

**Development Connections, International Community of Women
Living with HIV/AIDS and UN Women**

Virtual Forum on Violence against Women Living with HIV/AIDS

November 1-19, 2010

Final report



Washington D.C.

March 2011



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- **Background document:** Fiona Hale and Marijo Vazquez. Violence against women living with HIV/AIDS: A background paper. Development Connections and the International Community of Women Living with HIV (ICW Global), with the support of UN Women. Washington D.C. 2011

http://www.dvcn.org/uploads/client_70/files/VAPositiveWBkgrdPaper2011.pdf

- **Recorded sessions:**

- Fiona Hale (Salamander Trust) - Current definitions and data on types of violence, dimensions, social determinants and consequences of violence against women living with HIV.

<https://sas.illuminate.com/p.jnlp?psid=2010-10-27.0746.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>

- MariJo Vazquez (Salamander Trust) - Projects and programmes addressing violence against women living with HIV.

<https://sas.illuminate.com/p.jnlp?psid=2010-10-26.1123.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>

- Alice Welbourn (Salamander Trust) - Strategic issues regarding violence against women living with HIV for advocacy, research, programming and policy development.

<https://sas.illuminate.com/p.jnlp?psid=2010-11-01.0617.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>



Week 1: Definitions and data on types of violence, social determinants and consequences of violence against HIV positive women.

- **Statistics**

Like previous reports, all participants note the difficulty obtaining reliable data on the prevalence of HIV as well as VAW. In most settings, data are available for HIV prevalence among at-risk groups, but not among specific sub-groups. Data on violence prevalence are even scarcer, and actual figures for violence inflicted upon women living with HIV are almost universally absent. In low-prevalence countries where the HIV epidemic is largely concentrated among at-risk groups, connections are especially hard to make based upon epidemiological data alone. The national prevalence in **Egypt**, for example, is estimated at below 0.1%, with 5,300 people living with HIV (PLH) in-country. This makes the task of linking data on violence and data on HIV difficult, even though 50% of women are subjected to domestic violence by their partners, according to a recent study. Furthermore, a study showed that 96% of foreign women living in Egypt and around 82% of Egyptian women report harassment on the streets.

Other countries, where HIV is more prevalent, face different problems. **Malawi** has one of the highest HIV prevalence rates in the world, at 14% of the population. The HIV prevalence for women 15 to 24 years old is four times that of their male counterparts. However, there are no data available on women living with HIV and violence against them. In **Tanzania**, young women were 10 times more likely to report partner violence if they were HIV positive, and they identified domestic violence as ‘one of the most prevalent problems linked to HIV’. They report that it is usually triggered when a man arrives home drunk, when a woman comes home and tells her partner she has HIV, and when a woman will not have sex with her husband (Murray *et al.*, 2006).

Underreporting can result from cultural differences and from ambiguity regarding the definition and parameters of violence. Our participant from **India** remarked: “Barring activists and researchers, a good number of people in HIV-related work do not perceive violence in its broad context.”

In India, epidemiological trends suggest that HIV infections among women are increasing as a proportion of the whole. Currently, for every 100 people living with HIV, 61 are men and 39 women. In **Guyana**, approximately nine thousand people were infected with HIV as of December 2009.



Ghana reports an increase in the HIV infection rate among the general population, from 1.7% in 2008 to 1.9% in 2009. Over the same period, prevalence among pregnant women attending antenatal clinics increased from 2.2% to 2.9%. In St Lucia, by the end of 2005 there were 546 reported HIV cases. Numbers on violence are not available. In Tajikistan the official number of HIV infected people is 2,336, of which 492 are women.

- **Identifying violence and laws**

The most widely reported forms of violence are those restricting women in their autonomy and freedom. For example, women and girls living in **Tajikistan** are subjected to forced marriage, restricted access to education for girls, and economic dependence on their husbands. Our participant from **Malawi** reports similar trends. All these contribute to HIV vulnerability.

Participants from various countries report that although their governments have signed CEDAW and similar treaties, there are many impediments to the actual implementation of these. For example, **Egypt** follows Islamic Sharia law. Despite being signatory to many UN Human Rights and international conventions that are supposed to protect PLH, women and children, so many restrictions have been placed on these conventions that they are rendered moot.

In **Tanzania** as well as in **Malawi**, various acts of legislation have been passed to support HIV/AIDS prevention, treatment, care and control of the disease. Although these acts aim to protect the rights of PLH, in their aim to scale-up prevention and treatment, they advocate compulsory HIV testing for pregnant women, disregarding the lack of confidentiality. Thus, many pregnant women living with HIV/AIDS are denied the right to choose how, when and to whom to disclose their HIV status. Our participants from **St Lucia** and other countries report the same issue.

