



The Multiple Faces of the Intersections between HIV and Violence Against Women

**Development Connections, UNIFEM, Pan American Health Organization,
Inter-American Commission of Women and the Latin American
and Caribbean Women's Health Network**



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The findings, interpretations, and conclusions expressed here are those of the authors and do not necessarily reflect the views of the agencies supporting this publication.

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Presentation

Violence against women (VAW) and the human immunodeficiency virus (HIV) represent two profound problems for development and health. The integration of the policies and programs on comprehensive care for VAW and HIV is an urgently necessary strategy for halting both of these epidemics and for advancing gender equality. Development Connections, with the support of the United Nations Development Fund for Women (UNIFEM), is implementing an initiative focused on strengthening capacities to further this goal through: a) the creation of a community of practices on the integration of VAW and HIV policies and programs, and b) the design of a manual including the scientific evidence available, best practices and tools for the integration of policies and programs. In this context, several authors from various disciplines have produced the articles included in this publication, which analyze conceptual as well as specific aspects of the linkages between HIV and VAW in diverse population groups and contexts.

Various national and international organizations have promoted actions intended to stimulate inter-sectoral and integrated responses to HIV and VAW. UNIFEM has an on-going work strategy on HIV and VAW centered upon capacity building among those actors, which addresses the two issues on a global level, and also has an HIV/AIDS Window within the UN Trust Fund in Support of Actions to Eliminate Violence Against Women.¹ Also, PAHO/WHO should be recognized for prioritizing HIV and VAW within its cooperation strategies, and for assuming a regional leadership role in terms of technical assistance to the countries confronting these challenges. Currently, the PAHO/WHO Office of Gender, Ethnicity and Health, in consonance with the principles of gender equality and the commitment to ensure a comprehensive approach to VAW, promotes the sensitization of various audiences within the member states to support the integration of a gender equality perspective in the planning, execution, monitoring and evaluation of policies, programs, projects and research. Given that VAW and HIV constitute significant cross-cutting problems of gender inequality in health, it is hoped that the present publication will serve as an instrument to be used in the process of mainstreaming gender equality in health policies and programs in congruence with the commitments established in the Organization's Gender Equality Policy (2005).² For its part, the Inter-American Commission of Women (CIM/OAS) approved the "Declaration of San Salvador: Gender, violence and HIV"³ and, in accordance with its mandates, is developing a human resource training project on this subject in the Caribbean and will implement the initiative: "Integration of policies and programs of HIV and violence against women from a perspective of Human Rights in Central America" during the period 2008-2010. Furthermore, the Latin American and Caribbean Women's Health Network carries out on-going activities on advocacy and dissemination of information on VAW and HIV.

The present compilation of articles aspires to advance the inter-sectoral dialogue on the integration of policies, programs and projects on HIV and VAW at the local, national, and regional levels. The document is divided into three sections. Section I presents three articles, addressing different aspects of the conceptual framework of the intersections between HIV and VAW. Maria Antonia Remenyi explores the economic and social implications of these linkages, analyzing the relation between the Human Development Index, the Gender Index, and the prevalence of both problems. She examines the costs of both epidemics relative to care and treatment, care for orphans, the decrease in productivity and income for the individual and the family,

¹ Available at: http://www.unifem.org/gender_issues/violence_against_women/trust_fund_grantees.php#hiv

² Available at: <http://www.paho.org/Spanish/ad/ge/PAHOGenderEqualityPolicy2005.pdf>

³ Available at: <http://www.oas.org/cim/spanish/Asamblea%20XXXIII.Resoluciones%20aprobadas.htm>

and the institutional costs and the cost for society as a whole. She also argues that the elimination of VAW could be a means for halting the transmission of HIV. Anda Samson addresses the feminization of HIV and the role of VAW in this process. She explains how the lack of empowerment is a driving force behind both epidemics. Using the ecological framework developed by Lori Heise et al, she calls attention to the different factors associated with women's lack of empowerment at the macro, institutional, community, and individual levels which sustain the linkages between HIV and VAW. Nizarindandi Picasso, as a woman living with HIV, extends the discussion on the forms of VAW and raises several issues from the perspective of the experience of women living with the virus. She examines how violence can be present at every stage of a woman's life and how it is manifested in the daily life of women living with HIV/AIDS, in their relations with family, community, health services, the workplace, men and women in general, peers, and with themselves.

Section II touches on the conditions and needs of specific population groups. Florencia Aranda analyzes the intersections between HIV and violence against adolescent and young women, focusing on the dimensions of both epidemics in this age group. She examines the elevated risk for HIV transmission which results from the prevalence of sexual violence, trafficking and sexual exploitation of children and young girls, early marriage, genital mutilation and the lack of access to education. Carlos Güida identifies the increase in imprisoned women and the high level of sexual violence in prisons as a risk factor for the transmission of HIV. He presents other risk situations such as prostitution, institutional violence and the deficiency of services for women living with HIV/AIDS in prisons. Silvia Galán discusses how ethnicity can be a significant social determinant of vulnerability to HIV and VAW. She indicates the difficulties to determine the dimensions of these problems within indigenous populations due to the current lack of scientific evidence on the subject. She also examines the need to address the prevailing values and world view within the indigenous communities to establish coherent policies on both problems. Liliana Bilevich de Gastrón examines the scarcity, within the current debate on the intersections between HIV and VAW, of analysis regarding the situation of women over the age of fifty. She presents data on the dimensions of HIV and VAW in this age group and the implications for integrating policies and programs. She highlights the unpaid work of grandmothers and other older women as caregivers to people living with HIV and victims of VAW, and the urgent need for policies to consider the social and health burdens generated by these epidemics, and to support these women as they attend to the physical, social, and psychological consequences of HIV and VAW.

In Section III, two specific contexts are examined in which HIV and VAW are linked: migration and natural disasters. Jenny López presents the dimensions of migration in the current context and the implications for VAW and the transmission of HIV in women. The situations of refugees, undocumented immigrants, and trafficked and sexually exploited women, are the migration issues that exacerbate the risk to women of VAW and HIV. Teresa Ojeda shares the testimonies of victims of sexual violence in the aftermath of the 2007 earthquake in Peru. These testimonies describe the characteristics of VAW after a natural disaster: the lack of protection, the insufficient institutional response, and a lack of knowledge, on the part of families and the community, regarding the appropriate mechanisms for facing the challenges presented by emergency situations.

This compilation of articles constitutes an approach to the analysis of the linkages between HIV and VAW, which will be expanded upon with future policy dialogues and inter-sectoral exchange, for the purpose of promoting the integration of policies and programs on HIV and VAW. Integration will increase women's access to comprehensive services of care and prevention, will decrease risks to the life and health of women living with HIV and victims of violence, and will increase the effectiveness and impact of the present interventions on HIV and VAW.

Section I: Conceptual Approaches



Exploring the Economic and Social Implications of Violence against Women and HIV

María Antonia Remenyi⁴

Introduction

This report shows evidence of the relation between violence and the transmission of HIV to women. It outlines the deciding factors of violence against women (VAW), its relation to heterosexual HIV transmission, and the possible economic impact of both epidemics. Finally, it proposes economic arguments for the use of VAW prevention strategies as a mechanism to achieve the reduction of HIV transmission. A major constraint in the study was the unavailability of data; both related to the magnitude of VAW and to the prevalence of HIV in women. In both cases, there is massive underreporting in the information and available studies are limited. It is estimated, for example, that AIDS cases in Latin America are underestimated by 30% and HIV cases by 40%⁵. Sexual violence against women occurs at all socioeconomic and cultural levels. However, in many societies, tradition and the lack of effective policies become the main accomplices of the silence surrounding this serious human development problem.⁶

I. Violence against Women and HIV Transmission

Although in the early years HIV/AIDS mainly affected adult men, the more recent feminization of the epidemic led UNAIDS/WHO to estimate in its report on the Situation of AIDS that of the 30.8 million adults living with HIV in 2007, 50% were women⁷. In Central America the male to female ratio of the population that lives with HIV/AIDS has decreased from 23:1 in 1982 to 1.8:1 in 2004⁸. It is important to highlight that the feminization process of AIDS has not evolved at the same pace worldwide, as it has been estimated that in Sub-Saharan Africa approximately 61% of adults who lived with HIV in 2007 were women, while in the Caribbean this percentage was 43%, in Asia 29% and in Eastern Europe and Central Asia only 26%⁹.

In this feminization process of the epidemic, young women have been particularly affected. It is estimated that women account for 60% of people living with HIV between the ages of 15 and 24¹⁰. Among the factors that explain the feminization of the epidemic are:

- The greater biological risk to women due to the larger concentration of the virus in the seminal liquid and to the greater fragility of the feminine genital mucous membrane.
- Cultural factors related to the differential social roles that generate:
 - early sexual initiation of girls and genital excisions.
 - women's lack of control over their sexuality manifested by forced, nonconsensual sex and the inability to negotiate condom use.
 - discriminatory property and estate laws that facilitate women's economic vulnerability and acceptance of unsafe sexual relations.

4 María Antonia Remenyi. Economist, Consultant on issues related to health economics. Email: remenyi_antonia@yahoo.com

5 García Abreu, A; Noguera, I; Cowgill, K. "HIV/AIDS in Latin America: The Challenges Ahead." Human Development Network, The World Bank, quoted in World Bank (2003), page 4.

6 The World Bank (2008).

7 UNAIDS/WHO (2007), page 8.

8 The World Bank (2003), page 5.

9 UNAIDS/WHO (2007).

10 UNICEF (2005), page 1.

- acceptance and expectation that men have multiple sexual partners.
- The lack of education of women, as there is ample evidence that educated women have a greater probability of knowing how to prevent the HIV infection, delay the beginning of sexual activity, and take measures to protect themselves.
- Violence against women or fear of the same prevents many women from asking their partners to practice safe sex.

There is also evidence that women who have been forced to have sex or have been raped, are at greater exposure to HIV infection since this type of sex causes more injuries in the vaginal and anal tissue.¹¹

A recent World Bank publication¹² summarizes figures obtained from other studies on the magnitude of the association between VAW and HIV transmission:

- In Soweto, South Africa, violence (physical and sexual) on the part of the partner has been identified with a prevalence of HIV 1.4 times higher.
- In Rakai, Uganda, the prevalence of HIV increased significantly when women reported sexual coercion and the use of alcohol before having sex.
- In Kigali, Rwanda, women in stable relationships with HIV-infected partners had greater probabilities of reporting a history of physical violence or sexual coercion.

The multi-country study on violence against women carried out by the World Health Organization, states that the home does not constitute a safe haven for women because they are at greater risk of suffering violence in their intimate relations with their partners than in any other place¹³.

II. HIV, VAW, Poverty, the Human Development Index, and the Gender Development Index

In this section an attempt has been made to analyze whether there is any correlation between VAW, HIV and the Human Development Index and Gender Development Index, respectively. The hypothesis is that in countries with less human and gender development the prevalence of VAW and HIV in women is greater. This hypothesis, however, does not attempt to establish causal relationships between VAW and the socioeconomic level of women, since it is known that VAW affects women of all social classes and in all countries of the world. Nevertheless, the indicators included in the GDI (education, income and life expectancy at birth) are possible empowerment proxies that should be considered at the time of developing strategies for the prevention and integrated treatment of HIV and VAW. Unfortunately, constraints in the availability of information did not allow performing this analysis for HIV¹⁴. Alternatively, the prevalence of HIV/AIDS has been analyzed in relation to the per capita income level (as an approximation to poverty) of the regions most affected by the disease.

Correlation analysis is used to describe the existing relation between two or more variables. While regression analysis is used to describe the nature of the relation, correlation analysis describes the strength of that relation; without any causality implication. Correlation coefficients close to 1 show a strong relationship between the variables, while values close to zero indicate that there is not a defined relationship between the same. Positive signs of the correlation coefficient indicate a direct relationship, that is, when the value of one variable increases (decreases), it also increases (decreases) the value of the other. On the contrary, negative signs of the correlation coefficient indicate an inverse relationship, when the value of one variable increases, the value of the other one decreases, and vice versa.

The information on VAW has been obtained from the study on women's health and domestic violence against

¹¹ Luciano Dinys (2007), page 4.

¹² The World Bank (2008), page 56.

¹³ WHO (2005), Foreword.

¹⁴ We have tried to estimate the correlation between the prevalence of HIV in women aged 15+ and the Human Development Index but the quality of the information did not allow reaching consistent results.

women, carried out in several countries by the World Health Organization in 2005¹⁵. This study provides information for the following 10 countries: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania. The violence indicator used is the prevalence of the rate of sexual violence perpetrated by a partner, during a woman's lifetime, among women who have had a partner at some point. For some countries, the information corresponds to a major city or to the capital city. For other countries, the study provides information for a province. For still other countries the information is given for both a major city and a province. In this case, and with the aim of obtaining a single figure, a simple average of the two data¹⁶ was taken into consideration as shown in Table I.

Since the United Nations does not report information on the Human Development Index or Gender Development Index for Serbia and Montenegro, only 9 countries were considered in the estimate of the correlation coefficient.

Table I
Correlation between Sexual Violence and Human Development Index and Gender Development Index

Country	Prevalence of having experienced sexual violence at any time from a sexual partner	Average prevalence between city and province	Human Development Index 2005	Gender Development Index 2005
Bangladesh city	37.4	43.6	0.547	0.539
Bangladesh province	49.7			
Brazil city	10.1	12.2	0.800	0.798
Brazil province	14.3			
Ethiopia province	58.6		0.406	0.393
Japan city	6.2		0.953	0.942
Namibia city	16.5		0.650	0.645
Peru city	22.5	34.6	0.773	0.769
Peru province	46.7			
Samoa countrywide	19.5		0.785	0.776
Serbia and Montenegro city	6.3		n.a.	n.a.
Thailand city	29.9	29.4	0.781	0.779
Thailand province	28.9			
Tanzania city	23.0	26.9	0.467	0.464
Tanzania province	30.7			
Correlation Coefficient			-0.758	-0.762

Source: Author's own work based on information from the WHO study (2005).

Both the correlation coefficient between VAW and the Human Development Index and that of VAW and the Gender Development Index show an inverse relationship (- sign) between these indices and VAW in the order of -0.758 and -0.762, respectively. That is, the less human development and the less gender development, the more VAW. However, the relation is not very strong since, as pointed out before, VAW affects women of all social strata and in all the countries of the world.

¹⁵ WHO (2005).

¹⁶ The lack of information led us to consider a simple average but we recognize that this may be biased. The ideal would have been to estimate a weighted average by the importance of the population living in the cities and that one living in the provinces.

The HIV/AIDS epidemic has not affected all the regions of the world alike. Table 2 shows not only that more than 68% of HIV-infected adults live in Sub-Saharan Africa, and that 76% of deaths from AIDS occurred in this region but also that it is here where the prevalence of AIDS in adults is the highest (5%). According to information published by the World Bank¹⁷, it is precisely in this region where 63% of the countries with the lowest per capita income (US\$875 or less) are located. Moreover, from a total of 48 countries located in Sub-Saharan Africa, 34 of them (70.8%) are classified as low-income countries. That is, the poorest region of the world is precisely the most affected by the epidemic.

Table 2
Regional Statistics of HIV and AIDS, 2007

Region	Adults and children who live with HIV	Prevalence in adults	Deaths of children and adults
Sub-Saharan Africa	22.5 million	5.0%	1.6 million
Middle East and North Africa	380,000	0.3%	25,000
South and Southeast Asia	4.0 million	0.3%	270,000
East Asia	800,000	0.3%	32,000
Oceania	75,000	0.4%	1,200
Latin America	1.6 million	0.5%	58,000
Caribbean	230,000	1.0%	11,000
Eastern Europe and Central Asia	1.6 million	0.9%	55,000
Western and Central Europe	760,000	0.3%	12,000
North America	1.3 million	0.6%	21,000
Total	33.2 million	0.8%	2.1 million

Source: Author's own work based on UNAIDS data.¹⁸

The burden of HIV/AIDS mortality and morbidity, measured as the years of healthy life lost due to premature death and/or disease (DALYs), has been estimated in the Health Priorities¹⁹ study. These estimates show that between 1990 and 2001, there was a disproportionately larger burden in low- and medium-income countries (70,796 DALYs) than in high-income countries (665 DALYs).

¹⁷ World Bank (2007), page 287.

¹⁸ UNAIDS/WHO (2007), page 7.

¹⁹ Alan D. Lopez, Colin D. Mathers, Majid Ezzati, Dean T. Jamison, and Christopher J. L. Murray (2006). Table I.1.

III. The Potential Economic Impact of VAW, HIV/AIDS, Poverty, and Human Development

Studies on the subject point out that VAW is found at all socioeconomic levels and that it causes a great loss of well-being. The well-being loss can be emotional and cause psychological suffering, but it can also be material by causing loss of health and of economic resources. There is no doubt that the loss of emotional well-being is one of the major consequences of VAW. However, it is difficult to measure its magnitude and its costs and thus, they are known as intangible costs. It is very difficult to estimate the suffering of a woman who has been the victim of violence, although all of us can recognize the psychological impact that this can have on her and on other members of the household, especially the children.

The negative impact of VAW goes beyond the psychological harm it causes on the victim. This impact has not only a very high material cost for the woman and her family and the health institutions, but also for society as a whole. A cost that is even higher if we consider the relation between VAW and HIV transmission. There are several ways of classifying the costs of violence²⁰ and the one presented below breaks down the cost for society as a whole, the cost for the victim and her family members, the cost for the health institutions and the indirect cost in terms of productivity and of years of life lost due to premature death or disability.

The cost of VAW for the victim and her family members includes:

- The costs associated with medicines and healing materials to repair the physical damage.
- The cost of the time invested in the recovery of health as a result of the physical harm by the victim and family members who provide care.
- The costs of recovery from any psychological damage to the victim and family members, especially the children.
- If the victim contracts HIV, the cost increases for the victim's own treatment and because during birth and breast-feeding, she can transmit the virus to her children.
- If the mother dies, the orphaned children usually become cared for by other members of the family, generating an additional cost in terms of the time devoted to caring for these children.
- Decrease of family income due to absence from work.

The cost for the health institutions is linked to:

- The recovery of health as a result of the physical harm caused by the aggression.
- Treatment of sexually transmitted diseases and HIV/AIDS.
- Psychological treatment for mothers and children.
- VAW control and prevention programs.

The direct and indirect costs for society as a whole are linked to:

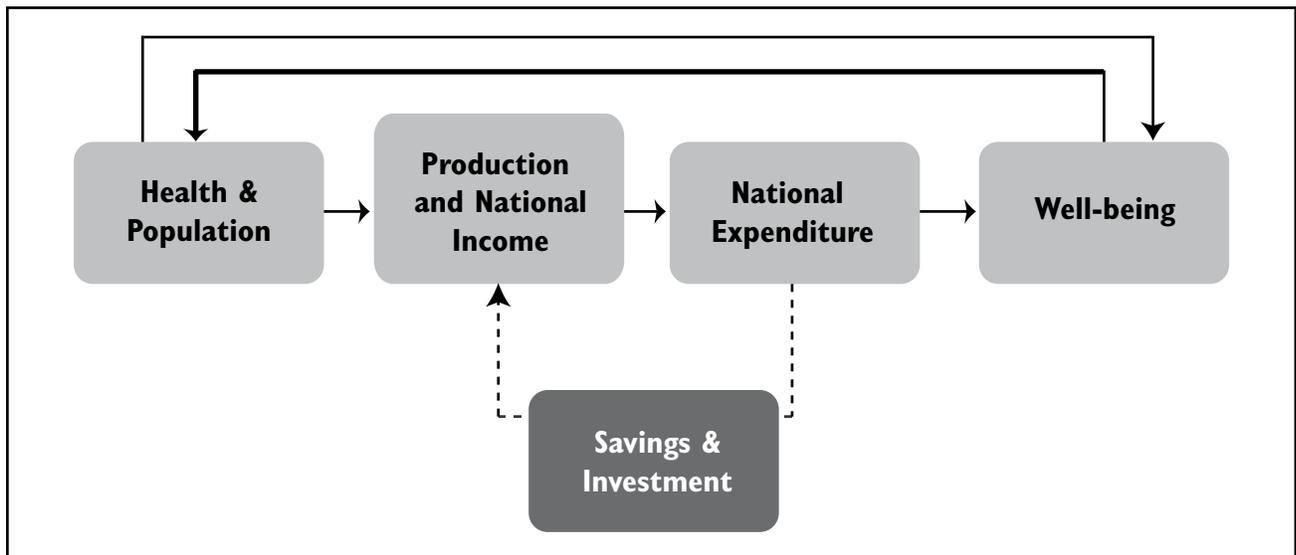
- Delivery of services to orphaned children.
- Delivery of police and judicial services to process the complaints from women.
- Lack of education of girls/adolescents victims of sexual abuse because they tend to drop out of school.
- Years of life lost due to premature deaths by violence and/or HIV/AIDS.
- Years of life lost due to premature deaths by abortions of unwanted pregnancies under unsafe conditions as a result of rape and/or violent sexual acts that prevent the use of a condom.
- Productivity losses related to what is not produced when a female victim of violence and/or HIV temporarily or permanently interrupts her productive work.

In addition to the immediate economic cost for society as a whole, it is important to take into account the long-term effect that VAW and its association with HIV transmission has on the economy as a whole. Women participate in the economy as economic agents, i.e., producers and consumers of goods and services. The health status of women plays an important role in the economy because of its direct effects on production, given that the health and education of the economic agents, be they men or women, determines labor productivity.

20 In this regard see José Luis Bobadilla, Víctor Cárdenas, Bernardo Couttolenc, Rodrigo Guerrero and María Antonia Remenyi (1996).

