural South Africa.

<https://sas.illuminate.com/p.jnlp?psid=2009-07-26.1153.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**3. Jacqueline Patterson** – Violence against Women and HIV&AIDS—Promoting Prevention

<http://www.dvcn.org/Documents/JacquiPattersonVol2No3Dec091.pdf>

## III. Care, support and treatment

**1. Deborah Billings** – Voluntary counseling and testing

<https://sas.illuminate.com/p.jnlp?psid=2009-08-28.1333.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**2. Fiona Hale, Salamander Trust (UK)** – Care, support and treatment

<https://sas.illuminate.com/site/external/jwsdetect/playback.jnlp?psid=2009-10-08.1137.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**3. Jody Lynn Myrum** – Integrating Services to Address Violence against Women and Girls in an HIV Care and Treatment Program in Kenya

<http://www.dvcn.org/Documents/JodyMyrumVol2No3Dec091.pdf>

#### IV. Key populations

**1. Jenny Lopez - Migrants**

<https://sas.illuminate.com/p.jnlp?psid=2009-08-27.1444.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**2. Marilyn Thomson – Adolescents**

<https://sas.illuminate.com/site/external/jwsdetect/playback.jnlp?psid=2009-09-23.1257.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**3. Caroline Allen – Sex workers**

<https://sas.illuminate.com/p.jnlp?psid=2009-10-08.0821.M.2DD2F5468818ACF401D20DDBBA6353.vcr>

**4. An interview with Msafiri Msedi on Disabilities, HIV and Violence against Women in Tanzania**

<http://dvcn.org/Documents/InterviewMsafiri091.pdf>

#### V. Policies

**Claudia Briones and Karin Mattsson – Towards Integrating VAW in HIV public policies: Building the case for the Mexican National AIDS Response**

<http://www.dvcn.org/Documents/CBrionesKMattssonVol2No3Dec0911.pdf>