The general communities of Tanzanian government understand that women are more vulnerable to HIV but do not focus on the specific needs of women living with HIV/AIDS, instead considering all people affected with HIV/AIDS equally.

The Constitution of **India** guarantees the right to life, health and equality to all citizens. An HIV/AIDS Prevention Bill was drafted in 2007; it embodies principles of Human Rights and



seeks to establish a humane and egalitarian legal regime to support India's response to the HIV epidemic. The original draft of the HIV Bill has several specific provisions to protect the rights of women. However, the bill is yet to be introduced in Parliament.

Participants from small countries like **Guyana** and **St Lucia** report difficulties in confidentiality, despite significant progress made in legislation.

- **Violence against HIV positive women**

Universally, stigmatization of HIV positive people is reported. In **Egypt** for example, people living with HIV/AIDS are subjected to structural, cultural and personal violence, ranging from verbal, sexual and physical abuse from families, communities and the general public to loss of work, loss of education, disinheritance, divorce and abandonment by spouses and families, ostracism by the family, community and society, and in some cases imprisonment, forced testing, and killings.

Women, regardless of HIV status, are generally discriminated against in the laws, religion and culture. This restricts their access to and control over HIV testing. In general, HIV and women in Egypt is something very much kept quiet and underground. Due to the very conservative Islamic context, women do not even access health care, never mind VCT. Most women in Egypt who are living with HIV were made to get tested by the authorities when their husbands tested positive or died of AIDS.



Week 2: Existing projects and programmes worldwide addressing violence against positive women

Although not commonplace, the integration of programmes on HIV and violence is a logical approach; the issues are intertwined and influence each other. Not integrating may limit the efficacy of a program, since the underlying causes for both problems may be linked. For example, violence and the fear of violence can deter women from seeking HIV testing, insisting on condom use, or disclosing their HIV status to their sexual partners.

- **Ingredients for projects that work**

According to participants, the main ingredient for a good program, either for HIV or for violence against women, is meaningful participation. All stakeholders need to be informed and involved, in other words, it must be a community-wide and community-led approach. This may mean involving



opinion leaders, faith-based organizations, elected representatives, and media/journalists, together with the men and women from the community that the program is aiming to reach. A good programme will have activities that address the causes of HIV and VAW at the regional, national and local levels.

PLH should be involved in the design and planning of the project as well as its evaluation. Without the involvement of PLH the programs will not be effective. If an HIV positive woman is abused because of her status, she will only report it as an abused woman and not as an HIV positive abused woman. Stigma and discrimination is at the root cause, leading people to hide their status and not to pursue the justice needed. Men and boys should not be forgotten as partners in the program. A good contextual and needs analysis of the linkages between HIV and violence must be conducted, emphasizing the role of empowerment. Each country and context has its unique blend of causes. One size or project design does not fit all. Group discussions can be a useful tool.

- **Pitfalls**

Lack of knowledge and available data is a worldwide problem. Despite more and more research linking HIV and violence, most available information is from other contexts and therefore only partially useable. Local data analyzing the strengths and weaknesses of specific countries or regions, including their cultural sensitivities, are often not available.

Alternatively, when the necessary data are available, the political will to consider violence against women who live with HIV may be absent. Directly related to this issue is the narrow understanding of VAW many policy makers and funders still have. Such a narrow framework will cause many instances of violence to go unreported and unnoticed, and hence un-addressed. Consequently, advocacy is still indispensable in creating awareness. Without awareness, donors will not fund integrated holistic programs or projects, since they often lack a conceptual understanding of the linkages.

Most funds, obviously, require transparency and accountability, which may be a problem; expenditure of project funds is not always accounted for. Trained, skilled workers are also needed to make projects run well. Many projects do not proceed because they get funds from donors for a limited period; when the funding period ends then the projects also fail to be sustainable.

While for practical reasons each project has its own specific areas of interest, this may lead to fragmentation of attention and thus to lack of cohesion. There may be a coordinating role for governments here, provided they are well informed. Still too many projects are established without enough research or hearing from the target group: women living with HIV/AIDS.



While everyone agrees that a good program is inclusive and community-driven, most existing programs are reporting difficulty to reach all groups within targeted communities. This may be because of the program itself (omitting men and boys), or because of social factors (difficulty getting women to participate in the project out of their fear of stigma or reprisals).

- **Successful programs**

Despite the challenges listed above, many participants report successful programs already being implemented. The centre that investigates sexual offences in **Jamaica** is operated by women. Previously that was not the case and therefore women were afraid to report rape to the male police officers who would sometime ridicule them. However with it now being operated by women there has been an increase in reports.