In general, the relationship between health and the rest of the economy can be outlined with the following chart. The rectangles represent the basic components of the economy and the arrows indicate the causal relations among these sectors. Double arrows imply that the relation is two-way, that is, that the components of the economy affect each other. Solid arrows indicate an immediate impact from one sector to another. Dotted arrows indicate a slower impact, where the effects are visible after some time (a year or more).

Chart I
Health and the Economy



Source: Mead Over (1991) page 6.

Production of goods and services generates the national income of a country. This income, in turn, is spent on goods and services or is saved and invested. Savings from the economy are used to finance investments, and investments, unlike recurrent expenses, are used to increase the future capacity of the economy to produce goods and services. Thus the arrow that goes from consumption (national expenditure) to production, through the investments, is a dotted line.

The way in which a country's national income is spent affects the well-being of the population since well-being does not increase if the national income is not spent on the goods and services desired or needed by society. What is the relation of health and population with the production of the economy? If, within the health and population sector, we consider aspects such as mortality, fertility, morbidity and nutrition of the population, we see that these factors affect the productivity of a country through the size of its work force and its productivity. Health improvement or recovery also has a direct impact on the well-being of people (thin line). However, this relation goes both ways because the well-being of the population also affects the economy (thick line) through a direct impact on the health of the population and the decision on the number of children to have. Developing an indicator for the level of well-being of a population is somewhat complex because it involves individual valuation. However, the degree of human development can be considered, where income, education, and health aspects are included, as an approximation of the same.

From this, it is derived that there is a vicious cycle among disease, poverty, and level of well-being. This situation worsens with the prevalence of VAW and its association with HIV. The relationship between family low-income levels, violence, and HIV transmission goes both ways, reinforcing each other through a vicious cycle of poverty and disease²¹, as observed in chart 2. Low-income levels lead to malnutrition and disease because

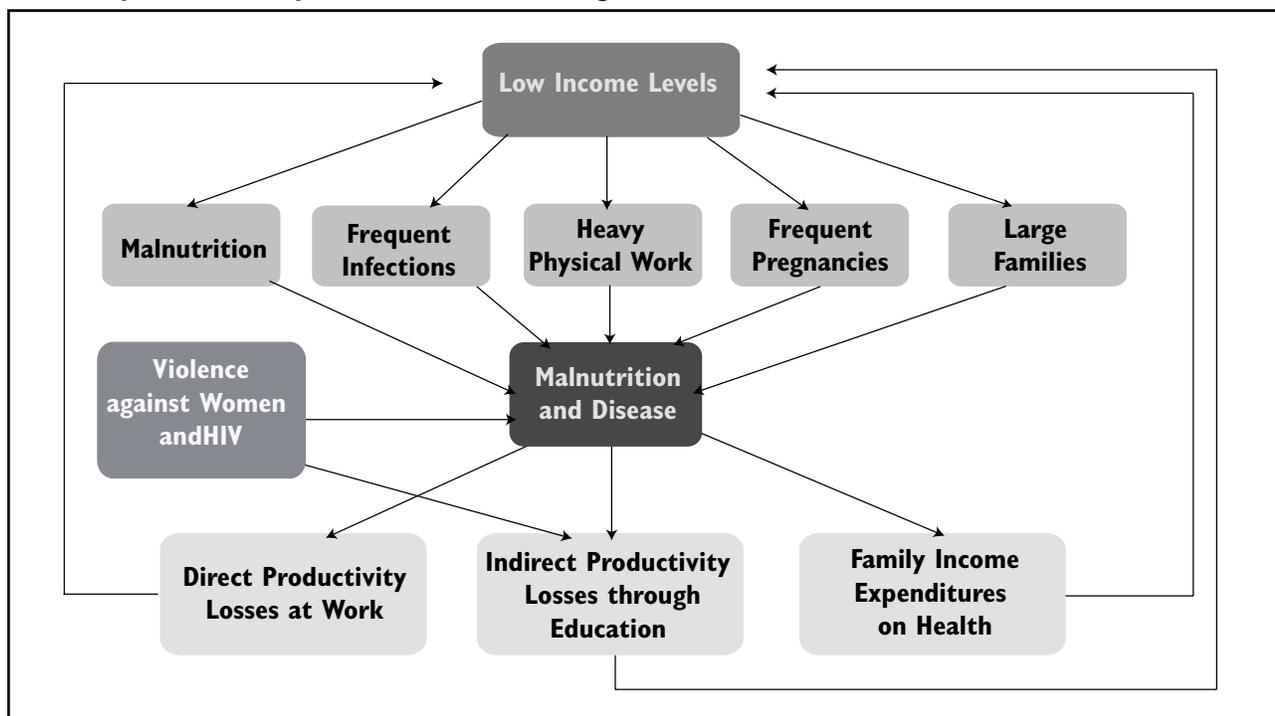
21 In this regard, see World Bank (2006) and Duncan & Frankenberg (2002).

poor families tend to have poor diets, are prone to infectious diseases, perform demanding physical labor, and present high fertility rates. These factors, in turn, increase malnutrition and disease.

VAW and its association with HIV transmission causes women to have low incomes through the direct impact of the disease on her productivity and her capacity to continue working and generating income. However, this loss of productivity can also be indirect through the effect that VAW, early pregnancy and HIV has on the education of adolescents. The eventual out-of-pocket expenditure in health services results in less income available to spend on other consumption.

Overall, this relationship between poverty and poor health is transmitted from mothers to children through the high probability that from one mother who is not well fed, is ill or has had many children, children are born with low weight or with some disease²². For them the cycle is repeated all over again. VAW and its association with HIV transmission strengthens these relations by the direct effects it has on the children born from mothers with HIV and from mothers whose pregnancy was the result of assault/rape. The effect is usually reinforced through low school performance and school dropout of orphaned boys and girls, children of teenage mothers and children who have experienced violence in their homes.

Chart 2
Vicious Cycle of Poverty, Health and Violence against Women



Source: Adapted from World Bank, *Repositioning Nutrition as Central to Development: A Strategy for Large Scale Action*. 2006, page 23.

The empirical evidence supporting this analysis is diverse; however, we can cite the following:

- One of every five working days that women lose for health reasons is the result of problems related to domestic violence.²³
- Violence during pregnancy has severe effects on the unborn child. Physical and psychological assaults result in higher prenatal and child²⁴ mortality rates.

²² Bhargava, A. (2001).

²³ Inter-American Development Bank (1997).

²⁴ Ibid.

- It is estimated that in 2001 there were already more than 11 million²⁵ orphaned children as a result of HIV/AIDS in Sub-Saharan Africa.
- In Thailand it is estimated that in 2005 there were 300,000 orphaned children of parents who died as a result of AIDS and that many of them were infected with the virus. Unfortunately, grandparents, relatives, or friends who take care of these children do not always have sufficient time to ensure adherence to ART treatment of the children since oftentimes they are also responsible for several other children.²⁶
- There is evidence that children living with HIV have higher rates of psychiatric illnesses, especially depression and behavior disorders, than children who are not affected by this disease.²⁷
- A study in Ivory Coast has shown that daily wages may be 19% lower for men whose health causes them to lose one working day per month in comparison with those who are healthy. Similarly, a study in Bangladesh found that the greater productivity of healthy men made it possible for them to have access to better paid jobs.²⁸
- The WHO multi-country study on violence against women²⁹ reports the following:
 - The prevalence of injuries resulting from violence of the domestic partner ranged between 19% (Ethiopia) and 55% (in rural areas in Peru).
 - In Bangladesh, Ethiopia, and the rural areas of Peru, more than a quarter of injured women reported having lost consciousness as a result of violence by their partner.
 - In the majority of the cases analyzed, women who at some time experienced physical or sexual violence, or both, reported health problems with greater probability than those women who never experienced violence by their partner. Women who at some time were abused declared having problems walking and in carrying out their daily work, feeling pains, loss of memory, dizziness, and abortion in the 4 weeks preceding the survey.
 - In all the countries an association was found between physical and sexual violence and the mental health problems of the victims.

IV. Elimination of VAW as a means to Reduce Heterosexual HIV Transmission

The idea that disease prevention is less expensive than its cure is widely known. In the case of HIV infection and its later development into AIDS there are no doubts about this assertion, since the treatment of patients who show AIDS symptoms is very expensive. The study on health priorities in developing countries³⁰ estimates that, in Sub-Saharan Africa, the cost for each avoided DALY by an intervention promoting the use of condoms in 100% of the population at risk of contracting HIV would be between US\$19 and US\$205; while anti-retroviral treatment would cost US\$1,500. In a study conducted by the World Bank³¹ it is pointed out that if Thailand had not invested in successful HIV prevention strategies between 1991 and 2002, the HIV and AIDS cases would have been much higher and consequently the cost of treatment of the disease would have increased. The study estimates that if no investment had been made in prevention, Thailand would have had 7.7 million cases of HIV and 850,000 cases of AIDS in 2005; approximately 14 times more than the existing cases following implementation of the prevention strategy. With this strategy, Thailand avoided having to spend approximately US\$18.6 billion in treatments between 2002 and 2012. The investment in HIV/AIDS (prevention and treatment) made by the government of Thailand in the 1990s was significant—US\$434 million in 2002 dollars. Nonetheless, this investment in HIV/AIDS allowed Thailand to save US\$18.6 billion in the following decade; that is, every dollar invested in HIV/AIDS generated US\$43 in savings in the future.

25 Michael Todaro and Atephen C. Smith (2006) page 399.

26 Ana Revenga, Mead Over, Emilio Masaki, Wieat Peerapatanapokin, Julian Gold, Viroi Tangcharoensathien, Sombat Thanprasertsuk (2006), page 66.

27 Ibid, page 66.

28 Reference taken from Ibid, page 39.

29 WHO (2005), pages 6-16.

30 Jamison Dean, Joel G. Breman, Anthony R. Measham, George Alleyne, Mariam Claeson, David B. Evans, Prabhat Jha, Anne Mills, Philip Musgrove (Eds.), summarized in PAHO (2007) page 7.

31 Ana Revenga, Mead Over, Emilio Masaki, Wieat Peerapatanapokin, Julian Gold, Viroi Tangcharoensathien, Sombat Thanprasertsuk (2006) page xxv.

Although it is less expensive to prevent HIV infection than to provide treatment to people living with HIV, in the case of women who suffer from abuse and violence on the part of their partners and cannot negotiate the use of condoms with them, the interventions that focus only in the prevention of HIV/AIDS are not effective. Many women are vulnerable to HIV infection even when they do not engage in risky behavior; in some cases, marriage itself constitutes a risk factor for them³². For this reason there is a recognized need to work from the gender perspective in a combined effort of education, empowerment, and women's rights to reduce VAW. Only when VAW decreases, women's educational status increases and laws that protect women's rights are created, the current trend of heterosexual HIV transmission could be reversed.

As recommended in the background document on Women and AIDS from the meeting of the executive directors of the international organizations³³:

“The World must recognize that HIV/AIDS and gender inequities are twin and intersecting challenges that must be confronted. Tangible ways in which development actors can work to expand women and girl's possibilities and choices have been demonstrated; the key is to take actions to scale simultaneously combating HIV/AIDS, gender inequality and poverty”.

Bibliography

Bhargava, A. (2001) “Nutrition, Health and Economic Development: Some Policy Priorities” WHO. Commission of Macroeconomics and Health. Working Paper Series. No. WG I: I.

Inter-American Development Bank (1997) “El costo de violencia doméstica. Una sangría para las economías de la región” (The cost of domestic violence. A bleeding for the economies of the Region) in <http://www.iadb.org/exr/IDB/stories/1997/esp/XV2c.&htm>.

Bobadilla José Luis, Víctor Cárdenas, Bernardo Couttolenc, Rodrigo Guerrero and María Antonia Remenyi (1996) “Medición de los costos de la violencia” (Measurement of the costs of violence). PAHO. Washington D.C.

Duncan Thomas & Elizabeth Frankenberg (2002) “Health Nutrition and Prosperity: A Microeconomic Perspective”. Bulletin of the WHO 80:106-113.

Jamison Dean, Joel G. Breman, Anthony R. Measham, George Alleyne, Mariam Claeson, David B. Evans, Prabhat Jha, Anne Mills and Philip Musgrove (Eds.) (2006). Disease Control Priorities in Developing Countries, 2nd Edition. Oxford University Press and the World Bank, also in <http://www.dcp2.org/pubs/DCP>.

Lopez Alan D., Colin D. Mathers, Majid Ezzati, Dean T. Jamison, and Christopher J. L. Murray (2006) “Measuring the Global Burden of Disease and Risk Factors, 1990-2001.” Oxford University Press and the World Bank. Also in <http://www.dcp2.org/pubs/GBD>.

Luciano, Diny (2007) “Explorando las intersecciones entre empoderamiento, VIH y violencia contra las mujeres en América Latina y el Caribe” (Exploring the Intersections between Empowerment, HIV, and Violence against Women in Latin America and the Caribbean). Development Connections, Washington DC in <http://www.dvcn.org/Documents/InterseccionesVIHVAV2.pdf>

UNAIDS/WHO (2007) “Situación de la epidemia del SIDA: Informe especial sobre la prevención del VIH.” (Situation of the AIDS Epidemic: A Special Report on HIV Prevention). UNAIDS/WHO. Geneva in www.universia.net.co/HIV/AIDS/view-document/document-648.html

PAHO/WHO. (2007) “Perspectives in Health”. Volume 11 No. 11. PAHO/WHO. Washington, D.C.

³² <http://www.unfpa.org/hiv/women.htm>

³³ UNICEF (2005), page 5.

Over, Mead (1991) *Economics for Health Sector Analysis: Concepts and Cases*. Economic Development Institute of the World Bank, Washington, D.C.

Revenge Ana, Mead Over, Emilio Masaki, Wieat Peerapatanapokin, Julian Gold, Viroi Tangcharoensathien, Sombat Thanprasertsuk (2006) "The Economics of Effective AIDS Treatment - Evaluation Policy Options for Thailand". The World Bank. Washington, D.C.

The World Bank (2003) "HIV/AIDS in Central America: An Overview of the Epidemic and Priorities for Prevention". Washington, D.C.

The World Bank (2006) "Repositioning Nutrition as Central to Development: A Strategy for Large Scale Action". The World Bank, 2006. Washington, D.C. in <http://siteresources.worldbank.org/NUTRITION/Resources/281846-1131636806329/nutritionstrategy.pdf>

The World Bank (2007) "World Development Report 2007." Washington, D.C.

The World Bank (2008) "Rapid Analysis of HIV Epidemiology and HIV Response Data on Vulnerable Populations - Great Lake Region". Draft Report in <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-110303715...> - -

Todaro, Michael and Astephen C. Smith (2006) *Economic Development* (Ninth Edition). Pearson Addison Wesley.

UNAIDS (2006) "2006 Report on the Global AIDS Epidemic." UNAIDS/WHO, Geneva, in <http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2006>.

UNICEF (2005) "Women and AIDS: Background Paper to the Joint Meeting of the Executive Boards (UNICEF, WFP, UNFPA, UNDP) in www.UNICEF.org/about/execboard/files/2005

WHO (2005) "Multi-Country Study on Women's Health and Domestic Violence against Women." Geneva in http://www.who.int/gender/violence/who_multicountry_study/Cover.pdf

Lack of Empowerment: A driving force behind the HIV and Violence Against Women epidemics

Anda Samson³⁴

In 2007, 2.1 million people died of AIDS, and worldwide 33.2 million people are now living with HIV. Despite recent numbers indicating that the HIV epidemic is leveling off, prevalence in the Caribbean, the second most affected area in the world, remains steady at 1%.ⁱ Although the decline seems to signify a real decrease in new infections in some sub-Saharan countries, in most countries the trend can be explained by other factors, such as a downward correction of estimates based on new statistical methods, or by a death rate that equals the rate of new infection. Among young people in the Caribbean and sub-Saharan Africa AIDS remains the leading cause of death. AIDS is a disease caused by infection with the Human Immunodeficiency Virus (HIV).

The HIV virus causes a failure of the immune system, usually many years after infection. Eventually this loss of immunity causes susceptibility to opportunistic infections, which are the main cause of death in AIDS patients. Infection can occur through various routes of contact with bodily fluids: mother-to-child, through infected blood transfusion products or the use of contaminated needles. By far the most prevalent route of transmission, though, is sexual intercourse.

A downward or stagnating trend in HIV prevalence among the general population may conceal a rise in HIV prevalence in a specific group or groups. In the absence of a vaccine, prevention continues to be the only way to slow the spread of HIV. Awareness of the pathways that can lead to the contraction of HIV provides insight into the specific populations at risk. Women in general – not just those in specific risk groups like sex workers or pregnant women – have shown to be a hidden risk group.

Feminization of the HIV epidemic

What was once thought to be an exclusively male infection has become, over time, one with a more even distribution between the sexes. In 1990, females represented 30% of HIV-infected patients worldwide. By 1997 the proportion had risen to 40%.ⁱⁱ Today, women make up half the HIV-infected population worldwide.² The steep increase in female infection is most acute in areas where heterosexual intercourse is the main route of transmission; in sub-Saharan Africa the proportion of HIV positive women grew from 50% in 1997 to over 60% in 2007, and in the Caribbean the proportion rose from 30% in 1997 to 50% in 2004ⁱⁱⁱ, remaining stable in 2007. When focusing on youth, the imbalance between male and female infection rates is even more clearly visible. In several sub-Saharan African countries, three quarters of HIV infected young people age 15-24 are female.^{iv} In areas where the epidemic is driven by other means of transmission, such as intravenous drug abuse, the trend of feminization is less visible.

The pathways leading to a woman's higher likelihood to contract HIV are complex and include a variety of socio-cultural and physiological factors. Although women are physically more vulnerable to contracting HIV infection,^{v,vi,vii} this factor alone does not fully explain the feminization of the HIV epidemic. The process is driven by women's social and economic power disadvantages within relationships. VAW has been increasingly

³⁴ Anda Samson. Medical doctor. Master's thesis "Connections between HIV and violence against women in Kenya. A broader view of empowerment issues." Leiden University/PAHO. Academic coordinator of the course "Empowerment, HIV and VAW in the Caribbean". DVCN, CIM/OAS, CAFRA and UNIFEM. 2008. Email: anda.samson@gmail.com

named as a pathway to the uneven spread of HIV among women.^{viii,ix,x,xi} This type of violence is defined as: “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.”^{xii}

A study in Rwanda, for example, showed that HIV positive women experienced more lifetime violence than HIV negative women.^{xiii} In Tanzania, a positive relationship was found between HIV and lifetime experience of partner violence among women visiting a voluntary counselling and testing clinic.^{xiv}

Violence against women

Physical and sexual violence against women (VAW) is most frequently, though not exclusively, perpetrated by a spouse or an emotionally close relative. This type of violence between intimate partners is far from rare. Heise et al showed in a 1998 study that worldwide, between 10 and 60% of women experience intimate partner violence, either sexual, physical or both, depending on the method of measurement.^{xv} In a 2005 WHO study, these data were confirmed with a range of 15 to 71% of women having experienced physical abuse by their partners, depending on the country.^{xvi} Women physically abused by their partners almost always suffer emotional violence, too, and a third to one-half experience sexual violence.^{xvii,xviii} VAW is the underlying cause of a significant proportion of the health burden of women. These various negative health outcomes range from psychological and emotional battering, to serious bodily injury and even deadly consequences, such as HIV infection.^{xix,xx,xxi,xxii,xxiii}

Since HIV is transmitted via contact with bodily fluids, and most frequently via sexual contact, physical or emotional violence against women cannot be a direct cause for the uneven spread of HIV; However, since physical and emotional violence can create an atmosphere under which decision making about safer sexual conduct is compromised, and because these types of violence are often accompanied by sexual violence, they are an important part of the causal pathway towards HIV infection and must be taken into consideration when discussing HIV prevention strategies.

Empowerment and HIV

VAW in all its varieties itself seems to be a result of a lack of power and control many women experience within intimate relationships.^{xxiv,xxv} Empowerment refers to the process of gaining power over one's life in the widest scope imaginable, as well as to the outcome of that process as compared to the starting position.^{xxvi} In a situation of abuse, there is by definition a disturbed equilibrium of power between abuser and abused. Women lack empowerment in many different dimensions: economically, socially, physically, politically, and personally.^{xxvii}

Without doubt a lack of empowerment itself cannot be a direct cause for HIV; in almost all cases the cause of transmission is unprotected sex, whether consensual or otherwise. A lack of empowerment does however create an environment where protection against HIV may be compromised, thus creating favourable circumstances for the virus to spread.

Since sexual contact is the major route of HIV transmission, control over sexual activities is an important tool to prevent infection. In the process of persuading a partner into sexual intercourse, the power disequilibrium encompasses more than sheer physical force. The threat of physical force, continuous psychological harassment compromising negotiation skills, economical dependency, or cultural convictions all contribute to a lack of power in sexual decision making.

Some women may experience violence when demanding the use of a condom, some may not even bring it

up out of fear of violence, and some may be culturally inclined to consider sexual activity their duty. Others consent to unsafe intercourse because it is the only means by which their partner will grant them money for basic necessities.^{xxviii} A lack of empowerment is therefore a risk factor for the experience of violence with all

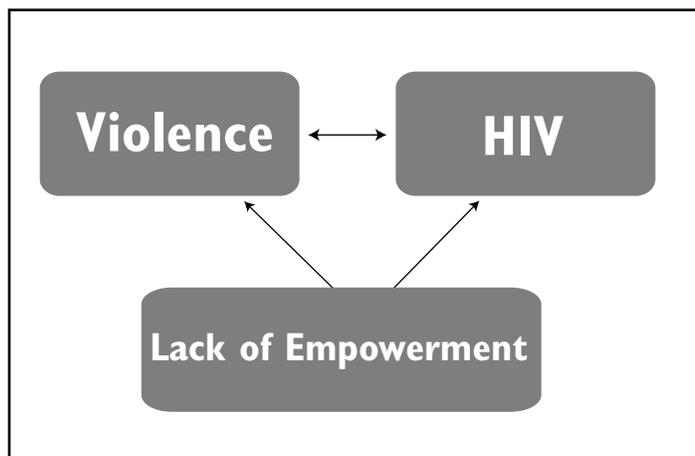


Figure 1: Lack of empowerment as a risk factor for violence and HIV

its other negative health outcomes as well as specifically for infection with HIV.

Heise et al. developed a comprehensive model of four levels on which women lack empowerment, to explain the multidimensional process of violence against women. To eliminate violence against them, women need to be empowered on all four levels. For each level, various ways of interaction between HIV, violence against women and empowerment can be identified:

(1) The norms and laws that exist in a society; Norms granting men power over women exist in many societies, hindering refusal of any decision including sexual decisions.

Public rejection of HIV positive people or myths about HIV also encourages sexual risk behaviour or refusal to be tested.

(2) Community characteristics; Driven by poverty, some women maintain sexual relationships in return for food, clothing or shelter.

(3) The characteristics of the relationship between perpetrator and victim, and communication styles; Wife-initiated condom use negotiation might raise suspicion of infidelity or could be seen as an act of distrust and may lead to violence within the relationship.^{xxix, xxx}

(4) Characteristics of the individual perpetrator and victim. The experience of IPV ever in a lifetime is connected to a higher degree of sexual risk taking.^{xxxi}

It is clear from this model that empowerment is not a process for women alone. Empowerment is sex-neutral, however it always means gaining empowerment relative to someone else, in this case the male partner. The male partner thus needs to be involved in the process of women's empowerment.

In many countries for example, the pervasive cultural message exists that marriage in itself is a form of protection against HIV. This has created a false sense of security among married women – and men – about their risk. In keeping with these beliefs, preventive efforts have mostly been directed at those groups considered to be at greatest risk for contracting HIV, for example men having sex with men, prostitutes, intravenous drug users and pregnant women.

As a result women and men in the general population, especially married women and women in long-term relationships, have been neglected as a risk group for contracting HIV and have therefore benefited less from public education and sensitisation efforts. A 2005 study in Cambodia showed, for example, that an estimated 45% of new HIV infections now occur among married couples.^{xxxii} In Chinandega, Nicaragua, married women are twice as likely as sex workers to be infected with HIV.^{xxxiii} Women may understand preventive messages telling them the importance of using a condom during sex; however, when they lack the power to demand this of their partner it is a lost effort. In building prevention programmes, it is of vital importance to keep in mind the four dimensions of discrepancies in empowerment between men and women. To do otherwise will lead to failure of these programmes.^{xxxiv, xxxv}

Conclusion

Differences in empowerment give rise to two public health epidemics with grave effects on the world population, namely HIV and violence against women. Many steps will need to be taken to counter the trends in both issues. Prevention programmes should be tailored towards both men and women, and need to take into account the different dimensions of a lack of empowerment of women. More research is necessary to monitor the effects of these programmes, in order to continually improve efforts to erase HIV as well as violence against women.

Endnotes

- 1 UNAIDS epidemic update 2007. Geneva, WHO/UNAIDS, 2007.
- 2 MMWR weekly November 30, 1990 / 39(47):845
- 3 2004 report on the global AIDS epidemic. Geneva. WHO/UNAIDS, 2004.
- 4 UNAIDS epidemic update 2005. UNAIDS/WHO, Geneva, 2005.
- 5 Sagar M et al. Identification of modifiable factors that affect the genetic diversity of the transmitted HIV-1 population. *AIDS* 2004;18(4):615-9.
- 6 Wang CC, Reilly M, Kreiss JK. Risk of HIV infection in oral contraceptive pill users: a meta-analysis. *J Acquir Immune Defic Syndr* 1999, 21: 51-58
- 7 Cohen CR et al. Increased interleukin-10 in the the endocervical secretions of women with non-ulcerative sexually transmitted diseases: a mechanism for enhanced HIV-1 transmission? *AIDS*. 1999;13(3):327-32.
- 8 State of world population 2005. The Promise of Equality. Gender Equity, Reproductive Health and the Millennium Development Goals. New York. UNFPA, 2005.
- 9 Meel BL. HIV-seroconversion following sexual abuse. *J Clin Forensic Med*. 2005;12(5):268-70.
- 10 Maman S et al. The intersections of HIV and violence: Directions for future research and interventions. *So Sci Med* 2000; 50: 459 – 78
- 11 Intimate Partner Violence and HIV/AIDS. WHO/UNAIDS, information bulletin series number 1, 2002.
- 12 Convention on the elimination of all forms of discrimination against women, 1979
- 13 Van der Straaten A et al. Sexual Coercion, Physical Violence, and HIV Infection Among Women in Steady Relationships in Kigali, Rwanda *Aids Behav* 1998; 2 (1): 61-73
- 14 Maman S. et al. HIV-positive women report more lifetime partner violence: findings from a voluntary counselling and testing clinic in Dar es Salaam, Tanzania. *Am J Public Health* 2002; 92 : 1331 – 1337
- 15 Heise LL. Violence against women: an integrated, ecological framework. *Violence Against Women*. 1998;4(3):262-90.
- 16 WHO multi-country study on women's health and domestic violence against women. Initial results on prevalence, health outcomes and women's responses. Geneva. WHO, 2005.
- 17 Ellsberg M, Pena R, Herrera A, Liljestrand J, Winkvist A. Candies in hell: women's experiences of violence in Nicaragua. *Soc Sci Med*. 2000;51(11):1595-610.
- 18 Coker AL, Smith PH, McKeown RE and King MJ. Frequency and correlates of intimate partner violence by type: physical, sexual, and psychological battering. *Am J Public Health*. 2000 Apr;90(4):553-9
- 19 Heise L, Ellsberg M, Gottmoeller M. A global overview of gender-based violence. *Int J Gynaecol Obstet*. 2002;78 Suppl 1:S5-14.
- 20 Staggs SL, Riger S. Effects of Intimate Partner Violence on Low-Income Women's Health and Employment. *Am J Community Psychol*. 2005;36(1-2):133-45.
- 21 Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002; 359:1331-6
- 22 Diop-Sidibé N, Campbell JC, Becker S. Domestic violence against women in Egypt – wife beating and health outcomes. *So Sci Med* 2006 Mar;62(5):1260-77.
- 23 Heise, L. Violence against women. The hidden health burden. World Bank discussion paper 255. The World Bank, Washington DC, 1994.
- 24 Dunkle KL, Jewkes RK, Brown HC. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet* 2004; 363: 1415 – 21
- 25 Samson AD. Connections between HIV and violence against women in Kenya. Master thesis 2006. Unpublished.

- 26 Kabeer N. Resources, Agency, Achievements. Reflections on the measurement of women's empowerment. Sida studies no 3. Sida, Stockholm, 2001.
- 27 Kishor S, Jonson K. Profiling domestic violence: a multi-country study. ORC Macro. Maryland. June, 2004
- 28 Fox AM et al. In their own voices: a qualitative study of women's risk for intimate partner violence and HIV in South Africa. *Violence Against Women*. 2007; 13 (6):583-602.
- 29 Go et al. When HIV prevention messages and gender norms clash: the impact of domestic violence on women's HIV risk in slums of Chennai, India. *AIDS Behav* 2003; 7 (3) 263 -72
- 30 Wingood GM, DiClemente RJ. The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *Am. J Pub health* 1997; 87 (6)
- 31 Bogart L. et al. The Association of Partner Abuse with Risky Sexual Behaviors Among Women and Men with HIV/AIDS. *AIDS and Behavior* 2005; 9 (3)
- 32 Duvury and Knoes. Gender Based Violence and HIV/AIDS in Cambodia Links, Opportunities and Potential Responses. GTZ. Eschborn, August 2005
- 33 AIDS epidemic update 2005. Geneva. WHO/UNAIDS, 2005.
- 34 Pettifor AE et al. A community-based study to examine the effect of a youth HIV prevention intervention on young people aged 15-24 in South Africa: results of the baseline survey. *Trop Med Int Health*. 2005; (10):971-80.
- 35 Shisana O and Davids A. Correcting gender inequalities is central to controlling HIV/AIDS. *Bull World Health Organ*, Nov. 2004; 82 (11): 812.
- 36 UNAIDS. At The Crossroads: Accelerating Youth Access to HIV/AIDS Interventions. New York: UNAIDS Inter-Agency; 2004.

Reinterpreting Violence from the Perspective of Women Living with HIV/AIDS

Nizarindandi Picasso³⁵

“I was an orphan. When I was young I was taken in by five women and in all cases I was battered, punished; they left me without food and without water if I did not carry out the domestic tasks as they asked or if I made a mistake. I suffered sexual abuse at age 13 and 14. I never sought assistance because whenever I did, it was worse for me. I did not have family and did not know to whom to appeal. When I lived in the street, I lived better, I felt safer because my companions helped and protected me. My husband hit me, he verbally abused me, saying that I was never going to get ahead and that I was going to die of hunger. I never let anybody strike my daughters. When they gave me my HIV-positive diagnosis, I was not concerned about me: I was a stone, I no longer felt any pain. And when they diagnosed me with advanced cancer, the physician asked me: “What are we going to do?” And I said: “One more disease for me, thanks to God.” Why should I curse something that I already have and that I can’t get rid of? Everything good that I learned came from bad experiences. If I did not have HIV, I would still be enduring my husband’s beatings and now I am learning from the struggle. I learned to write, to help my companions, to live well and to love myself. Now I can identify violence and do something about it, I have more knowledge and I know where I can go and not let anyone strike me or humiliate me.”

Several studies show that violence can be a cause and consequence of the HIV transmission in women.³⁶ This dual relationship between the two problems establishes a continuum in which political, economic, cultural, and community factors as well as social relations interact, thus we must permanently revisit the forms in which these links are expressed. The women’s movement has managed to make visible the different forms of violence achieving important advances in its definition and measurement. Currently, the majority of the countries of Latin America and the Caribbean (LAC) have laws, programs, care and research networks that will serve as the basis for its progressive eradication. However, the specificities of the different groups of women should be considered when establishing these strategies because violence against women (VAW) is not a static problem and, in addition, it acquires nuances differentiated according to given circumstances and contexts. In this regard we believe that the experiences of women living with HIV/AIDS (WLHA) can contribute new elements for its analysis and approach in the policies and programs. The reflections presented below have been expressed by the WLHA in different scenarios and disseminated through various means; in this document I have only attempted to group them and place the voices of the women to illustrate our experiences. The majority of WLHA have experienced some form of violence: physical, emotional, economic, and psychological; and once they receive an HIV-positive diagnosis all these forms of violence become accentuated or they live those which they had not experienced before.

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36 Luciano, Dinys. Exploring the Intersections between HIV and Violence against Women in Latin America and the Caribbean. Development Connections. Washington, D.C., 2007.

I. HIV, Violence, and Women's Life Cycle

The analysis of violence in the lives of women living with HIV/AIDS (WLHA) should incorporate the different experiences during their life cycle because they interact among themselves, thus increasing their vulnerability to different forms of violence and HIV and other sexually transmitted infections (STI). An example of this is the relation of violence in childhood with other forms of violence, such as forced prostitution and the trade and trafficking of people. Although a direct causal relationship between the two problems cannot be established, it is interesting to note that several studies on sex workers repeatedly report experiences of sexual abuse, mistreatment, abandonment, and neglect in childhood. Our experiences of violence in childhood and adolescence reduce our ability to protect ourselves; thus it places us at a greater risk for HIV and other STIs. Oftentimes violence is experienced since childhood in the home and it is usually performed by the male figures as parents, brothers, etc. Violence is also performed against the mothers, daughters, and boys who show feminine behavior; and it is reproduced in a daily continuum, becoming so habitual that it is seen, felt, and lived as something normal. Seldom do the individuals that exert violence and those who suffer it, have access to support and care programs to prevent, diminish and, at best, to eliminate it.

On the other hand, the lack of information and access to the same, hinders the recognition of violence in the different stages of the life cycle and of its consequences, thus making it necessary to study the relationships between the perception of risk of HIV and the re-infection in the case of WLHA and the experiences of violence. Unfortunately, HIV is the medium through which women recognize violence in our lives. "In the majority of the cases women stated that they suffered some form of violence, they could see it, it annoyed them, but they did not identify it and this made it difficult to seek assistance. They learned to recognize it once they received an HIV-positive diagnosis."

The lack of empowerment generated by violence and other expressions of gender inequality in the life history of women constitutes a risk factor seldom addressed in the HIV/AIDS prevention and care strategies, thus compromising their effectiveness. The inability or disinterest of the State in eliminating VAW prevents the few initiatives or existing programs from fulfilling and effectively carrying out the functions for which they were created.

II. Sexual violence and HIV

Sexual relations with a partner may be the space through which women acquire HIV and at the same time where violence is exerted after the HIV-positive diagnosis.

a. HIV transmission by the Partner – Intentionally or by Negligence

Although in many countries the legal framework on HIV/AIDS establishes that people aware of their serological status must report it to their partner, WLHA report in a repetitive manner that their spouses/partners knew that they lived with HIV and never informed them, engaging in unprotected sexual relations. Women of all the countries of LAC report that they became cognizant of their serological status through pre- and post-natal health care services or when their children died as a consequence of diseases associated with HIV. Their partners deny having been the first to be infected and publicly accuse the women of having brought HIV to the family and of having infected them and the children. The social stigma attached to this accusation discredits the women within the family and the community which in turn leads to other experiences of violence in the life of WLHA.

On the other hand, many women believe that our partners can only acquire HIV with another woman or a sex worker, not knowing about the possibility that our partner may be having sexual relations with other men.

b. Episodes of Physical and Sexual Violence on the Part of the Partner following a Positive Diagnosis

WLHA face the risk of physical and sexual violence on the part of our partner once we report our serolo-

gical status. In the United States of America, 4 out of 20 studies report that women in the study experienced violence as a consequence of reporting the results of the HIV test, on average 8%, between 3.2% and 24%; and some authors indicate that women with a history of physical or sexual violence are more probable to suffer violence as a result of reporting their serological condition.³⁷ In LAC we frequently hear that the partner usually humiliates them, accusing them of infidelity, telling them that they are no longer good for anything, and that they do not love them. Others report that they abuse them sexually as a way of punishment.

c. Inability to Negotiate Safe Sex

Violence also reduces our options for negotiating condom use with our partner because in relations marked by violence, speaking about safe sex puts us at risk of suffering further assaults, and even losing our lives. The lack of power exposes us to infection and to re-infection: “Not having learned to negotiate the use of condom, we are exposed to re-infections.” Violence also reduces our capacity to perceive the risk or else when we do, we are unable to protect ourselves against re-infection, the contraction of other STIs as well as unwanted pregnancies.

d. Psychological Violence and Sexual Orientation

The violence faced by WLHA with our partners is not exclusive to heterosexual relations and can take similar expressions in same-sex couples: “I am a lesbian with HIV... My former partner struck me, insulted me and made me feel defective; she said that I had to thank God because she was with me.”

Violence in the relationship is one of the main obstacles to the development of women because it disturbs our lives; it diminishes self-reliance and affects our self-esteem. Furthermore, it limits participation in public life, restricts choices, and imposes restrictions on information and services, while constituting an abuse of our rights. Similar to women who do not live with the virus, WLHA do not seek help because we feel shame or lack of confidence; or we face more violence if we do. We consider violence in the relationship as something private, believing that we do not have any alternative; we focus on the children or hope that the partner will change.

III. Violence in the Family and the Community

Some WLHA are attacked by members of the family when they learn about their serological status. Furthermore, in light of the difficulties faced by WLHA to have access to a job, many are forced to return to the house of relatives, usually with the children. Very often our families welcome us, but they use us as domestic workers without remuneration.

Furthermore, often WLHA have to flee from their community because they or their children are attacked since even if the children are negative they are attacked and expelled from schools. This in addition increases the circle of social vulnerability because we are forced to abandon our countries and assume the high cost of moving to other geographical areas.

IV. Self-inflicted Violence in WLHA

Not only do we receive violence from the people with whom we interact and the spaces in which we move about, but we have also learned to handle the previous experiences of violence by hurting ourselves. We self-inflict violence through the lack of self-care, through self-destructive behaviors and, often, through suicidal ideas and attempts. An HIV-positive diagnosis triggers a series of feelings such as fear, pain, rage, anger, impotence and self-loathing that translate, in turn, as triggers for destructive behaviors. An activist woman with HIV states that we ourselves can exercise violence or it can come from outside, when we blame and scourge ourselves for being HIV-positive. “We punish ourselves when we do not accept the treatment or resist following the same.”

V. Violence: Internal, intra-gender, and among Peers

WLHA face violence on the part of men and women in society in general who do not live with the virus but

37 WHO. 2003. Gender Dimensions of HIV Disclosure to Sexual Partners: Rates Barriers and Outcomes. Geneva.

also on the part of persons living with HIV/AIDS (PLWHA). Due to the stigma and prevailing discrimination, some people who are not or do not know that they are HIV-positive, replicate the predominant values that place responsibility for HIV infection on the PLWHA, instead of on the social, political, and cultural structures that characterize the disease. The idea that HIV is a problem of specific socially stigmatized groups such as sex workers, drug users, and men who have sex with men, causes society in general to visualize us as the cause of the problem and not as the manifestation and result of inequality.

This situation can get worse when combined with discrimination based on sexual orientation. "Being different makes you vulnerable to violence: I am a lesbian with HIV; I acquired the virus in a blood transfusion. I have been the recipient of violence from heterosexual women because I am different, from other lesbians because if I was infected it means that I sleep with men."

VI. Violence in the Health Services

In addition to violence exerted by the partner, the family, the community and the workplace, WLHA face violence performed by the health institutions in charge of caring for PLWHA. Forms of violence in the health services are, among others, the following:

- a) Communicating the result of the HIV test without previous counseling and after the test, as happens in the majority of cases.
- b) Violation of confidentiality since in some cases, they deliver the results first to the partner, or to the family and not to the woman tested.
- c) Aggressive and discriminatory treatment, including professional negligence regarding the specific needs of WLHA.
- d) Refusal to provide health care to pregnant women. Many women have been forced to give birth alone in their homes because hospitals do not want the responsibility of attending the delivery.
- e) Forced abortion and contraception: Some WLHA are coerced to have an abortion or to submit themselves to definitive contraception methods without taking into account whether the woman already has children or wishes to have more. When a WLHA requests in the hospitals to be provided with information on the contraceptive methods that she can use, such information or access to these methods is refused because providers of health services assume, think, or decide that if you are a WLHA you no longer exercise your sexuality. If you become pregnant, you are subjected to a series of judgments and lectures for daring to get pregnant when you are a WLHA.

The stigma and discrimination that must be faced whenever a woman must use the health services generates an overwhelming emotional drain. From hospitals that ask you to bring your disposable vaginal mirror, unlike the women that do not know whether they are living with the virus or know it but do not say it, to long hours waiting since there are physicians who give you appointments for 7:00 am and end up seeing you at 2 pm, only because you are a WLHA.

VII. Corporate/Business Practices and the Rights of WLHA

Many of the WLHA lose their employment and have few possibilities of getting another one. We are consumed by fear of applying for a job because many companies perform HIV tests without the consent of the applicants and, as a result, we run the risk of not being contracted. Although carrying out these tests is prohibited, they continue to be done. At times, WLHA are coerced to resign from our jobs and thus lose the right to a just pension that would make it possible to support ourselves. We also lose any possibility to have access to benefits such as to acquire a home within a social benefit system. We face many obstacles to live a decent life and many of these are related to the violence that we live at the interpersonal, community, institutional, and labor levels. Sometimes the partner dies first and the woman is forced to assume the responsibility of caring, attending, and burying him. Once this process is over, WLHA are left without economic support or social security that protects them and without the possibility of getting a decent job. The discriminatory business practices against the PLWHA constitute an institutional form of violence that in particular affects

women since we fulfill the social role of caregivers and after our partners die we must raise the children alone and with very limited options of getting a job.

VIII. Looking to the Future: How can we comprehensively address VAW and HIV?

- Promote and disseminate the human rights of women, as well as the existing laws to prevent and eradicate VAW.
- Continually monitor the impact on the population of the promotion and the dissemination of the laws that protect their rights; and monitor the enforcement of these laws.
- Ask the State to allocate equitable resources and equal opportunities for women.
- Provide continuing training to public servants so that they carry out their functions in accordance with the law and in case they do not comply, discipline and/or dismiss them from public service.
- Strengthen current programs to prevent and eliminate VAW and integrate them in the prevention and care of HIV/AIDS strategies.
- Carry out specific campaigns aimed at women on HIV prevention illustrating how violence makes them vulnerable to the transmission of HIV.

- Create programs for continuing education that promote ownership of human rights and of the laws that protect women so that these are recognized by them and feel as subjects under the rule of law. These programs should be designed and adapted so that women of all ages can have access to them.
- Request the State to deal severely with all communications media that promote, reinforce, and reproduce violence toward women as something valid and accepted.
- Create support programs and facilitate access to them so that the people who exert violence and the victims receive care.
- The organizations working with women, VAW, and HIV can carry out collaborative and collective interventions to optimize efforts and avoid duplicating resources.
- Create support and surveillance networks so that WLHA feel they are supported and protected when they decide to denounce the violence of which they are victims.
- Include the populations affected by HIV in decision-making and in the design of policies that help reduce the impact of the consequences of VAW.