In **St Lucia** there is a special unit within the police force called the Vulnerable Persons Team. This unit was established to specifically assist persons who are victims of any form of abuse. Yearly training is being provided by the department of Gender Relations in the area of intimate partner abuse in order to help police officers to be more sensitive to victims and to be more efficient in the help which they provide.

The Rapid Funding Envelope (RFE) established in 2002 by **Tanzania** brought massive support for HIV/AIDS programs in that country. The RFE focuses on filling gaps in technical and geographical support, funding innovations, testing replication, and supporting projects of HIV/AIDS. Another program is known as Tanzania Network of women living with HIV and AIDS (TNW+).

The Government of **St Lucia** received assistance from the World Bank to develop and implement a National Aids Council to coordinate the National Aids Response. Capacity Building for Mainstreaming Gender Analysis in HIV/AIDS Programming is also a regional project which St Lucia is a part of. The project was implemented locally by UNIFEM with a number of supporting partners in response to the escalating prevalence rate of the HIV/AIDS epidemic, particularly among young women, to support capacity building on Gender and HIV/AIDS.

The Social Inclusion and Gender Equity in the AIDS Response in **India**. The query was posted through the Solution Exchange AIDS and Gender Communities of Practice (CoPs) of Solution Exchange. To read the original query, individual responses, summary of responses, comparative experiences and related resources, please download the PDF version at <http://bit.ly/Gen-Equity-HIV>.



In 2004, the Ministry of Public Health and Social Assistance of **El Salvador** implemented the SIPPE (Integral System of Post Exposure-HIV Protection), in which women victims of sexual assault or work-related accidents have access to antiretroviral prophylactic medications. The SIPPE is part of the public health policies of El Salvador that attempt to protect women from illness related to gender-based violence. This is part of a successful campaign to prevent vertical transmission of HIV in the country. Also in El Salvador, among the many advances being made to address GBV (since around 1994), policies have stated clearly that women victims- survivors of sexual violence have a right to post-exposure prophylactic treatment.



Week 3: Strategic issues regarding violence against positive women for advocacy, research, programming and policy development.

A big challenge is choosing which evidence to use, and when and where to use it. An observation made in one part of the world may not be applicable universally. Resource allocation can present another big problem. When budgets are being cut and funds reallocated, gender equality issues (VAW, gender and HIV) may be among the first to be compromised or eliminated.

Since the factors contributing to HIV infection and violence are multi-dimensional, programs aiming at these issues should recognize that causes, consequences and interventions need to be focused at multiple levels (individual, family, society, policy, etc.). Furthermore, proposed interventions need to be intimately tied to one's (local) analysis of the causes. Local ownership is crucial to the successful development of interventions. The Ecological Model developed by Lori Heise can assist in this regard because it pushes us to look beyond individual-level interventions and to recognize the importance of addressing issues at all levels.

Some participants mentioned that improved cooperation between the preventive and curative sectors may lead to better results when targeting women living with HIV/AIDS. This may also hold for increased coordination between different curative organizations. One participant commented: *“There is a centralized lab and hospital that treats PLHIV and distributes ART centrally but no peripheral clinics or centers and no referrals from one service provision are to another for example between STI clinics and VCT and ART.”* Establishing a program support network among agencies and organizations working with victims of gender based violence and those working on issues of HIV was mentioned as a possible aid in this. A network like this might also help to prevent challenges such as those mentioned by a participant from **Tanzania**: international NGOs, instead of channeling investment of resources



and relocating funds to local NGOs, thereby empowering them, are operating direct from the grassroots level by exercising direct control of its activities.

Many countries have much to gain by addressing their policies regarding the distribution of antiretroviral medicines. In some countries, despite free antiretroviral therapy, some patient groups are still underserved. Refugees are one example. A solution would be for refugees to be integrated into the NAP and ART distribution and treatment, as well as integration into VAW projects given the high levels of domestic violence and marital rape. Moreover, integration of STI, VCT, VAW, and PMTCT would really help early diagnosis, treatment and prevention.

Free treatment alone, however, is not enough. Women need to be empowered economically. Tanzania possesses a policy of providing free medication for people living with HIV/AIDS, that is ARVs but apart from that free provision of medication. Governments might consider allocating within their national budget some kind of financial assistance to HIV positive women that would complement efforts like skills training.

Underreporting of HIV/AIDS, for example in **St Lucia**, makes it difficult to provide a true picture of the epidemic; the situation requires stronger infrastructure and systems to monitor and manage. Governments could invest more in surveillance.

Lastly, more research is needed on Violence against women (and men?) living with HIV, especially in local settings. These should take into consideration not only existing laws and policies, but also local beliefs, cultural habits and attitudes.