“Do not provoke abrupt violent acts with women, take small steps, and make gradual changes, when we want to make abrupt changes we do not take into account that we are causing and generating violence.” (Words of an HIV activist in Ciudad Juárez, Mexico).

Section II: Specific Groups, Specific Needs



Intersections between HIV and Violence against Adolescent and Young Women

*Florencia Aranda*³⁸

Worldwide, adolescents and young adults represent almost one fourth of all people living with HIV and half of all new cases³⁶. According to data from UNAIDS, the increase of HIV is even greater among girls and adolescent females, and young women constitute approximately 60% of the people between 15 and 24 years old living with HIV/AIDS. Young women have 1.6 times more probability of being infected than males of the same age. The available evidence indicates that age is a social determinant of HIV transmission in women in all the regions of the world.

In sub-Saharan Africa, 76% of the young people who live with HIV are women. In Zambia and Zimbabwe, young women have from 5 to 6 times more probability than their masculine peers³⁷.

In the Caribbean, young women have 2.5 times greater probability of being infected than young males³⁸. In Trinidad and Tobago, according to a 2005 study, HIV infection levels are six times higher among girls 15 to 19 years old than for boys the same age³⁹.

In the Middle East and North Africa, young women have double the probability of infection as young men⁴⁰. According to UNFPA, in Southeast Asia 62% of the people age 15 to 24 living with HIV are women, versus 38% men.

The vulnerability of young women and girls to HIV infection results from biological factors but especially from social, economic, and cultural factors as a result of gender inequalities that expose them to suffer abuses of power, violence, poverty, marginalization, and lack of education. Biologically, girls and adolescents have a greater risk of being infected with HIV because their genital organs are just developing and their tissues are more fragile and, as a result, are more susceptible to infection. However, the effects of this biological vulnerability could be reduced if girls and adolescents could choose freely about their bodies, their sexuality, and their lives.

The intersections between violence and HIV in girls and adolescents are multiple. Throughout the world girls and adolescents are victims of sexual violence, domestic violence, violence during courtship, human trade and sexual exploitation, rape during armed conflicts, as well as harmful cultural practices such as genital mutilation, which increase their vulnerability to the virus. Due to their condition as women and young people, their voices are not heard, thus suffering the effects of double discrimination that threatens their lives.

I. Sexual Violence and HIV — Girls and Adolescents are Most Vulnerable

Sexual violence rates in this population group are ever-growing. Throughout the world girls and adolescents are victims of rape and sexual abuses that threaten their physical and psychological integrity and contribute directly to the spread of HIV infection. It is estimated that 40 million boys and girls are subject to abuse each year everywhere in the world⁴¹. A national survey conducted among high school students in Kenya found that 40% of all the girls that said they had had sexual relations, indicated that their first experience had been forced or that “they were deceived into having sex”⁴². In the Caribbean, 47% of the adolescents who have had sex report that their sexual initiation was forced⁴³. In Peru, 45% of the adolescents and in Brazil 14% of the adolescents who live in urban areas report that their sexual initiation was forced⁴⁴.

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A high percentage of the sexual violence exercised against girls and adolescents occurs within the family, perpetrated by the father, stepfather, family member, or domestic partner. Intra-family rape of girls and adolescents is a subject that today still seems invisible, and even though there are statistical data available about early and adolescent pregnancies, there is little information concerning the circumstances that lead to the pregnancies of 12 or 13 year old girls. The Demographic and Family Health Survey (ENDES, 2000) of Peru cites studies where it is estimated that 6 out of 10 pregnancies in girls aged 11 to 14 are the result of incest or rape⁴⁵. Girls and adolescents who suffer from sexual abuse and family rape have fewer probabilities of seeking and as a result receiving medical care and prophylaxis post exposure to HIV, due to the threats and manipulation of the aggressor that makes them keep the abuse secret. Since the abuse and intra-family rapes tend to be chronically repeated, and the assailants tend to be adults who engage in sexual relations with other partners, there is a high risk of infection.

“My uncle used to beat me with electricity cables. Before living with my aunt and uncle, I lived with my mother’s older sister, and my brother used to take me to the shrubs. Then he raped me. I was 8 or 9 years old. I was afraid. He told me he was going to beat me if I told anyone⁴⁶.” (Account of a 12-year-old African girl, Human Rights Watch, 2005)

Another manifestation of the VAW to which adolescents are exposed, is violence during dating or courtship, a problem that has yet to be incorporated into the violence and HIV prevention programs and policies aimed at adolescents. When we speak about violence in the couple there is a tendency to associate it with intimate relationship structures of the formal type, such as the common-law marital union or marriage; however, a large number of adolescents are abused physically, sexually, and psychologically by their boyfriends. In 2005, a study conducted in a hospital in the city of Buenos Aires, Argentina, pointed out that “around 50% of the girls who began their sexual activity between the ages of 13 and 16, said that they did not want to have sex at that age, but accepted under some form of pressure, from rape to the threat of breaking up.”⁴⁷ Adolescents and young women who suffer from this type of violence lack the necessary power within the relation to negotiate the use of a condom, which exposes them directly to the HIV virus.

“He was 23 years old and I was 16. We were at his mother’s home, with a group, listening to music. All of a sudden, he closed the door of the room, undressed me and I became paralyzed... He was stronger than me.” Yanina A. 17 years old, published in *Diario Clarín*. The first time. Oct. 3, 2005, Argentina.

In armed conflict situations, sexual violence is even higher. Rape has been and is used as a weapon of war in order to torture, terrify, humiliate, obtain information from and exercise power over women and girls, as well as with a view to destroying the communities to which they belong. Girls and adolescents who suffer rape in armed conflict situations do not receive adequate medical treatment and have a greater probability of suffering permanent injuries in their genital organs as well as contracting HIV and other STIs. In the genocide of Rwanda in 1994 it is estimated that between 250,000 and 500,000 women and girls were raped. In a study conducted by AVEGA, of the women surveyed who had been victims of rape during the genocide, 67% had contracted HIV⁴⁸.

“I was born in 1973. I was in the 4th year of high school at the time of the genocide. I was raped by several men. They turned me into their sex slave throughout the war. (...) I was a virgin when they raped me. I was young and I had never been with man. Since that sexual slavery, I have never been with another man. It’s been three years since I learned that I have HIV, where do you think I got it from? I was a student, I had a future ahead of me, they took everything from me, killed my family, and gave me death.”

Fragments of the testimony of a rape victim in Rwanda in “The Right to Survive: Sexual Violence, Women and HIV/AIDS”, Françoise Nduwimana, 2004.

II. Trafficking in persons and Sexual Exploitation of Girls and Adolescents

Girls and adolescents who are sexually exploited must not only withstand rapes and degradation from the clients, but also suffer all sorts of abuse on the part of their captors, including sexual violence. Only in recent years has an effort been made to document and make visible the number of girls and adolescents who are kidnapped, deceived, abused, and enslaved with a view to sexually exploit them.

It is estimated that between 100,000 and 200,000 Nepalese women and girls are forced to work in India, the majority of them under 18 years of age⁴⁹. Approximately 10,000 women and girls from neighboring countries work in commercial sex establishments in Thailand. A large number of girls only 13 years old, mainly from Asia and Eastern Europe, are subject to trade as “mail brides for sale.”⁵⁰

“I am Janaina, I was born in Recife, Pernambuco in 1976. When I was little, I suffered much ill-treatment from my mother and her partners. When I was 9, I was “sold” to a woman who became my adoptive mother. My name was Sandra, but she changed my name. She raised me as her domestic worker and when I turned 13 she forced me into prostitution. When I was able to, I ran away to the interior of Pernambuco where I worked as a prostitute. I became pregnant twice. During the second pregnancy they tested me for HIV, and it was positive.” Testimony of Janaina, Pernambuco, Brazil in “Las mujeres no esperamos: Acabemos la violencia contra las mujeres y el VIH/SIDA, YA!” Publication for Latin America and the Caribbean”, FEIM, Gestos, ActionAid, RSMLC, and IAWC, 2007.

Although the intersections between this form of violence and the risk of acquiring HIV in girls and adolescents are undeniable, there are few studies and data that reflect these links. A study of the American Medical Association carried out a follow-up of sexually exploited Nepalese girls, of which 38% turned out to be infected with HIV. From the same group studied, of the 33 girls under 15 who were enslaved and sexually exploited, more than half had contracted HIV⁵¹.

In general, girls and adolescents in a situation of trade and sexual exploitation do not denounce their captors due to the constant threats to them and their families. Furthermore, they rarely have access to health services, which makes them even more vulnerable in the face of HIV/AIDS.

III. Married Girls and Adolescents at Risk of HIV/AIDS

In developing countries, the practice of marriage at an early age continues to be common; 82 million girls in these countries who currently are between 10 and 17 years old will be married before reaching age 18⁵². In many countries, girls and adolescents are forced to get married and then forced by their spouses to have children, often at premature ages, resulting in a risk to their physical and psychological health. In other cases they feel obliged due to poverty, the lack of options, and domestic violence. In Asia and Africa, 50-60% of the girls marry before reaching age 18. In the majority of the countries, adolescent girls (15-19 years old) have at least double the probability of being married as their male peers. In Brazil, the probability for a girl to be married is five times greater, and in Kenya, 21 times greater⁵³.

Married young women and girls face a high risk of HIV infection, have a greater probability of being victims of violence, have less access to information concerning HIV than their unmarried peers and have great difficulty in negotiating the use of condoms within their marital relationship. Furthermore, their spouses tend to be older men, with previous or concurrent sexual partners, and as a result with greater probabilities of being exposed to HIV. According to one study, in Uganda nine out of 10 (88%) HIV-positive women 15-19 years old were married⁵⁴. In Kisumu (Kenya) and Ndola (Zambia) it was confirmed that the levels of HIV infection between sexually active married girls 15-19 years old were 48% and 65% greater, respectively, than among their unmarried peers⁵⁵.

The marriage of girls and adolescents is one more of the many forms of gender-based violence since it is the result of cultural practices supported by the imbalance of power between men and women that result in the violation of their rights and in the increase of their vulnerability to HIV.

IV. Female Genital Mutilation

The practice of female genital mutilation is another factor that contributes to the spread of the HIV and AIDS epidemic among girls and adolescents. According to Amnesty International, “it is estimated that 135 million girls and women have suffered genital mutilation and that each year two million girls run the risk of being mutilated, approximately 6,000 each day.” This practice is carried out in some 28 countries and in general affects younger women and is extremely risky for the sexual, reproductive, and psychological health of the girls and adolescents who are subjected to it. In general, genital mutilation is carried out under unhygienic conditions, using the same instrument for different girls, directly exposing them to various infections that threaten their lives, in particular to HIV/AIDS.

V. Lack of Access to Education: An Additional Form of Violence toward Girls and Adolescents

Violation of the right of girls and adolescents to education because of gender inequality is another form of violence. Worldwide, there are 115 million boys and girls who do not attend school, of which 57% are girls. In Sub-Saharan Africa, 54% of the girls do not complete primary school⁵⁶, and in Southern Asia only 1 of 4 young people aged 15 to 19 have completed their primary studies⁵⁷.

Education is one of the most effective forms of preventing HIV. In Uganda, according to the data of a study, the boys and girls that completed high school had 7 times fewer probabilities of contracting HIV than those non-schooled⁵⁸. Girls and adolescents who remain in school develop skills and acquire knowledge that makes it possible for them to protect themselves and reduce their vulnerability to HIV infection.

VI. Recommendations for HIV/AIDS Policies and Programs

Policies and programmes whose objective is to guarantee universal access to the prevention, care, and treatment of HIV/AIDS should incorporate the fight against violence toward girls and adolescents as a priority through the following actions:

- Design and financing of health services programs for girls and adolescent victims of sexual violence, that incorporate information and counseling about HIV/AIDS.
- Guarantee that girls and adolescent victims of rape, under peaceful or armed conflict conditions, receive the post-exposure prophylaxis to HIV and the emergency hormonal contraception within 72 hours from occurrence of the rape.
- HIV/AIDS prevention programs should incorporate comprehensive sex education from a perspective of human and gender rights. The formula which relies on abstinence, faithfulness, and the use of condoms does not protect those girls and adolescent victims of sexual violence from HIV, as they do not have any choice or possibility to negotiate. Neither is abstinence an option for those girls and adolescents forced to get married and please their spouses.
- Train the personnel of the health services and HIV prevention programs, regarding the intersections between HIV and violence against girls and adolescents, and in particular on topics such as violence during courtship and early marriage.
- Promote the empowerment of girls and young women, through access to education, information on their rights, and inclusion in the prevention programs aimed at their peers.

Endnotes

37 IPPF, UNFPA, Young Positives. Change, Choice and Power: Young Women, Livelihoods and HIV Prevention. Literature review and case study analysis. IPPF, UNFPA, Young Positives; 2007

38 Ibid, 2.

39 UNAIDS. WHO. Situation of the AIDS Epidemic: 2005. Paris:UNAIDS; 2005.

40 Ibid, 2.

41 WHO. Prevention of Child Abuse and Neglect: Making the Links between Human Rights and Public Health. Geneva:World Health Organization; 2001.

42 UNICEF. Las niñas, el VIH y la educación. Nueva York: UNICEF; 2004.

- 43 PAHO/WHO. Discovering the Voices of Adolescents. Definition of Empowerment from the Perspective of Adolescents. WHO; Draft 2006.
- 44 Ibid, 8.
- 45 CEPAL. Not One More: The Right to Live a Life Free of Violence in Latin America and the Caribbean. CEPAL; 2007.
- 46 Human Rights Watch. A Dose of Reality: Women's Rights in the Fight against HIV/AIDS. New York: Human Rights Watch; 2005.
- 47 Downes P. Iniciación Sexual: La mitad de las chicas debuta presionada. Clarín, Oct. 3, 2005. Society Section.
- 48 Global Coalition on Women and AIDS. Sexual Violence in Conflict Settings and the Risk of HIV/AIDS. Global Coalition on Women and AIDS; 2004.
- 49 Action Canada for Population and Development. Trade of Girls. ACPD; 2002.
- 50 Ibid, 14.
- 51 Puente Beresford L. A la "infame esclavitud sexual" de niñas, se suma el VIH/SIDA. Criterios Periodismo Independiente. August 3, 2007. Sect. Salud Sexual.
- 52 UNFPA. Status of the World's Population 2003. Chap. 2, Inequality of Gender and Reproductive Health. UNFPA; 2003.
- 53 Global Coalition on Women and AIDS. Keeping the Promise: Agenda for Action on Women and AIDS. UNAIDS; 2006.
- 54 Ibid, 18.
- 55 Ibid, 19.
- 56 UNAIDS. UNFPA. UNICEF. Women and HIV/AIDS: Confronting the Crisis. UNAIDS. UNFPA. UNICEF; 2004.
- 57 Ibid, 21.
- 58 Ibid, 21.

References

UNAIDS. At The Crossroads: Accelerating Youth Access to HIV/AIDS Interventions. New York: UNAIDS Inter-Agency; 2004.

IPPF, UNFPA, Young Positives. Change, Choice and Power: Young Women, Livelihoods and HIV Prevention. Literature review and case study analysis. IPPF, UNFPA, Young Positives; 2007

Ibid, 2.

UNAIDS. WHO. Situation of the AIDS Epidemic: 2005. Paris: UNAIDS; 2005.

Ibid, 2.

WHO. Prevention of Child Abuse and Neglect: Making the Links between Human Rights and Public Health. Geneva: World Health Organization; 2001.

UNICEF. Las niñas, el VIH y la educación. Nueva York: UNICEF; 2004.

PAHO/WHO. Discovering the Voices of Adolescents. Definition of Empowerment from the Perspective of Adolescents. WHO; Draft 2006.

Ibid, 8.

CEPAL. Not One More: The Right to Live a Life Free of Violence in Latin America and the Caribbean. CEPAL; 2007.

Human Rights Watch. *A Dose of Reality: Women's Rights in the Fight against HIV/AIDS*. New York: Human Rights Watch; 2005.

Downes P. *Iniciación Sexual: La mitad de las chicas debuta presionada*. Clarín, Oct. 3, 2005. Society Section.

Global Coalition on Women and AIDS. *Sexual Violence in Conflict Settings and the Risk of HIV/AIDS*. Global Coalition on Women and AIDS; 2004.

Action Canada for Population and Development. *Trade of Girls*. ACPD; 2002.

Ibid, 14.

Puente Beresford L. *A la "infame esclavitud sexual" de niñas, se suma el VIH/SIDA*. Criterios Periodismo Independiente. August 3, 2007. Sect. Salud Sexual.

UNFPA. *Status of the World's Population 2003*. Chap. 2, *Inequality of Gender and Reproductive Health*. UNFPA; 2003.

Global Coalition on Women and AIDS. *Keeping the Promise: Agenda for Action on Women and AIDS*. UNAIDS; 2006.

Ibid, 18.

Ibid, 19.

UNAIDS. UNFPA. UNICEF. *Women and HIV/AIDS: Confronting the Crisis*. UNAIDS. UNFPA. UNICEF; 2004.

Ibid, 21.

Ibid, 21.

Violence and HIV in Women Deprived of Freedom

Carlos Güida Leskevicius³⁹

I. Women in prison... An Invisible Population

Historically, the majority of the studies and the actions on the imprisoned population have been androcentric, justified by the high percentage of incarcerated men. The female prison population has significantly grown, but studies of their conditions and specific needs have been scarce even though UNAIDS has recognized that prisons constitute an enabling environment for sexual violence and the spread of HIV.⁴⁰ The proportion of women in prison, in comparison with men, is low. In Panama in 2006, the Public Defense Office found that women constituted 6.8% of the total imprisoned population.⁴¹ In Ecuador, women represented 10.2% of the penitentiary population in 2004.⁴² The crime statistics in England in 2000 indicated that 19% of offenders were women.⁴³ In the United States of America (2004), according to the FBI (FBI's Uniform Crime Reporting), women represented 23.2% of total arrests and, in 2003, 20.4% of all women arrested were under 18 years old.⁴⁴

Women also live situations of deprivation of freedom in contexts of armed conflict. In April 1994, Rwanda

Sexual Violence in Prisons (Amnesty International, 2001)

- The rape of female prisoners by prison, security or military staff always constitutes torture. Other forms of sexual violence committed by the staff in charge of enforcing the law may include torture or cruel, inhuman or degrading treatment.
- The acts of sexual violence committed against a prisoner by a security agent, a military person or a policeman cannot be considered "personal" or private acts. Several decisions of international and regional organizations support the argument that rape committed by these staff always constitutes torture, even when committed in the home of the victim.
- According to international standards, sexual violence exercised by some prisoners against others can also constitute torture or mistreatment. Penitentiary authorities have the responsibility of protecting all the prisoners, and the fact of not guaranteeing compliance with standards such as the separation of women and men can constitute acquiescence to sexual violence.
- Practices such as allowing male staff members to search and strip prisoners, and letting male personnel patrol areas where they can see the women in their cells while getting dressed, washing or showering themselves, constitute inhuman and degrading treatment.

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40 UNAIDS. Prison Environments. Available in: <http://www.unaids.org/es/PolicyAndPractice/KeyPopulations/PeoplePrison/default.asp>

41 Anthony, Carmen. Mujeres invisibles: las cárceles femeninas en América Latina (Invisible Women: Female Prisons in Latin America). This article is a true copy of the one published in the journal NUEVA SOCIEDAD No. 208, March-April 2007, ISSN: 0251-3552, <www.nuso.org>. Available in: http://www.nuso.org/upload/articulos/3418_1.pdf

42 Pontón Cevallos, Jenny. Mujeres que cruzaron la línea: vida cotidiana en el encierro (Women who Crossed the Line: Daily Life in Prison). FLACSO-Ecuador. Quito. 2006. Available in: http://www.flacso.org.ec/docs/mujerescruzaron_jponton.pdf

43 Statistics on Women and the Criminal Justice System. A Home Office publication under Section 95 of the Criminal Justice Act 1991. 2001. Available in: <http://www.homeoffice.gov.uk/rds/pdfs/s95women01.pdf>

44 National Criminal Justice Reference Service. Women and Girls in the Criminal Justice System. Available in: <http://www.ncjrs.org/spotlight/wgcjs/Summary.html>

underwent one hundred days of violence aimed at the Tutsi population and the moderate Hutus. Sexual violence against women and girls was a core part of the genocidal strategy. In 1996, the special rapporteur of the UN Human Rights Commission calculated that during the genocide between 250,000 and 500,000 rapes had been committed. Many of the victims were raped in the barricades raised by the young interahamwe militias or were held as sexual prisoners in exchange for temporary protection against the army and the aforementioned militia. The Rwandan Patriotic Army also committed sexual abuses and other acts of violence during its military advance—sometimes as reprisal against the Hutu population—as well as in the months and years after the genocide. Members of the Defense Forces of Rwanda (the current Rwandan army), security forces, and unpaid militia continue to perpetrate acts of sexual violence and force women into marriage. AVEGA, the association that defends the rights of the widows of the genocide, calculates that “almost 70 percent of the women raped during the genocide contracted HIV, and that 80.9 percent of those that survived the violent acts perpetrated during the genocide are still traumatized. Although not all the cases of HIV/AIDS among rape survivors can be attributed to these acts of sexual violence, the massive rapes committed during 1994 contributed significantly to the spread of the virus in Rwanda, as it is believed that these rapes represent a high index of HIV transmission⁴⁵.”

There was a recent case of an adolescent imprisoned for theft in the Abaetuba prison in the state of Pará, Brazil, who was sent to an institution for minors and was forced to share the cell with 20 men, who sexually abused her. Cezar Britto, president of the Lawyers Association of Brazil, declared that this is a nefarious and intolerable crime, unthinkable in modern history, and a serious attack on the Brazilian constitutional system.” According to an article from IPS agency, “this aberrant fact attracted public attention (...) but human rights organizations and members of the government of the Worker’s Party admitted that these types of episodes are common. The governor of Pará recognized that only six of the 132 state prisons have separate wards for women. According to the Ministry of Justice, women make up 5 percent of the prison population and percent of them are in prison for drug trafficking crimes, and 21 percent for theft.”

Source: Article published on 11/22/07 in *El Pais.com*

On the other hand, women who have been victims of violence during their lifetimes are especially vulnerable to deprivation of their freedom and also to HIV, in the face of other socio-cultural and economic factors that reinforce their vulnerability under conditions of imprisonment, for example:

- Migrant women in undocumented status or labor exploitation⁴⁶ and their difficulty to obtain access to HIV screening, prevention and health care as shown in the “European Study on Access to Health Services by People in Undocumented⁴⁷ Status” (2007).
- Women belonging to ethnic minorities, as shown in the study by Teresa Martín Palomo⁴⁸ (2002): “The Gypsy population in Spain is estimated at around 1.4% of the total population, while among the imprisoned population Gypsy women represent 25% of the total of imprisoned women.”
- Sex workers or those in a situation of sexual exploitation (Luciano, D. and Tapia, M. 2005)⁴⁹ and/or participating in networks trafficking in illegal substances.

45 Amnesty International (2004) Rwanda: “Marked for Death.” Rape Survivors Infected with HIV/AIDS. Summary.

46 Human Right Watch Report, “Exported and Exposed Abuses against Sri Lankan Domestic Workers in Saudi Arabia, Kuwait, Lebanon, and the United Arab Emirates.” Vol. 19, No. 16. (2007)

47 European Observatory of Physicians of the World on Access to Health Services.

48 Gipsy Women and the Penal System published in the electronic version of *La Ventana* No. 15 (2002).

49 Luciano, D. and Tapia, M. Consumo de drogas y experiencias de violencia en mujeres dominicanas víctimas del trato de personas. Observatorio Nacional sobre migración y tráfico de mujeres y niñas en República Dominicana (CEAPA – DVCN) (Drug Consumption and Experiences of Violence against Dominican Women Victims of Trade of People. National Observatory on Migration and Trafficking of Women and Girls in the Dominican Republic).

- Women within the framework of armed conflicts.
- Women who use intravenous psychoactive substances.

In countries that have gone through dictatorial periods, or that are undergoing armed conflict or the absence of the rule of law, the violation of the human rights of imprisoned women is a daily reality. Various documents provide accounts of arbitrary detentions, torture, disappearances and even homicide of girls and women under dictatorships. A clear example of specific violence against women is reported in the investigative report entitled “Women Victims of Sexual Violence such as Torture during the Political Repression in Chile. 1973-1990: An Open Secret,” prepared by the Fundación Instituto de la Mujer and Corporación La Morada (2004). The effective rule of law does not necessarily guarantee the rights of women deprived of their freedom, constituting violations of their human rights. In a report of Amnesty International⁵⁰, it is stated that “torture and mistreatment of women under custody are a daily reality. Just between January and September 2000, Amnesty International documented cases in such different countries as Saudi Arabia, Bangladesh, China, Ecuador, Egypt, Spain, the United States, Philippines, France, India, Israel, Kenya, Libya, Nepal, Pakistan, Democratic Republic of the Congo, Russia, Sri Lanka, Sudan, Tajikistan, and Turkey.”

The Regional Plan of HIV/STI for the Health Sector 2006-2015 (PAHO–WHO, 2005) points out that “populations deprived of their freedom constitute a neglected group with regard to public health interventions, despite the fact that the prevalence of HIV among prisoners is very high throughout the Region. In the Caribbean, a series of surveys carried out in 2004-2005 showed that prevalence rates among prisoners ranged between 2% and 4%, while in the Dominican Republic and Argentina the rates were 19% and 18.4%, respectively.” The social and cultural dynamic in societies has changed quite rapidly and it has had an impact on the problems of deprivation of freedom in the different nations (changes in family configurations, legal and illegal migration, forced displacements, influence of the communications media, new criminal modalities such as drug trafficking, etc.).

II. Links of HIV and Violence against Women in Prisons

a. Sexual Violence

There are reports available of women forced to have sex with male prisoners and with those in charge of security in the prisons. The Inter-American Commission on Human Rights accepted a complaint in this regard against policemen who on many occasions sexually abused the prisoners, particularly when accompanying them to hearings of their cases.⁵¹ The exposure to HIV under these conditions is high since the prevalence of HIV in the male population is high. In the U.S., the rates of HIV among prisoners are 8-10 times greater than those of the population in general (Center for AIDS Prevention Studies, 2000).⁵² In Argentina, according to UNAIDS data, prisoners in the principal urban

“Women Deprived of Freedom. Regional Report: Argentina, Bolivia, Chile, Paraguay, Uruguay” (CEJIL, 2007) quotes: “a recent study of the Inter-Institutional Commission of Visits to Prisons reported that women in the Buen Pastor prison are forced to prostitute themselves to the people assigned to them by guards or custodians in the Tacumbú prison. The violence scheme is organized when women go to the Tacumbú prison for marital visits with their partners. In this regard, it was reported that in this penitentiary there is a photo album of women in the Buen Pastor prison. Each month this prostitution ring brings in an average of 300,000,000 Guaranis to the National Penitentiary of Tacumbú.

50 “Broken Bodies, Destroyed Minds. Sexual Violence against Women Deprived of their Freedom. Amnesty International (AI: ACT 40/001/2001/s).

51 Anthony, Carmen. *Mujeres invisibles: las cárceles femeninas en América Latina*. (Invisible Women: Women’s Prisons in Latin America). *Ibid.*

52 Luciano, Diny. Curso “Empoderamiento, VIH y violencia contra las mujeres en América Latina y el Caribe”, Módulo sobre Poblaciones Clave. (“Empowerment, HIV, and Violence against Women in Latin America and the Caribbean” Course, Key Populations Module). Development Connections. Washington, D.C. 2007.

prisons are among the most affected population groups. In 2004 it was found that 17-28% of the prisoners surveyed in the province of Buenos Aires were infected with HIV.⁵³ Sexual violence in the prisons endangers women of all ages, including those that are in prisons for minors (underage). Imprisonment in establishments for minors does not guarantee total reduction of exposure to HIV, as demonstrated in the study entitled “Vulnerabilidade à infecção pelo HIV entre mulheres com alto risco de exposição – menores infratoras e detentas do estado de São Paulo, Brazil” (Strazza, L. et al, 2005).

A report on the Penitentiary Agency of Argentina indicates that women imprisoned in Unit 3 of Ezeiza question the severity of their treatment, which involves, for example, the unjustifiable repetition of humiliating physical searches,

in total undress, during which they are forced to bend down, even older people, a clearly degrading⁵⁴ treatment. In regard to these treatments in Unit 3, 17.9% of the women declared having suffered physical violence, consisting of blows, kicks, pushes, or unwanted sexual contact, either by the personnel or other women⁵⁵. Inspections represent the most violent act of humiliation and disempowerment exercised within the prisons. Other cases were also recorded in Santa Fe, a province of Argentina. In Chile, an aspect of violence and loss of the right to privacy of the imprisoned is that male security officers record the images of naked prisoners after riots or raids in the penitentiaries,⁵⁶ a practice that clearly constitutes sexual violence⁵⁷. In addition to this there is the exchange of sex for drugs, cigarettes, telephone calling cards, or other items.

b. Women are Powerless to Protect Themselves against HIV/STI

The risk situations to which women are exposed in the prisons due to forced sex are exacerbated because they cannot protect themselves as they lack the power to negotiate with the people in charge of security and the male prisoners.

To a great extent imprisoned women also depend on penitentiary authorities to have access to information on HIV and the prevention of other threats to their health and integrity, as well as to protection means such as condoms, needles, and sterile syringes and health services. Even though much has been learned on what produces results with regard to HIV prevention and treatment in prisons, some authorities prefer to turn a blind eye rather than address the challenge of illegal activities taking place in the penitentiaries.

With regard to this vulnerability a United Nations report states: “In addition, many prison populations worldwide struggle to address other health care issues that are related to HIV/AIDS. High levels of mental illness and drug dependency among prisoners are common in many countries. Opportunistic infections (OIs) associated with HIV/AIDS, such as toxoplasmosis, are common in the developing world. Prevention of mother to child transmission (PMTCT) of HIV is important for pregnant women living with HIV/AIDS inside and outside of prisons. Overcrowding, poor conditions of confinement, and inadequate medical services exacerbate negative health impacts and complicate the provision of care by prison health staff. Therefore, efforts to reduce the transmission of HIV in prisons, and to care for those living with HIV/AIDS, must be holistic in approach, and be integrated with broader measures to tackle inadequacies in general prison conditions and health care.”⁵⁸

53 UNAIDS. Fact Sheet 05 06. Latin America. Available in: http://data.unaids.org/pub/GlobalReport/2006/200605-FS_LatinAmerica_es.pdf

54 Cf. Procuración Penitenciaria, op. cit., p. 33. Forty-nine percent of the population declared that relations with inspection personnel are bad. Cf. Public Defense Ministry, Survey of Ezeiza Unit 31, op. cit.

55 Cf. Public Defense Ministry, Survey of Ezeiza Unit 31, op. cit.

56 Cf. Diario Punto Final, Issue 603, April 21, 2006. Report of a “routine” raid carried out on 2 February 2006 in which the female prisoners would have been filmed naked.

57 This is, furthermore, the position of the Inter-American Court on this type of treatment. Cf. Inter-American HR Court, Case of the Penal Miguel Castro Castro, op. cit., par. 306.

58 UNITED NATIONS OFFICE ON DRUGS AND CRIME (Vienna, 2006) HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings. A Framework for an Effective National Response. Co-published with the World Health Organization and the Joint United Nations Programme on HIV/AIDS

c. Sex Work in the Prisons

Sex work can be a common practice in the prisons. Amnesty International points out that women suffer the same violations experienced by men --torture, very bad conditions, corruption, violence among prisoners-- and in addition suffer rapes because they lack protection because they are women: sexual abuse from guards and prisoners, sharing prisons with men, lack of access to maternal health, etc.

d. Institutional Violence and Access to Services for Women Living with HIV/AIDS

Violence against imprisoned women and HIV+ status have several intersections, among which are the lack of access to timely diagnosis with the corresponding tests, access to information and to preventive methods, and to full treatment in time and form. These are measures that should already be in place from a comprehensive health and human rights standpoint: access to emergency contraception and to immediate post-infection medication and a ban on the use of disposable syringes.

With respect to this last point, an article by Gatali and Archibald⁵⁹(2005) *BMC Women's Health* (2005) cite two studies carried out in the Quebec prisons that confirm an increase in the levels of HIV prevalence rates comparing imprisoned women and men (9.8% vs. 3.6% in one study and 7.6% vs. 2.2% in the other), as well as higher rates of intravenous drug use (16% vs. 7.7% and 15.6% vs. 8.5%). Furthermore, both studies found that seropositivity to HIV among prisoners was related to prostitution and contact with an HIV-positive partner, either through sexual contact or through intravenous drug use. More than a decade ago (1994), a pilot program to supply sterile needles to imprisoned women in Hindelbank (Switzerland), proved to be effective in reducing HIV infection and hepatitis B60. Similar initiatives have been implemented in Europe, Africa, and Asia.

Specific violent situations may take place against HIV+ women in prisons, such as threats, punishments and deprivation as constituted by the lack of access to medication in time and form, the absence or the irregularity in para-clinical examinations and transfers to specialized health centers for tests or treatments, as well as exclusion from work and educational programs and marital visits of their partners. Lack of access to timely treatment is a form of institutional violence against the physical and psychological integrity of women.

II. Racial Violence and Access to HIV/AIDS Prevention and Care

The modalities of exclusion and subjugation of women's human rights become synergistic in certain vulnerability contexts. This has been demonstrated in the case of illegal migrants who are carriers of HIV, as substantiated in a report from a prestigious NGO.

“Research carried out by Human Rights Watch on HIV/AIDS care to immigrant people arrested in the United States—which included interviews of both current and past prisoners as well as DHS and detention center staff members, in addition to an independent medical review of the treatment provided—found that detention centers supervised by the Immigration and Customs Control Service (ICE):

- Did not provide consistent complete antiretroviral regimens. This practice leads to the risk of developing resistance to drugs, thus endangering the health of the arrested person and the general public health.
- Did not carry out the necessary monitoring of the clinical condition of arrested people, including CD4 cell counts, viral load and drug resistance tests. These analyses are essential for an effective treatment of HIV/AIDS.
- Did not prescribe prophylactic drugs when medically prescribed to prevent opportunistic infections.
- Did not ensure continuity of medical care when people under arrest were transferred to other centers nor ensured their access to the specialized care they required.
- Did not ensure medical care confidentiality, exposing arrested people to discrimination and harassment.

⁵⁹ Available in the Web page of *BMC Women Health*.

⁶⁰ WHO Report: Prisons and AIDS. Technical Update of UNAIDS. UNAIDS Collection of Best practice (1997).

Addressing the structural, social causes that make girls and women vulnerable and that expose them to violence, to HIV, and to deprivation of freedom should be a priority strategy of governments and the ethical horizon of the interventions.

HIV and Violence against Indigenous Women

Silvia Galán⁶¹

I. HIV Situation and Violence against Indigenous Women

It is estimated that there are between 300 and 500 million indigenous people in more than 70 countries worldwide, who represent a diversity of cultures and languages in all the continents.⁶² According to data from PAHO/WHO, there are approximately 42 million indigenous people living in the Americas, comprising 400 different ethnic groups and 6% of the total population of the American hemisphere and almost 10% of the population of LAC. Eighty per cent live in Central America and the Central Andes (40.2% of the total population in Mexico, Guatemala, and Peru; 59% in Bolivia, and 35.3% in Ecuador).⁶³

Violence against indigenous women

Indigenous women face various forms of violence in the family, the community and their interaction with other populations. These forms of violence are articulated among themselves, creating a continuum of inequality and social vulnerability and, particularly, HIV and other STIs. To date, there are very few studies that have addressed violence against indigenous women. Demographic and health surveys that have included a set of questions on violence in marital relationships and sexual violence in childhood generally do not include the ethnicity category, and the few that do so, do not disaggregate the data on violence according to ethnic group. Even though ethnicity has been identified as an important determinant of social inequality, the availability of data on health and development in the indigenous populations is scarce. In a study carried out in the region of Cuetzalan (Mexico) on domestic violence it was found that of 50 women interviewed 54% indicated they had suffered violence at different stages of their lives; 59% indicated they had suffered it during their childhood from their father, mother, or stepfathers; 44% witnessed violence against their mother, grandmother, or another woman in the household during their childhood; 29% were battered by their fathers-in-law, and 68% by their first or second husband.⁶⁴

Due to the poverty conditions faced by the indigenous communities, many women are inserted in the labor market in jobs that expose them to various forms of violence. In a study conducted in Peru with live-in domestic workers of the Andean region, it was found that they face sexual and psychological violence, and that this situation is associated with their condition of "Being an Andean woman, dressed with indigenous clothing, having Quechua as their mother tongue and not being fluent in the Spanish language"⁶⁵, has been the origin of continuous scorn, insults, humiliations, mockeries, contempt, and degradation."⁶⁶

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62 Foro Permanente sobre cuestiones indígenas de las Naciones Unidas (United Nations Permanent Forum on Indigenous Issues). 2008. The indigenous Populations in their Own Voices. Seventh Session. Available in: <http://www.cinu.org.mx/prensa/especiales/indigenas/index.htm>.

63 Pan American Health Organization. PAHO. Gender, Equity and the Health of Indigenous Women in the Americas: How are they related to ethnicity, gender and health? Information Sheet of the Women, Health, and Development Program. Available in: www.paho.org/generoysalud.

64 Mejía Flores, Susana. Mujer Indígena y Violencia: Entre esencialismos y racismos. Revista México Indígena No. 5. Available in: http://www.cdi.gob.mx/index.php?id_seccion=611.

65 This lack of command of the Spanish language at times was given as the reason by employers to justify not facilitating domestic workers with access to education.

66 Ojeda, Teresa. Domestic Workers Victims of Sexual Violence in Lima, Peru. Development Connections. Washington D.C. Available in: <http://www.dvcn.org/Documents/VSTrDom3.pdf>

In the United States, sexual violence against indigenous women is generalized: these women have a probability of at least 2.5 times higher of being raped or sexually assaulted than women in the United States in general.⁶⁷ On the other hand, indigenous women face forms of violence such as sexual harassment and violence from state agents which have been barely documented, for example, the violence exercised in the border between Nicaragua and Honduras against Miskito women who travel back and forth between the two territories to work the land and/or grow medicinal plants.⁶⁸

The results of the course “Empowerment, HIV and Violence against Indigenous Women” (DVCN, Diakonía, and Family Care International, 2008), reported that in Colombia, “sexual violence against women, in particular from armed groups present in our territories, includes rape, sexual harassment, forced nudity and pregnancy, courtship of girls and women as a war strategy, and contagion of sexually transmitted infections.”⁶⁹ Likewise, the Yanomami of Brazil reported that some soldiers entrenched in their land without their consent, have induced underage young Yanomami into prostitution.⁷⁰

II. HIV in Indigenous Communities

According to Survival International (2007), the HIV epidemic is spreading in the indigenous communities worldwide. For example, in West Papua where there are 312 different tribes, HIV rates are up to 15 times higher than in all of Indonesia. In the tribes of Botswana’s Central Kalahari HIV was practically unknown before the indigenous populations were expelled from their lands by the government. In the New Xade settlement, in 2002, at least 40% of Bushman deaths were due to HIV/AIDS. On the other hand, the Yanomani indigenous population of Brazil has reported that soldiers sited in their lands have brought gonorrhoea and syphilis to their communities through the sexual exploitation of the women of their tribes and fear that this same trend may occur with HIV.⁷¹ In Australia, the probability of indigenous women living with HIV is 18 times higher than among non-indigenous women and 3 times higher than among non-indigenous men. (Wright et al., 2005)⁷²

Definition of Indigenous Population

The International Labor Organization (ILO), in Convention 169 (1989) on Indigenous and Tribal Populations in Independent Countries, defines indigenous population as the people descending from populations that dwelled in a geographical region at the time of the conquest or colonization or of the establishment of current state borders and that conserve their own social, economic, cultural and political institutions, or part of them. Due to the diversity of indigenous populations, no agency of the United Nations system has adopted an official definition of “indigenous population”. On the other hand, the system has prepared a modern interpretation of this term based on the following elements:

- Free identification as member of an indigenous population at a personal level and accepted by the community as a member.
- Strong link with the surrounding territories and natural resources.
- Well-defined social, economic and political systems.
- Differentiated language, culture and beliefs.
- Integral part of groups not predominant in society.

Source: *International Labor Organization (ILO). Agreement on Indigenous and Tribal Populations in Independent Countries. 1989. Full text available at: <http://www.oitchile.cl/pdf/Convenio%20169.pdf>*

67 Amnesty International. Violence against Indigenous Women. 16 November 2007. Available in: <http://www.amnesty.org/es/campaigns/stop-violence-against-women/issues/implementation-existing-laws/indigenous-women>

68 FIMI. 2006. Mairin Iwanka Raya - Indigenous Women Stand against Violence, A Companion Report to the United Nations Secretary-General’s Study on Violence Against Women.

69 Foro Nacional de Mujeres Indígenas. Bogota – September 27, 2006. Available in: onic.org.co/img_upload/.../CONCLUSIONES.doc._FORO_MUJERES.doc. Quoted by: Development Connections, Diakonia and Family Care International. 2008.

70 Survival. Indigenous Women are Especially Vulnerable to Violence. 22 November 2007. Available in: <http://www.servindi.org/archivo/2007/2912>.

71 Survival International. HIV Spreading among Indigenous Communities. 2007. Available in: <http://www.cdcnpin.org/scripts/display/NewsDisplay.asp?NewsNbr=49752>.

72 Wright et al., 2005. Quoted in: FACT SHEET: HIV/AIDS in Australia and the Region. Available in: <http://www.ias2007.org/admin/images/upload/840.pdf>

The analysis carried out by PAHO/WHO (2004) in Guatemala, a country in which more than half the population is of direct Mayan origin, the number of AIDS cases has increased significantly. Both in the southwest, where 60% of the people are Mayan, and along the pacific coast, a region of recent indigenous migration from other areas, as well as in the Army that recruits Mayan soldiers, the problem has significantly worsened (IDEI cited in PAHO 2002, Draft Document). In the case of Suriname, the evidence suggests that sexually transmitted diseases have increased among the maroons and indigenous communities.⁷³

III. Ethnicity and the Links between HIV and Violence against Indigenous Women

The International Forum of Indigenous Women (FIMI)⁷⁴ has indicated that a more in-depth contextual analysis is necessary to uncover the causes of violence against indigenous women; however, the available information is enough to determine the factors that contribute to their vulnerability. In the name of tradition millions of women are subjected to genital mutilation at a young age (highlighted by the high index of women with HIV between the ages of 15 and 24) and to ritual practices of widow cleaning (upon the death of the husband, the widow is subjected to what they call a “cleaning,” forcing her to engage in sexual relations without protection with men that do not belong to their social caste).⁷⁵ With respect to education, in many towns, women are the ones in charge of transmitting the knowledge of traditions, but whenever resources are earmarked to carry out studies, usually the men are selected because traditionally they are the ones that in the future “will establish the extra family relations in the community or outside of it and, thus, they should have the tools that will facilitate that function.”⁷⁶

- Early marriage: Early marriage exposes girls and adolescents to risks to their health, increasing their exposure to HIV and restricting their likelihood of education. The focus of their functions in reproduction and care of the household becomes a barrier to decision-making in the family and the community, regarding their bodies and their sexuality, as well as in their access to work outside the home and to education.
- The household and the community as referential opportunities of belonging and identity: Some indigenous women have difficulties in abandoning their homes in cases of mistreatment or abuse, because for them separation represents threats of violence, uprooting of their habitat, their community⁷⁷, their religious environment and loss of identity. Nevertheless, those that do leave are forced to insert themselves in a context of forced assimilation, with the consequent discrimination and violence that increase the risks of violence and HIV.⁷⁸
- Predominant notions on violence: The concept of VAW has special connotations for indigenous women. Some groups of indigenous women have indicated that violence does not come only from gender discrimination and submission within their family and communities but also from the attitudes and policies that infringe the collective indigenous rights. They identify with the land, which means that degradation of the same is a form of violence against their people and themselves. Women are the ones that protect the health and well-being of the environment in which they live. They are caretakers of the natural environment, the ones in charge of getting the water, preparing the food, preserving the knowledge of medicinal plants and animals, which linked to their religion, integrate their cultural

73 PAHO/WHO 2006. Sexual Health Promotion and VIH-AIDS and STIs Prevention in the Indigenous Populations of the Americas. Available in: <http://www.ops-oms.org/Spanish/AD/FCH/AI/SSIA06.pdf>

74 FIMI. Indigenous Women face Violence. Supplementary Report to the Violence against Women Study of the Secretary General of the United Nations. www.indigenouswomensforum.org

75 Ibid.

76 Coordinator of NGOs of the Cuenca Alta of Río Samalá, Quetzaltenango, 1997. Quoted in Indigenous Women in Latin America: Gender or Ethnic Gaps? Can be consulted in: www.eclac.org/mujer/noticias/noticias/5/279051/FCalfio_LVelasco.pdf

77 The concept of community for many indigenous populations encompasses ancestors, the present and the coming generations as their members.

78 When women cross borders they are exposed to extreme risk situations. They are usually harassed, extorted for money or raped by the customs agents themselves.

identity. For the majority of the indigenous populations water has a spiritual value.⁷⁹ Women in particular identify water scarcity, pollution, and privatization of water resources in the world as a threat, as another form of violence against them.

- Violence, HIV, and poverty: In different regional encounters of women leaders where indigenous women participated, in their conclusions they affirm: “Impoverishment, gender, ethnic, and racial discrimination increase the risks of thousands and thousands of women who do not have access to education and to quality health that incorporates a strategy for the prevention and treatment of HIV/AIDS.”⁸⁰
- Specific situation of young women: Young women are especially vulnerable to forced sexual relations and most frequently live with the virus, which in turn causes an increase in violence for being carriers. This often leads them to conceal it, out of fear, which keeps them from carrying out an adequate treatment or seeking assistance.
- Language barrier and access to information on HIV: Many rural indigenous women are not fluent in Spanish, which is the language of public education, the communications media, and of the courts, constituting yet another barrier to access to the necessary information on the risks of unprotected sex, forms of contagion of HIV, and prevention measures.

In addition to all these aspects that place members of indigenous populations in a vulnerable position, there are rapes, forced prostitution, and enforced servitude to which they are subject during armed conflicts.

VI. Proposals for the Prevention of Violence and HIV for Indigenous Women

There are deficits in enforcing the rights of women in accessing good quality services, work sources, protection against violence, participation and development opportunities. Although progress has been made with regard to recognizing their individual and collective rights, there is still a gap with respect to the participation of indigenous women in the specific policies that allow compliance of their human rights. As violence against women and gender inequality are increasingly documented as determinants of the risk of women to contract HIV, it is clear that the linkages among the different types of VAW, HIV, gender equality and the empowerment of women should be examined and addressed critically if the Millennium Development Goals are to be achieved.⁸¹

The national governments, international organizations, civil society organizations, women’s movements, and grassroots organizations, among others, that work on the issue of violence against women and HIV/AIDS in the region, have the task of addressing these two public health problems, jointly and comprehensively, to slow or stop the perpetuation of VAW, the spread of HIV/AIDS, and the growing double danger that these two dilemmas represent for women and girls in LAC.

The ECLAC Document⁸² suggests policies identified on the basis of the demands of indigenous women, which can be carried out as concrete tasks. Some of these are:

Rights and participation

- Dissemination campaigns of the rights of indigenous women (so that the rights of indigenous women are recognized and international conventions are complied with).

⁷⁹ In the Declaration of Kyoto of Indigenous Populations on Water, paragraph 3, it is stated that the relation of these people with water constitutes the physical, spiritual and cultural basis of their existence and that they assume the role of guardians, with rights and responsibilities, that defend and guarantee the protection, availability, and purity of the water. Third World Forum on Water, Kyoto, Japan, 18 March 2003. Mentioned in the International Forum of Indigenous Women. www.indigenouswomensforum.org.

⁸⁰ Latin American Faculty of Social Sciences (FLACSO), 2003. Regional Encounter of Women Leaders. The Development and Integration Challenges from the Women’s Perspective. 25-26 and 27 April 2003. Available in: www.flasco.or.cr/fileadmin/documento/FLACSO/ARCHIVOS_FLACSO/Encuentro_Mujeres/La_Etnicidad_desde_la_acci_n_Regional_Alta_Hooker.doc

⁸¹ Rojas, Rocio. Health of the Indigenous Populations of the Americas Program. Action Plan 2005-2007. PAHO.

⁸² ECLAC — International Seminar on Indigenous and African Descendent Populations of Latin America and the Caribbean: Importance and Relevance of the Socio-Demographic Information for Policies and Programs. 2005. Available in www.cepal.org.

Economic Promotion and Work

- Training of indigenous women on social security and labor rights;
- Respect the intellectual property of handicrafts;
- Credit establishment (to recognize the inputs of indigenous women to the local and national economy and to support economic and productive initiatives).

Health and the Environment

- Link the knowledge of traditional with western medicine
- Eradication of domestic violence and alcoholism prevention programs
- Sex education
- Promotion of non-transgenic seed planting (for comprehensive intercultural health services, environmental promotion).

Education and Culture

- Bilingual intercultural education
- Adult education
- Academies constituted by indigenous men and women
- Establishment of fellowships and subsidies for indigenous women at all educational levels
- Participatory research and promotion of workshops to strengthen self-esteem (with a view to establishing equal conditions with respect to education, with equal opportunities for indigenous men and women, promotion of the indigenous languages in education, and support for the training of indigenous women).

A major advance in the achievement of the millennium goals was the First International Forum of Indigenous Women “Sharing Progress for New Challenges” that took place from 13 to 16 April 2008 in Lima, Peru.⁸³ The main objective was to create a space where indigenous women could share their perspectives and experiences, in order to develop a dialogue with representatives of international organizations and other social movements and demonstrate solidarity and strength through regional and international activism.

Among its recommendations⁸⁴ on Violence against Women, Reproductive Sexual Health, and HIV/AIDS Prevention, we can highlight the following:

- Improve the opportunities of girls, adolescents, and indigenous women and reduce the vulnerability of maternal morbidity and mortality through the delay of marriage, reduction of early pregnancy, and increase of educational levels.
- Carry out actions in order to eradicate violence against women at all levels and in all forms, promoting a long-term cultural change and involving various sectors.
- Include violence against women as a violation of human rights, and recognizing loss of the land, identity, and language as forms of violence.
- Implement prevention measures for violence against women within their communities and take measures to include the rights of indigenous women in the indigenous justice systems.
- Work with great urgency in the prevention of HIV, implement rapid detection services in rural areas, and carry out research on the status of the disease in indigenous communities.
- Integrate traditional medicine and western medicine in health clinics and health services, staff the same with indigenous and bilingual personnel, and recognize the value of midwives in the reproductive process, prenatal check-ups, childbirth, and puerperium.
- Promote the participation of indigenous organizations and women in particular, in community, regional, and national monitoring of the quality of the health services.

⁸³ The organizations that sponsored this event were the International Forum of Indigenous Women (FIMI); the Coordination of the Continental Link of Indigenous Women, South America Region, the Network of Indigenous Women of Mexico, Central America, and the Link Mexico and Chirapag, the host organization.

⁸⁴ The Recommendations and Declaration of the International Forum of Indigenous Women are available in http://www.mujireshoy.com/secc_n/3927.shtml.

HIV/AIDS and Violence: Implications for Older Women

*Liliana Bilevich de Gastrón*⁸⁵

The ties between violence against women (VAW) and HIV have been documented by various organizations at the international level, placing special emphasis on girls, youth, and women of childbearing age. The forms in which both problems are related in the case of older people has been addressed in a few studies, such as in the study by Alica Pográn yivá (2006 “El Sida y las personas mayores” (AIDS and the Older People) which analyzes three levels of intersection: a) older people living with HIV/AIDS, b) those who care for people living with HIV/AIDS (PLHA); and c) those who care for grandchildren who are orphans because of AIDS.

I. HIV and VAW: Between the Stigma and the Silence

a. Older People and HIV

The age of PWLHA is rising. At the end of 2007 it was estimated that there were more than 33.2 million PWLHA in the world and it is possible that there are more than 27 million people who are not aware that they are infected (UNAIDS/WHO, 2007). In the United States, some 78,000 people age 50 or older live with the virus, representing between 10% and 15% of all cases. In some cities, between 15% and 25% of PLHA are age 50 or older (Infonet, 2008). Around 50% of older persons living with HIV were infected one year ago or less. Many people disagree with the definition of “older person” as anyone over the age of 50. However, it is common to use age 50 for statistical purposes when dealing with “older persons” with HIV (Infonet, 2008).

According to HelpAge (2007), the information on HIV rates in people over 50 years old is limited since the international data concentrates only in people who are between 15 and 49 years old. However, where it is available, the information suggests that people older than 50 years are at risk of transmission. In Uganda, (HelpAge, 2001, 2003, 2004) 4.6% of the people who used the voluntary services for testing and care (VCT) between 1992 and 2002 were people older than 50 years. Of these, one of every five was HIV-positive (24% women and 18% men). A study in South Africa showed that the HIV rates for people older than 50 were 12% for men and 15% for women.

The HelpAge International program in Ethiopia found that of 45 older persons who used the VCT services between September 2002 and August 2003, 22 were HIV-positive. A study carried out in a VCT center in Addis Ababa showed that 2.3% of those examined were older than 50 years and that 39% of them were HIV-positive (HelpAge International, 2007). In Chiang Mai, Thailand, it is estimated that approximately 5% of PLWHA are older than 50 years; in the province of Yunan, China, it is estimated that this figure is 7% (HelpAge International, 2007).

In the United States, 10% of new AIDS cases present in people over 60 years of age (UN, 2002) and in Western Europe new AIDS cases occur in people older than 50 years. The figures fall to 4.3% in Central Europe and to 0.7% in Eastern Europe (UN, 2002). In recent years, new cases of HIV/AIDS worldwide among older people increased 40% (UN, 2002).

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In Spain there are currently 66,334 recorded cases of AIDS and of this number 6.9% are people older than 50 years (INE, 2004). According to the experts, sexually transmitted infections are increasing among women of median age (Tabnak & Sun, 2000). In Argentina, those older than 50 years constitute 10% of total male AIDS patients, and 5% of the female patients. The epidemiological report of the city of Buenos Aires (Ministry of Health of GCBA, 2008) informs that in the last year people over the age of 50 comprised 12% of the diagnoses (254) and adolescents comprised another 13.1%, thus it recommended looking at these age bands as separate groups in order to design specific strategies, even though the data does not report on gender matters.

Why is HIV/AIDS increasing among older people, despite the relative stability and even the decline, in some areas, of the epidemic? As pointed out, postmenopausal women are not included in safe sex messages, and they are erroneously considered low-risk. Physicians at the Radcliffe Hospital in Oxford note that older people are actually more susceptible to sexually transmitted diseases, including HIV (Mahar & Sherrard, 2005).

There are various reasons, among which “ageism” is no small issue. This term is used to refer to a set of stereotypes and prejudices against older persons. A common myth or misconception is that this life stage is asexual, as if at a certain age a person can no longer engage in sexual relations, and at the same time, as if age were a protective factor against violence, including that which takes place within couples. These prejudices are also found among health workers, especially with respect to women. These prevalent perceptions that disconnect old age from sexual activity have serious implications when addressing the intersections between HIV and VAW:

- Health providers do not explore the possibilities of HIV transmission in older persons. Routine examinations do not include inquiring about their sexual activity, sexual behaviors or risk situations (homosexuality, heterosexuality), nor about drug use, or experiences of violence; this hinders prevention and/or detection of cases.
- Many older persons become single again due to divorce or widowhood. While they were in a couple, they did not pay attention to messages on HIV prevention. For older women—more widowed and divorced than men in demographic terms—it is more difficult to find a new, stable partner and, therefore, they do not protect themselves during occasional sex relations.
- Lack of preventive information aimed at older persons since the conventional wisdom is that HIV and violence affect only young women or women of childbearing age.
- Lack of information on how to protect themselves when engaging in sexual relations and against violence.
- Sharing needles with infected people (produces approximately 17% of the infections in people older than 50)
- Unprotected sexual relations, both heterosexual and homosexual. The use of Viagra and other drugs that help men achieve and maintain an erection contributes to a greater index of sexual relations and of contagion of sexually transmitted diseases. In order to improve their performance, older men tend to resort to certain dangerous practices such as the non-use of condoms in their extramarital relations, thus placing their stable partners at risk.
- Among older people the contraception relation makes them think that, after menopause, they do not need protection since there is no longer a risk of pregnancy.
- The sexual needs of older people are not recognized, and especially in the elderly, thus there are social barriers to the discussion of their sexuality, sexual violence; consequently, there are few effective strategies for this population group.

b. Biological Considerations

Older people pose a risk higher than that of other ages because their age decreases the efficiency of their immune system. The female population of this age is in an especially vulnerable situation, since they do not know the importance of measures such as condom use, associating it to birth control. This situation is mag-

nified due to anatomic-physiological factors such as the friability of the mucous membranes in postmenopausal women (Mariñansky, 2007). These women seem to present a greater degree of incidence than men since, in the last five years, the new female cases of HIV/AIDS increased by 40%. But this datum does not indicate at what age they were infected. Many of them could have been carriers of the virus during many years before it was detected. At the time it was diagnosed, the disease may have been in the most advanced stages (Mariñansky, 2007). On the other hand, estrogen deficiency makes the vaginal tissue and the cervix more fragile, which can result in injuries that lead to greater susceptibility to HIV transmission (Mahar & Sherrard, 2005). Relevant situations have been observed in this population to analyze the intersections between HIV and violence, such as:

- Late diagnosis and therefore the antiretroviral therapy is started when the disease is already in an advance stage.
- High prevalence of sexual transmission and transmission of unknown origin.
- Progression from infection stage to disease stage in a relatively short period of time.
- High frequency of opportunistic infections.
- Within this group, consideration should be given to the importance of co-morbidity, drug interactions, and poly-pharmacy.
- High mortality in the first month after the diagnosis and low survival rate after four years can also be cited.

Symptoms of the infection tend to be nonspecific, such as fatigue, anorexia, weight loss, lower physical activity and deficient cognitive function. Opportunistic infections present in these patients tend to be: Pneumocystis Carini pneumonia, tuberculosis, Mycobacterium avium complex, zoster herpes and cytomegalovirus. Certain dementia characteristics induced by the HIV may not distinguish it from Alzheimer's disease. With regard to its association with tumors, we can mention Kaposi's sarcoma, lymphomas, multiple myeloma, and solid neoplasms. There are also hematological disorders accompanied by thrombocytopenia or pancytopenia.

c. Violence against Older People

Older people, according to the European Council (FNG, 2000) suffer several types of violence. In this regard, we can point out that older people suffer from:

- Active negligence by the health care services due to ageism behaviors on the part of health professionals.
- Passive negligence due to the lack of information concerning the need to use protective measures in their sexual relations and against violence.
- Physical/conjugal violence on the part of their sick partners who force them to engage in sexual relations even against their will.
- Emotional violence by being forced to take care of their sick children, often terminally ill, based on social mandates linked to the "care provider gender."
- Violence through the loss of their rights when they are forced to assume responsibility for sick children and orphaned grandchildren, based on cultural mandates, without any kind of social or community assistance, and even without having received any training and information regarding the care tasks they have to perform.
- Economic violence whenever they are expected to assume responsibility for their treatment needs and medications using their own savings or their small pensions, if any.
- Economic violence and loss of their rights when they have to abandon their jobs to respond to the demands of their sick children and their orphaned grandchildren, without any type of compensation.

Given the cumulative and interactive nature of the different forms of VAW, its effects can be particularly documented among older persons, something that has not been done up to now.

III. Older Persons as Caregivers of the Sick and Orphaned as a result of HIV/AIDS

Deficiencies in the response of the government and the community to the family sequelae leads to a socially institutionalized modality of violence that places the responsibility for the care of patients and orphans on older persons, despite the personal impact and the risks to episodes of violence in the care and treatment tasks this implies.

Research projects undertaken in Sub-Saharan African countries point out the following (HelpAge International, 2001, 2003 and 2004):

- 90% of the care of PLWHA is given in the households, usually by elderly women.
- Up to two thirds of PLWHA are cared for by their parents, usually their mothers, who are between 60 and 70 years old.
- More than 60% of orphaned boys and girls in highly affected countries live in households headed by grandmothers.
- In Thailand, more than 64,000 people over the age of 50 lost one or more adult sons or daughters to HIV/AIDS in 2001.
- Nine out of ten orphaned children live with the extended family.
- More than 60% of orphaned boys and girls live in households headed by the grandfather or the grandmother in Namibia, South Africa and Zimbabwe; in Botswana, Malawi, and Tanzania, they account for more than 50%.
- Less than 1% of the households are headed by boys or girls.
- Households headed by older women have double the probability of including orphans than those headed by older men.

Due to the high prevalence of VAW, women who live with HIV suffer the violence sequelae that take place before and after a positive HIV diagnosis. Several studies have shown that women exposed to violence seek assistance from family members and friends and only seldom from formal health care systems, thus, older people become the main caregivers of women living with HIV who, in addition, have suffered violence before and after the positive diagnosis of the virus.

According to data from the United States (CNISM, 2007), the majority of grandparents who raise their grandchildren are between 55 and 64 years old and almost 25 percent are over 65 years old. Furthermore, grandparents who raise their grandchildren today, whose number is increasing, have much more probability to be female, people of color, and living in poverty. The 2000 Census of this country reported that 4.5 million children live in households headed by grandparents (a 30 percent increase since 1990). In accordance with the Association of Retirees of the United States (CNISM, 2007), one reason for this is because one of the parents is living with HIV/AIDS.

Grandmothers responsible for caring or raising grandchildren suffer more stress and depression than grandmothers without those obligations. These are elderly who may have their own health needs. Thus, taking care of a grandchild who may have health problems, development problems, or a greater need for care causes more stress to these grandmothers. The age of the grandchildren can also be a factor. Younger children require more physical effort, but grandparents often have to spend more mental and emotional energy on the older children. One report (WHO, 2002) reveals the suffering of older persons who deal with their HIV-infected adult children or with their orphaned grandchildren. The monograph that served as the basis for this report was carried out in Zimbabwe. It emphasizes that elderly people face an additional stigma when caring for orphans and PLWHA.

Older people, usually women, are practically left to assume, on their own, the important role of caring and helping their terminally sick adult children and, when they die, to raise the orphans. They do it with meager means, without recognition, and often with poor health. Their contribution is essential in the general context

of improving access to the care and assistance to HIV/AIDS patients but society is usually not aware of it. HIV/AIDS has a devastating effect in economic, social, and psychological terms. It should be noted that the elderly are burdened with providing care and treatment of patients without really knowing how to perform that role, since often they are people with functional illiteracy, without training for the task and, in addition, unaware of the risk of being infected themselves with the virus.

It should be noted that older persons are under risk of infection. However, they are completely ignored by the HIV programs of the health services. This case of active negligence is one of the types of violence against older people, and is precisely exercised by the health authorities.

The report recommends that the function as caregivers performed by older people be recognized and supported. It points out that if the caregivers do not enjoy good health they cannot continue to provide the necessary care. A change in the attitude of health workers and other service providers is necessary, as well as a change in the health policies and in other institutions in order to ensure that elderly people have adequate social, economic, and emotional assistance.

A study was conducted in 2001 in six of the 10 provinces of Zimbabwe. Mixed qualitative and quantitative research methodologies were used to survey 685 elderly people who provided HIV-related care, of whom 40% were urban

families and 60% rural families; two thirds of all the caregivers were women. The main findings of the research were the following:

- Loss of economic assistance because they no longer receive the contributions of their sick or dead adult relatives;
- Lack of access to essential products and services, such as food, clothing, and medical care;
- Limited access to health care services, due to lack of transportation and the high cost of the services;
- Economic hardship that prevents them from being able to pay medical or school expenditures;

The stigmatization and negative attitudes from health agents with respect to elderly people, and people with HIV; Physical and emotional stress derived from the growing levels of violence and mistreatment, often accompanied by accusations of witchcraft.

In addition, the study recognized that in most societies older people are a vulnerable group, because of their life of suffering, malnutrition, and poverty, and because at their age they run a high risk of suffering chronic diseases. The AIDS pandemic imposes one more burden on them, increasing their vulnerability.

In a study carried out in the village of Kagabiro (Tanzania), it was shown that when there was a member with HIV/AIDS in a family, 29% of the domestic work corresponded to tasks related to that disease. In two-thirds of the cases, two women were charged with providing patient care duties and, on average, total job loss for these families was 43% (HelpAge International, 2004).

Research has established that up to 90% of the assistance allocated to the disease is provided in the household. The vast majority of the women and girls who carry the burden of HIV/AIDS care, do so with very little material or emotional support. They do not receive training or conventional materials such as gloves, medication, or food, and they do not have means to pay school enrollment fees for the children. The combination of the physical and psychological burden of caring for sick members of the family—including the orphans and other family members who are affected by the disease—in their attempts at ensuring an adequate supply of food and medications, paying the school enrollment fees for the children, and replacing the lost income, often forces women to disregard their own health and well-being.

Considering that increasingly a larger number of working age people become ill and die because of HIV/

AIDS-related diseases, the loss of family income forces older women to go back to work. At their advanced age, these women frequently become the only people who take care of and sustain their adult children and orphaned grandchildren.

Young adults and adolescents are forced to sacrifice their education in order to help take care of the family and face few prospects of obtaining a decent job. For example, it has been reported that in Swaziland school enrollment has declined by 36% because of HIV/AIDS and such enrollment reduction primarily affects girls.

The growing impact of the epidemic has highlighted the fact that HIV/AIDS home care needs to be expanded beyond support for the HIV-infected person to include support for their family and family members. Home care programs have stopped limiting their approach exclusively to medical and nursing care and now include technical assistance, food assistance, social services support, and school enrollments for the orphans and income generation for the widows.

Some programs have successfully achieved the involvement of men and have demonstrated that working with them helps change traditional cultural attitudes and beliefs concerning gender-based differentiated roles, something essential in reversing the course of the epidemic. The care of adult children and orphaned grandchildren is a financial, social, and emotional burden to older persons, pushing them more and more into poverty.

In some countries, community support programs are being developed by civil society associations or municipal governments, but these are still insufficient. At this time the focus should be on increasing awareness, disseminating data and information so that governmental entities and relevant organizations assume their responsibilities and involvement.

References

Aidsinfont.org, 2008, Older Persons and HIV, InfoRed, Fact Sheet No. 616 in: http://www.aidsinfont.org/factsheet_detail.php?fsnumber=616&newLang=es

Le Breton D., 1985, Corps et Sociétés, Librairie des Méridiens, Paris.

Worldcom Foundation, 2007, Women's bodies are a battlefield, in <http://www.worldcom.org>: 80/
UNAIDS/UNPFA/UNIFEM, 2004, Women and HIV/AIDS: Confronting the Crisis, New York, in <http://www.unfpa.org/women>

Pogrányivá A., 2006, El SIDA y las personas mayores/AIDS and the Elderly, in Gerokomos, 17, 2, Madrid.

07 AIDS Epidemic Update, 2007, UNAIDS/WHO, Geneva, in:
http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

HelpAge International, 2007, El impacto del VIH/SIDA para las personas mayores (The impact of HIV/AIDS on the Elderly), Working Document.

HelpAge International, 2001, Informe VIH/SIDA: por qué las estrategias deben incluir a las personas mayores (HIV/AIDS Report: Why strategies should include the elderly), Tercera Edad y Desarrollo 8, pp. 6-7.

HelpAge International, 2001, Pobreza y VIH en Tailandia (Poverty and HIV in Thailand), Op. cit., p. 4.

HelpAge International, 2003, Paul, G., Cómo afecta el VIH/SIDA a las personas mayores (How HIV/AIDS affects the elderly), in Horizontes 61, VIH/SIDA y personas mayores, pp. 4-5.

HelpAge International, 2003, How to reduce the stigma, according to the Training Manual on Ageing in Africa, in Op. cit., p. 10.

HelpAge International, 2004, Monasch R. & Clark F. Creciente rol de abuelos como cuidadores (Growing role of grandparents as caregivers), in Tercera Edad y Desarrollo 16, VIH/SIDA, ¿Quiénes los cuidan? pp. 6-7.

HelpAge International, 2004, Clark F. Los last in the line of the treatment?, in Op. cit., p. 9.
INE, 2004, Instituto Nacional de Estadísticas de España, Statistical Yearbook.

Tabnak, F. & Sun R., 2000, Needs of HIV/AIDS Early Identification and Preventive Measures among Middle-Aged and Elderly Women, American Journal of Public Health 288, 90, 2.

Ministry of health GCBA, 2008, (Situación Epidemiológica del VIH/SIDA en la Ciudad de Buenos Aires (Epidemiological Situation of HIV/AIDS in the city of Buenos Aires).

Mahar F. & Sherrard J., 2005, Sexually transmitted infections in Sexual Health and The Menopause, The Royal Society of Medicine Press, London.

Mariñansky C., 2007, HIV en el adulto mayor (HIV in the elderly), Medical Anthropology, Teaching Career, Medical School, University of Buenos Aires, (mimeo).

UN, 2002, United Nations, II World Assembly on Aging, Madrid (Dissemination documents).

CNISM (National Information Center on Women's Health), 2007, Envejecer bien, vivir bien, in <http://www.4women.gov/espanol/mayores/index.cfm?style=large>

WHO, 2002, Impact of AIDS in the elderly of Africa, Geneva.

UNAIDS, De Santis, D. Documentos de antecedentes: Atención, mujer y SIDA (Background documents: Care, women, and AIDS) in http://data.unaids.org/GCWA/GCWA_BG_care_es.pdf

FNG, (Fondation Nationale de Gérontologie), 2000, La Maltraitance, Gérontologie et Société, 92, Paris.

Section III **Context and priorities**



WORLD MIGRATION AND ITS IMPACT ON HIV AND VIOLENCE AGAINST WOMEN

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I. Migration within the Current Context

Today the migration phenomenon is regarded as a decisive global factor of the 21st century. At no other time in history have there been so many immigrants, as it is estimated that approximately 192 million people (3% of the world's population) currently live outside their country of origin⁸⁷. The demographic and economic dimensions of the migration phenomenon are multiple. It is estimated that in 2006 the flow of remittances exceeded US\$276 billion worldwide, of which US\$206 billion was sent to developing countries. At the same time, there are between 30 and 40 million undocumented immigrants, representing between 15 and 20 percent of the world's immigrant population.⁸⁸

Although most migrations are associated with the search for new economic opportunities, there are also migrations caused by persecution, violation of human rights, conflicts, and wars. According to recent data of the Office of the High Commissioner of the UN for Refugees, there has been an alarming increase in the number of refugees worldwide. In 2007, 26 million people were displaced by internal conflicts in at least 52 countries, compared with 24.5 million the previous year. The number of refugees at the global level reached 11.4 million people in 2007, compared with 9.9 million in 2006⁸⁹.

One would think that rich countries such as those in Europe would constitute the main destination of these refugees; however, the available data indicates that there is a greater index of refugees in the developing countries, and the fact is that the most developed countries are increasingly studying and applying new ways to control the influx of refugees and immigrants.

Overall, although migrations may be seen as a constant evolutionary process, a source of enrichment for the nations, and an invaluable contribution to development, they are also marked by inequality, discrimination, and exploitation, as well as the proliferation of groups on the fringes of the law, specializing in illegal trafficking of people, and subjecting their victims to the worse abuses.

Currently in many countries, immigrants have become a synonym of social degradation, usually accused for the increase in crime indices and the decrease in economic indices. Thoraya Obaid, Executive Director of the United Nations Population Fund (UNFPA), has stated that despite the efforts of international organizations and NGOs, "the rights of immigrants continue to be violated."⁹⁰ For example, in the United States since 2004, there have been 62 deaths of immigrants—many of them undocumented—who were held in immigration service and customs centers, for lack of the medical treatment they needed.⁹¹ One of the cases was a Nicaraguan immigrant living with HIV, and even though his family alerted the immigration service of his

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⁸⁷ "Global Estimates of the United Nations" Report on Immigration Trends. United Nations. New York. 2005.

⁸⁸ World economy prospects. The World Bank. Washington, D.C., 2006.

⁸⁹ Norwegian Council on Refugees. Global Displacement and Development Trends. Norway, 2005.

⁹⁰ Proceedings of the sessions of the World Congress on Human Movements and Immigration, A challenge for the 21st century. Barcelona. 2004.

⁹¹ Centro de Medios Independientes. 2008. <http://argentina.indymedia.org/news/2007/07/532885.php>

condition and his need for antiretroviral drugs, the detention center denied him a supply of the same, and soon after he died.

The American Civil Liberties Union (ACLU), the largest organization that defends civil rights in the country, states that arrest conditions of immigrants have raised numerous complaints in recent months, after United States authorities increased the number of raids to arrest undocumented persons in response to strong political pressure to address illegal immigration. In 2007 Hispanic and human rights defense organizations, among them Amnesty International (AI), protested in front of the Hutto (southern Texas) detention center where undocumented persons were held to denounce the arrest of undocumented children and to demand the closing of the prison⁹².

Acts of aggression against immigrants have also been reported in Europe. In Madrid, Spain, two videos were published in April 2008 of Metro guards striking Latin American immigrants without any reason, shouting insults at them and laughing while they assaulted them. Meanwhile, the 27 governments constituting the European Union (EU), on May 15, 2008, approved a law in Brussels ordering the deportation of all undocumented immigrants. This means that in the next few months nearly 8 million undocumented immigrants will be expelled from the entire European Union.

In Africa, the history of abuse related to migration is not different. The continuous civil war in Sudan has displaced 4 million people fleeing from the conflict; some seek refuge in other cities within the country, and others migrate to Ethiopia, Kenya, Uganda, and Egypt. The heartbreaking part is that when they arrive in the refugee camps where they hope to find safety, they often meet worse abuses than those of the conflict they left behind. The most serious cases are reflected in the denunciations of sexual abuse of children by international peacekeepers and relief workers. A report of the British organization Save the Children, based on research in Sudan, Ivory Coast, and Haiti, indicated that more than half of the children interviewed knew about cases of statutory rape and groping and that in many cases those children knew of another 10 or more incidents of that type perpetrated by philanthropic organization employees or United Nations soldiers. The report also details many types of sexual abuse such as food exchanges for sexual relations, lascivious kisses, forced prostitution, and the use of minors for pornographic purposes. The threat of reprisals, and the stigma sexual abuse implies were the reasons for not denouncing these facts⁹³. These denunciations demonstrate the vulnerability to which immigrants and refugees are exposed, even by people who are supposed to protect them.

Asian immigrants are also victims of abuses and mistreatment. In Saudi Arabia, where immigrant workers from Southeast Asia (Bangladesh, India, Pakistan, Sri Lanka, and Nepal) contribute to most of the development of the country and the Persian Gulf area, the discrimination, exploitation, and lack of governmental protection they suffer are daily occurrences.

II. Interrelationships among HIV, VAW, and Migrations

Women constitute 49.6% of the world's immigrants, according to the UN report of 2005.⁹⁴ They usually face double discrimination: as immigrants and as women. According to Esohe Agathise, of the Coalition against Trade of Women, "Usually, they are incorporated in the services sector (domestic service, care of elderly people, etc.), and this makes them more vulnerable because they do not have social coverage and are often held in their place of work. Another high percentage of women are victims of human trafficking and are exposed to mistreatment and sexual exploitation."⁹⁵

92 Centro de Medios Independientes. 2008. <http://argentina.indymedia.org/news/2007/07/532885.php>

93 The Associated Press. Report of sexual abuse of children by relief workers, by Edith Lederer. 2008. http://www.elnuevoheraldo.com/articulos/abuso_21093____article.html/naciones_unidas.html

94 "Global Estimates of the United Nations." Report on Immigration Trends. United Nations. New York. 2005

95 Proceedings of the sessions of the World Congress on Human Movements and Immigration, A challenge for the 21st century. Barcelona. 2004.

The vulnerability of immigrant women exposes them to multiple physical and psychological abuses and mistreatment; moreover, they are at a higher risk of contracting HIV or of being discriminated against if they are already HIV-positive. The risks to which immigrant women are exposed, associated with the link between VAW and HIV, are reflected in the sexual trade and exploitation (prostitution), in the refugee camps where the strong take advantage of the circumstances, in the prisons of immigration services where immigrants are discriminated against and their needs are ignored, in border crossings where the traffickers take advantage of the desire of women to seek a better life, in the workplaces where the bosses sexually harass immigrant employees, threatening them with deportation, and in their relations with citizens of the destination countries, where women become victims of violence in exchange for obtaining their legal status.

a. Trafficking in persons, Sexual Exploitation of Immigrant Women

Trafficking in persons is the slavery of the modern era. According to the United States State Department,⁹⁶ it is estimated that between 600,000 to 800,000 people, for the most part women and children, are victims each year. The International Organization for Migration defines the trafficking of women as any transportation or illegal displacement of immigrant women and their subsequent trading for economic or personal activities, such as sexual exploitation.

Among the related causes on the supply side of people who can be trafficked, particularly in Latin America and the Caribbean, are poverty, better standards of living in other places, weak social and economic structures, lack of employment opportunities, organized crime, violence against women, governmental corruption, and political instability. The spread of HIV/AIDS and other diseases and the trafficking of people also represent concerns for public health.

Due to the conditions of seclusion and isolation, financial control, debt slavery, violence, and drug and alcohol use to which sexual trafficking victims are subjected, their capacity to negotiate protected sex is invalidated. Forced sex causes women to lose control of their lives, their health, and their sexuality, thus making them one of the most vulnerable populations to contract HIV. These are women who often do not know when they acquired HIV due to the lack of access to prevention and care services, and by not receiving adequate treatment in time, their disease advances to the point of death and the virus continues to be spread.

The United States State Department classifies countries in 3 categories according to their record against trafficking in people: category 1 includes countries that have better laws and programs to combat this scourge and in category 3 are those countries that have the least regulation to control it.

In Latin America and the Caribbean, the following countries are in category 2 and in line for continuous investigation (a list of the countries that will continue to be investigated by the State Department): Argentina, Costa Rica, Dominican Republic, Guatemala, Guyana, Panama, and Venezuela.

Within the region, Belize, Brazil, Chile, Colombia, Costa Rica, Ecuador, Guyana, Honduras, Jamaica, Peru, Nicaragua, and Venezuela show primarily internal trafficking, although some also serve as suppliers for the trade—mainly of women and girls—to the United States and Western Europe for sexual exploitation.

The Dominican Republic, El Salvador, Guatemala, Mexico, and Paraguay are the principal suppliers to other countries in the region. The corruption of these governments limits the fight against illegal trafficking in people; for example, in September 2003 it was discovered that a Congressman was one of the principal traffickers of people in the Dominican Republic.⁹⁷

⁹⁶ State Department of the United States. Facts and Data on Human Trade. Washington, D.C. 2004-2008.

⁹⁷ Department of the State of the United States. Report On the Trade of People. 2004. <http://www.state.gov/g/tip/>

In other regions, the data are alarming⁹⁸. In the case of Japan, in recent years the profits from the sex industry total approximately 4.2 trillion Yen per year. In Poland, the police estimate that for each Polish woman delivered, the trader receives some 700 dollars. In Australia, the Federal Police estimate that the profits generated by 200 prostitutes can amount to US\$900,000 per week. The delivery of a Ukrainian or Russian woman—both highly valued in the sex market—represents a profit of between US\$500 and US\$1,000 for the criminal organization that trafficks them. It is estimated that each woman serves an average of 15 clients per day, thus earning approximately US\$215,000 per month for the criminal organization.

It is estimated that in recent years several million women and girls have been trafficked within and from Asia and the former Soviet Union, two of the principal trafficking areas. Trafficking increase in both areas is related to the poverty conditions affecting women themselves or their homes or parents, who sell them to intermediaries. With the implementation of market policies, unemployment rates among women in Armenia, Russia, Bulgaria, and Croatia reached 70% and in Ukraine 80%.

b. HIV/AIDS and VAW in Refugee Camps

The trauma of war, violence, and persecution, followed by exile, are usually the fate of refugees. And the pain of those exiled is still greater in the regions of the world most affected by HIV. Refugees are often accused of spreading HIV and are in addition excluded from large programs that help in the treatment of this disease. The reality of the interaction between HIV and refugees is more complex than what is believed. Recent studies⁹⁹ have found that there are no statistics that demonstrate that the conflicts in and of themselves increase the indices of HIV within the population. The risks are associated with:

- Prevalence of cases in the country of origin of the refugees
- Prevalence of cases in the destination country
- Prevalence of cases in communities around the camps
- Degree of interaction between the bordering communities and the refugees.

This is the case of the refugees in the north of Uganda in Africa, where the prevalence of HIV has declined. Paul Spiegel, of the Office of the United Nations for Refugees¹⁰⁰, states that “in the majority of the cases the refugees do not bring in HIV to the destination countries, however, they can bring higher indices of HIV to their countries of origin if there was a high prevalence of cases in the communities bordering the camp where they sought refuge and the interaction of the refugees with these communities was high.”

Also, in the camps refugees receive HIV/AIDS education and prevention in addition to medical care. For example, in the camps in Kenya, refugees are well informed concerning the disease, in contrast with the population in the south of Sudan (from where the majority of the refugees come) where less than 10% of the

Factors Associated with the Vulnerability of Women during Natural Disasters

- a) Women have less access to resources (essential in disaster preparedness and mitigation and subsequent rehabilitation).
- b) The division of labor by gender (women tend to be over-represented in the agricultural sector, in independent and informal work, and also among the unemployed)
- c) Lack of possibilities of migrating and to look for work, because they are responsible for the care of children, the elderly and the disabled.
- d) Relocation in refugee camps hinders the execution of their housework activities, preventing them from looking for other sources of income.
- e) Once women lose their economic resources, their bargaining position at home is impaired.
- f) Women do not receive adequate care for their sexual and reproductive health during relief efforts following a disaster. (6)

98 Cotidiano Mujer Magazine. “Las Contrageografías de la Globalización” by Saskia Sassen, 2002.

99 UNICEF AND UNHCR. Report of the XVI Conference on HIV/AIDS and Displaced Persons. Toronto, Canada, 2006.

100 Agency of the United Nations for Refugees. Publications on HIV/AIDS and displaced persons. 2007. <http://www.unhcr.org>.

young population of that sector is informed about the disease. According to a 2005 survey,¹⁰¹ young people did not know how to prevent the disease or what a condom was. Thus, the programs of international organizations are important in that when the refugees return to their country of origin, they become leaders in the prevention of HIV infection.

The vulnerability of the refugees in these camps is evidenced by acts of discrimination and abuse of power on the part of some of those in charge or responsible for safeguarding the camps. This is what actually puts them at risk of not receiving medical care if they live with HIV and of not denouncing rapes for fear of reprisals.

Forced population displacement leads to major social problems associated with marginality, overcrowding translated as lack of privacy, social exclusion, violation of basic rights, sexual abuse and the mistreatment of women and children. In addition, the fragility of the social networks such as access to health services, education, and recreation, increases the vulnerability to sexually transmitted infections (STI) and HIV/AIDS.

c. Crossing the Border

The lack of opportunities in the countries of origin causes millions of women to think of migrating as the best option for their future and that of their family. During the border crossing the risk of becoming victims of VAW and of contracting HIV is very high. Traffickers collect large sums of money for transporting immigrants across the border and in the specific case of women, sexual abuse and threats of abandoning them or of retaining them as prisoners once they arrive at their destination are systematic practices.

Sexual harassment in the workplace is also prevalent among undocumented immigrant workers who do not denounce it for fear of being deported. Tijuana, a Mexican city marked by migration, takes second place in the incidence of HIV/AIDS. And this because the migration phenomenon creates a whole series of social situations that condition the behavior of individuals, which puts them at risk of contracting HIV, and limits their chances of survival once they have acquired the disease. In Spain, where 41% of the immigrants come from South America, and 19% from Africa, the cases of HIV/AIDS imported within the immigrant population are also mostly from Latin America (27.5%) and Africa (22.3%)¹⁰².

Possibly some of the characteristics of migratory policies and the methods used to enforce them help make immigrant women even more vulnerable and leave them with few possibilities of going to the authorities. If they are undocumented—this being the most common situation—they will not be treated as victims of abuse, but as violators of the law since they have violated the laws related to income, residency, and work. Attempts at addressing the problem of immigration without documentation and the trafficking of people through more rigid controls on the borders, increases the probability of women using traffickers to cross the border, and it may be that some of these belong to criminal organizations linked to the sex industry.

It is for this reason that efforts should be made to seek models of policies that address not only the migration problem, but also consider the relation it bears with the link between VAW and HIV. It is necessary that governments address this problem taking into account gender-related problems, and thus offer effective responses that contribute to the empowerment of women and their protection.

III. Selected International Experiences

In Thailand, one of the countries with a greater index of sex tourism, since 1994 the foundation New Life Center has been carrying out courses on HIV education and prevention and the sex trade in indigenous provinces of the country, through an interactive curriculum that includes charts in native languages, drama and music skits. Close to 400 provinces have benefited from the program.

¹⁰¹ Agency of the United Nations for refugees. Publications on HIV/AIDS and displaced persons. 2007. <http://www.unhcr.org>.

¹⁰² AIDS Study Group – SEIMC. Immigration and HIV in Spain, by J. L. Pérez Arellano, 2004.

One of its model projects was duplicated in provinces of Sipsong China, from where many of its young people migrate to work in Thailand, facing risks of becoming sex trade victims and contracting HIV. The project was aimed at young women, between 20 and 25 years old, that almost always migrate to Thailand to work as waitresses, dancers, masseuses, or prostitutes, in order to send money to their families to build houses in their provinces and send their brothers to school. They were asked a series of questions before the beginning of the program, to evaluate their knowledge of the risks and prevention of HIV infection and the sex trade; initially they had little knowledge concerning the two subjects. Some thought that HIV was contracted through breathing or through the use of the same toilet as an HIV-positive person. After the training sessions, they were again asked the same questions and their responses indicated an increase in their knowledge. They already had an understanding of the risk factors and protection of HIV as well as the deceptions used by the mafias of the illegal trafficking of people. In total, 3,472 people were trained in 12 remote provinces of China, who learned about the risk factors, facts and current statistics on HIV, human trafficking, and drug use.

In August 2007, the United Nations General Assembly presented its report for the protection of immigrant working women.¹⁰³ This report contains the following recommendations to the governments:

- Recognize the increase in female migration caused by socioeconomic factors and implement international migration policies that include this trend.
- Emphasize the responsibility of the authorities in the countries of origin, transit, and destination in promoting an environment that prevents and combats the violence against immigrant workers, the abuse and exploitation they suffer.
- Create and increase the database on policy-making and strategies to tackle the problem of violence against immigrant women.
- Regulate Internet sites that deceive women with marriages and false documentation to migrate.
- Create empowerment programs for immigrant women in order to reduce their vulnerability to abuse.
- Continue cooperation among governments in the exchange of information concerning cases of abuse of immigrant women.
- Incorporate a chapter on human rights and gender in international migration legislation and in labor laws, emphasizing zero tolerance against discrimination of women, regardless of their immigration status.
- Discuss and implement policies that promote legal migration.
- Cooperate internationally, together with NGOs and the private sector, to subsidize programs and information materials to educate women on the facts about migration, its costs, risks, rights, duties, work laws and adjustments of status.
- Provide immigrant women with immediate assistance, after being victims of abuse, providing counseling, legal advisory services, consular access, and temporary refuge.
- Reinforce sentences and penalties for those that illegally traffick in people and for perpetrators of violence against female immigrants.
- Train border security personnel on general information on violence against immigrants and provide them with intervention tools appropriate for these women.

In general, migration contributes to the increase of risk factors of HIV and VAW. The main causes of this are: socioeconomic inequality in the countries of origin, deficient migration policies, governmental corruption, misinformation of immigrants, lack of education on HIV and VAW in the countries of origin, and violation of the human rights of immigrants in the destination countries.

¹⁰³ United Nations General Assembly. Report of resolutions adopted against violence of immigrant women. A/62/433 (Part II). 2007

All these factors contribute to the promotion of forced sex, the lack of empowerment of women to demand protection during sexual relations, high-risk sexual behaviors in childhood and adolescence, little or no access to prevention and care centers, and the fear of people living with HIV/AIDS to use the health services for fear of violence and discrimination.

*Being a foreigner fills me with sorrow
I don't find comfort and I miss my country
Foiled old dreams vanish
And today I suffer the abuse of the distant land*

Natural Disasters and Violence against Women: The Case of the 2007 Earthquake in Peru

Teresa Ojeda Parra¹⁰⁴

Characteristics of the Disaster

On Wednesday, August 15, 2007, at 6:41 pm (local time), a devastating earthquake shook the southern coast of Peru, with a magnitude of 7.0 on the Richter scale and 7.9 on the moment magnitude scale (MMS). The disaster significantly affected the cities of Pisco, Ica, Chincha and other surrounding communities within an approximately 250 km radius (the so-called “little south”). The epicenter was located 60 km to the west of the city of Pisco, in the sea. (1)

This earthquake is considered the most damaging to hit Peru in the last century and was noteworthy for its duration (approximately 4 minutes). (1, 2, 3) The death toll was 595 people, with 318 missing people, and 19,025 injured, of which 2,771 were seriously injured. Of the approximately 246,000 dwellings registered in the Census of Victims, around 76,000 dwellings were destroyed and/or seriously damaged (in both cases requiring reconstruction), thus becoming uninhabitable. (4) The strong telluric movement cut off electric power, drinking water, and food supplies; homes and buildings were destroyed, as well as roads, and people had no place to sleep but the streets. Survivors were left without shelter exposed to the dust, wind, cold, and the lack of latrines.

The first responders from among the local populace played a decisive role in the rescue of the injured and victims until the arrival of the rescue brigades from Lima. The national health sector was mobilized to provide care to the wounded, and international assistance was swift to arrive, in relation to rescue of survivors and recovery of the dead, as well as to health care. Field hospitals were installed in strategic points by EsSalud, the United States, Mexico, and Cuba, among others; all staffed with physicians, medicines, fumigation equipment, and electricity-generating equipment. The health centers of Pisco, Ica, Chincha, and Cañete were reinforced with professionals from the Ministry of Health, as well as from the Red Cross, Doctors without Borders, the School of Medicine, the NGO ADRA, and physicians from Colombia, among others. The international community offered US\$40 million in humanitarian assistance¹⁰⁵ for the thousands of victims in the affected areas. (5)

One of the urgent measures taken by local authorities was the relocation of the victims to tent camps for temporary shelter. Although this was a feasible and adequate solution to the lack of housing, overcrowding was unavoidable in these camps. Hundreds of people were left homeless and the tent camps could not accommodate everyone, prompting many victims to construct their own shelters with mats, plastic materials, wood pieces, and cardboard. Recovery of the bodies was a tedious task; however, it was carried out methodically, taking the necessary precautions to avoid leaving the dead exposed to the elements for too long. The population was actively involved and the task of recognizing the bodies was carried out promptly.

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¹⁰⁵ International cooperation included the support of teams of professionals specialized in disasters, in addition to the provision of prefabricated houses, tents, blankets, water treatment tablets, medicines, clothing, food, disposable diapers, water treatment plants and electric power generators, surgical materials, among others.

Three weeks after the earthquake, the International Brigades left the areas: their work had come to an end. By this time, the disaster and the tragedy were no longer headline news in the newspapers. However, in the areas damaged by the earthquake, the devastation could still be felt as water and food shortages and lack of

HIV and Violence against Women (VAW) during Emergencies

- a) Violence and HIV are pandemics that seriously affect the life of women, especially their sexual and reproductive health; and the risks tend to increase in post-disaster emergencies. (7, 10, 11, 12, 15, 16, 17, 18, 19)
- b) VAW and HIV are development, health, and human rights problems that acquire specific characteristics depending on the context. The risks and vulnerabilities of HIV and VAW in emergency situations link each other with conditions faced by women prior to the disaster; these can worsen in the stages after the event. (16, 17)
- c) The interrelationship between HIV and VAW during emergencies tends to become invisible with respect to other priority situations considered. (14, 15, 16, 17, 20)
- d) The population in general is still unaware about how to prevent sexual violence and how to cope with this situation in post natural disaster contexts.
- e) The response of the health sector in cases of sexual violence and HIV prevention during emergencies is still insufficient and inadequate.

electric power continued to affect some areas. Despite the efforts of local authorities and the State, and the courage demonstrated by the population from the beginning, new problems began to appear as the impact of the earthquake and its aftermath sunk in affecting the mental health of the victims (sleep disorders, fear, and anxiety, among others).

II. Impact of the Disaster on Women

The earthquake in the southern part of Peru had serious implications in the development of the families in the affected areas, but it fell especially on women to carry the largest burden, dealing tirelessly day to day with the difficulties and seeking solutions according to their possibilities, such as arranging for food distribution through “communal pots” prepared with whatever each woman could obtain. But as stated by PAHO, “what the media does not show, however, is that women form a vital part of disaster mitigation and response efforts, acting within their roles, or transcending them.” (6)

The families whose dwellings were destroyed by the earthquake were relocated in various shelters. This displacement carried with it space limitations, privacy restrictions, as well as difficulties for women to carry out with ease the domestic activities socially assigned to their gender. (6) Under these conditions women found their movements and performance restricted, and at the same time their schedules were overloaded. In this regard, PAHO affirms that “the inadequate establishments for daily tasks such as cooking increase the domestic burden of women, leaving them without the possibility of looking for alternative sources of income.” (6)

Although all the victims faced the risks and dangers of the effects of the earthquake, these were heightened in relation to the vulnerability of the individual. Each person’s level of exposure to the risks, and capacity to survive and recover from the devastating effects of the disaster was affected by various factors directly and mainly related to gender identity, age, status, and economic stratum. In this regard, women fared worse because “they are disproportionately affected by natural disasters, usually as a result of their gender position in society,” (6) together with children, adolescents and the elderly.

There are studies that report an increase in the levels of domestic and sexual violence following disasters (McCarrher, D. R. and P.E. Bailey, 2000; Enarson, E. 1998, quoted in I). This is because the attackers take advantage of the increased vulnerability of women in the aftermath of disaster. (7, 8, 9) In the case of sexual violence,

When the victims were adolescents, they themselves were the ones who decided not to tell anybody about what had happened because the attackers threatened to harm or to kill them; in addition they thought that if they told their parents they were going to get angry at them or beat them, and that fear stopped them from speaking up, from reporting what had happened.

its different expressions¹⁰⁶ are aimed primarily at young women and girls (7, 8, 9); these episodes tend to come to fruition through manipulation, intimidation, blackmail, coercion, use of force, or the threat of its use, or any other threat, in addition to any form of behavior that limits and/or invalidates the voluntary decision of the victim with regard to her sexuality and reproduction. (13)

III. Testimonies

During the days following the earthquake of August 15, 2007 in southern Peru, sexual violence events were not absent in the various localities affected by the disaster.

Following are the accounts of indirect witnesses to the facts as well as the voices of the victims themselves¹⁰⁷.

“I know the case of a girl who was raped.... I learned of this because during my work I had the opportunity to care for many families that were relocated after the earthquake of August 15 to the José Picasso Peralta Stadium in Ica...”

(Specialized Physician)

“Oh, Miss, what happened to me is so awful!... (sobs)... We live in Chincha and we had just lost my mother and my two brothers in the earthquake, that is, a sister and a brother and couldn't find comfort in those days... I was like in a daze, lost... (crying)... We had moved to a tent for victims, and that's when that man took advantage of me and raped me!”

(Sexually abused adolescent, 18 years old)

“A month after the earthquake I traveled to the south to work as a volunteer for one month... I am a psychologist and knew that I could help a lot of people and I was right... this experience was unbelievable because the first case I saw was exactly that of a teenager who had been raped”

(Psychologist — Volunteer)

“I don't know about this case directly, but I received this information from the health workers who work with me... They reported that they had a case of a 12-year-old girl who was pregnant as a result of a rape... and all because she was alone in the shelter a few days after the earthquake! One tragedy after another!”

(Specialized Physician)

“I will never be able to forget when those men raped me, Miss... That is something that hurts my soul, my spirit and there are even times when I feel that my body still hurts... There are also times that I curse and weep for what happened to me and I think to myself ‘if there hadn't been an earthquake this disgrace wouldn't have happened to me!’ of course, because I would have been in my own house, at ease, with no need to go outside looking for a bathroom or a clearing to pee... (crying)... but now I can't change the past... I can't!”

(Sexually abused adolescent, 17 years old)

When the victim is a girl or a teenager, she is more vulnerable to sexual violence events. (7, 8, 9) The age of the victims of the cases collected in the disaster area ranges between 9 and 18 years.

¹⁰⁶ Among which are child sexual abuse, incest, sexual rape (marital, during dates, and by strangers), genital mutilation of women, forced marriages, and harassment (at work, school, and other public areas) trade of women and girls for sexual purposes, commercial sexual exploitation and sexual slavery, sexual rape in times of war. (7, 10, 11, 12, 13)

¹⁰⁷ The testimonies quoted were collected to explore the circumstances in which sexual violence events tend to occur after a natural disaster. Five testimonies were collected, three of which correspond to professionals who provided care to the victims after the earthquake (two physicians and one psychologist) and the other two from victims of sexual violence.

“The victim was a girl... she was 9 years old.”

(Specialized physician)

“... at the time I was raped I was 18 years old, now I'm 19...”

(Sexually abused adolescent, 18 years old)

“She was a young girl of 14...”

(Psychologist — Volunteer)

“I was 17 when they raped me; I was in 4th year of secondary school... Now I'm 18 and I am finishing secondary school...”

(Sexually abused adolescent, 17 years old)

“This concerns a 12-year-old girl who was raped a few days after the earthquake...”

(Specialized physician)

The collected testimonies reveal that the attackers tend to be strangers and, in some cases, the victims knew the men, in fact, they shared the same shelters. In the latter circumstance, the victims were probably previously observed by the attackers, who waited for “the most adequate moment” to commit the violent act.

“As reported to me, it was a stranger who raped the girl while she was alone in the shelter for the victims of Chincha... It was in broad daylight!”

(Specialized physician)

“The man who raped me was a gentleman who had also moved to the tent with his wife and children...”

(Sexually abused adolescent, 18 years old)

“The rapist was a stranger...”

(Specialized physician)

“The person who raped her was from the same neighborhood as the young woman and who had also been relocated with his family to the shelter...”

(Psychologist—Volunteer)

“I didn't know them... when I looked, there were two men whom I had never seen before, I didn't know them... one was older, about 30 years old and the other a little younger, around 22 years old... or maybe 23... yes, he was around that age, the younger man...”

(Sexually abused adolescent, 17 years old)

The episodes of sexual violence suffered by the victims took place while they were alone, in some cases because their parents were working, in others, because the young woman went alone outside the shelter to look for a place to urinate; one young woman was deceived by a neighbor.

“As told to me, it was a working day, that is a work day and the parents of the girl were not in the shelter, and had left her in charge of a woman, but at some time this woman left her alone because she had to get some water...”

(Specialized physician)

“The day of the rape the little girl was alone... It was a weekday, her father had gone to work, and her mother had gone to meet with other ladies to see how she could cooperate with the communal pot... It was

under those circumstances when the girl was raped...”

(Specialized physician)

“My father, my younger brothers and I had moved to the tents set up for those who were left homeless in Chincha... That day my father had to work, my brothers had gone to school... I am a student at a computer science institute... and I had stopped going to the institute because I was in charge of the meals since my mother and my older sister were no longer with us... (sobs)... Suddenly right there while I was arranging the mattresses and the blankets this man grabbed me from behind... (sobs)... and threatened to kill me if I screamed... (crying)... there was no one inside the tent!... then he raped me there in the tent... He grabbed me by force! (crying)... and I could not scream because he began to press my neck and told me he would kill me if I screamed... I had to keep quiet!... (crying)... I was afraid... I was very afraid! And I endured the pain... (sobs)... I kept very quiet until he finished raping me... I remained trembling on my mattress... (crying)... I was in pain and bleeding from my private parts... I felt filthy with his semen mixed with my blood...! (crying)”

(Sexually abused adolescent, 18 years old)

“The adolescent knew the rapist since he was a neighbor from her neighborhood, as she told me, ‘he was a proper gentleman and his family had a lot of respect for him’. For this reason she was not suspicious when he asked her to help him bring food from a nearby area to the shelter and offered to share some of the food with her... but everything was a sham, and he took her to a clearing and there he raped her...”

(Psychologist—Volunteer)

“I remember very clearly the day I was raped... I was in the tents that they set up for those of us who had lost our homes... It was the second day that we were living in the tent, it was around 7 p.m., and I needed to urinate, but since there was no bathroom I had to go some ways so that nobody would see me urinate... There was no light in that part of the camp... Suddenly I felt someone covering my mouth from behind and I heard some voices that told me not to scream or try to escape or they would kill me... (sobs ... my whole body began to tremble... (crying)... I was very afraid! Then they grabbed me and lowered my trousers and my underwear and between the two they raped me, first one and then the other one... (crying)... I couldn’t defend myself, I could not escape! (crying ... it’s been horrible what happened to me!... they left me there lying in the dirt, covered with their semen and my private parts hurting... my vagina was bleeding and my rectum, too... (crying) And I didn’t have anything to clean myself... Then I took my underwear and I cleaned myself as well as I could and then I wrapped it and discarded it there...”

(Sexually abused adolescent, 17 years old)

None of the cases identified was reported. It is observed, for example, that when the parents learned about the sexual violence event, they decided against submitting the corresponding complaint, opting to keep silent and arguing that in this way they were protecting the minor from any retaliation from the rapist. One case came to light because the victim was interviewed by health workers during the prenatal check-up of pregnant women, but the parents did not want to report the rape.

“The case was discovered through the detection of pregnant women, an activity carried out by health workers for prenatal check-ups of pregnant women in the area. That is where the case was detected and it caught their attention because it concerned a minor...”

(Specialized physician)

“The family members kept quiet about the case, according to them to protect the girl since the rapist was a stranger, they feared he would retaliate... unfortunately they didn’t want to denounce it and the case is one more case that was lost in there...”

(Specialized physician)

“When she came to the doctor’s office, she had not said anything of what happened to anyone in her family circle... her parents knew absolutely nothing and she did not want them to know because she thought that they would blame her for what happened and besides she felt very ashamed...”
(Psychologist—Volunteer)

“And I thought about my mother, how it would annoy me if I told her because surely she would yell at me for being so careless... (crying)... and without doubt she would tell my father and he would certainly beat me... (crying)... When I returned to the tent I told my mother that my belly hurt and that I wanted to go to bed... But I couldn’t sleep all night long... I cried but I held it in... I held it in like this, otherwise my eyes would get swollen and my mother would notice...”
(Sexually abused adolescent, 17 years old)

“... and not satisfied with having raped me he continued to threaten me... he said ‘if you tell anyone I am going to kill you with no qualms!’... I didn’t know what to do after they raped me... I just cried... I just cried... and I didn’t want to tell anything to anybody, even less to my father because I was sure he was going to get angry and beat me up... I didn’t want anyone to know about my misfortune... (crying)... I kept my sorrow to myself...”
(Sexually abused adolescent, 18 years old)

In addition to not making a complaint, none of the victims received medical care immediately after the sexual violence event. In some cases it was the parents or family members who were against the minors receiving care, thus the health professionals felt they could not do much, recognizing they have difficulties handling cases of sexual violence. In other cases it was the adolescents’ lack of knowledge regarding the possible consequences to their sexual and reproductive health. In the case of the young woman seen by the psychologist, she received the corresponding counseling, agreed to get therapy, and was immediately referred to a health facility.

“What is worst is that the young girl did not receive medical care; the parents did not want the rape to be known and even though they were told about the risk of the girl contracting some STI or even HIV, they could not be convinced... her relatives did not perceive the risk as real, it was as if nothing like that could happen to the girl... and we can’t force them, right?... instead what they did was to leave the stadium as soon as they could and now we know nothing of them... it is difficult to deal with rape cases, and even worse in the case of girls or adolescents... on the one hand one empathizes, but on the other hand one can get into legal problems...”
(Specialized physician)

“The girl was raped and she became pregnant at age 12... and she was brought in for examination only because she is pregnant, if not she would not have received any care at all... but how can you make them understand, both the parents and the girls themselves, that they should go to a health facility after a rape?”
(Specialized physician)

“No, I have not received medical care... I didn’t know that I could be infected with those sexual diseases... if you hadn’t told me, I wouldn’t have known...”
(Sexually abused adolescent, 17 years old)

“After listening to her I managed to calm her and told her how important it was for her to undergo a medical examination... I had to tell her about the STIs and HIV, about how they are transmitted and also that treatment must be received as soon as possible... fortunately she agreed to tell her mother and she accompanied her to the medical examination...”
(Psychologist—Volunteer)

The very fact of having had forced sex placed all the victims at risk of exposure to STIs, including HIV. This risk increased to the extent that they did not go immediately to a health care facility and did not receive the prophylaxis required in these cases. (14, 15, 16, 17)

This glance at certain circumstances present when sexual violence events occur after a natural disaster, does not attempt to generalize on the findings or to arrive at definitive conclusions; however, it intends to provide some light to guide future research and interventions that link the relationship between sexual violence, sexual and reproductive health, and natural disasters.

Furthermore the goal is to emphasize that, as well as in other circumstances and whatever the case, the assailants threaten the human rights, sexual, and reproductive rights of the victims; they affect the dignity of the women, as well as their rights to physical integrity, to the free development of personality, to life, to not becoming victims of physical or psychological violence, or be subject to inhuman or humiliating treatment of the sexual freedom and dignity of the victims in addition to their other sexual and reproductive rights, especially their right to control their sexual and reproductive capability. (21, 22, 23, 24)

IV. Measures to Prevent Violence and Provide Care for HIV/STI in Emergencies

- Make evident the impact that natural disasters have on the unpaid productive work of women, as well as the corresponding increase in physical and emotional fatigue.
- Develop recovery and reconstruction strategies sensitive to the problems faced by women during the post-disaster stage.
- Develop and integrate sectoral policies and strategies for the prevention and action during disaster situations with regard to sexual violence and HIV.
- Develop a continuing education plan aimed at health workers that includes awareness and training in comprehensive care in cases of sexual violence and prevention of HIV infection.
- Carry out a risk evaluation with regard to sexual violence in post disaster stages, identifying how conditions for these risks are created and who are the most exposed to them.
- Prepare a prevention plan on sexual violence and other forms of violence against women in communities located in areas most likely to suffer natural and/or similar disasters.
- Disseminate the links between VAW and HIV among health professionals, researchers of these subjects, and the general population. In the education sector, strengthen teachers so that they give quality sex education to schoolchildren, emphasizing and promoting gender impartiality, social skills, sexuality and the exercise of civil rights.
- Carry out VAW and HIV prevention campaigns and promotion of the exercise of civil rights through the communications media, taking into account cultural awareness.

Bibliography

INSTITUTO GEOFÍSICO DEL PERÚ–SISMOLOGÍA. Earthquake of 15 August 2007. Available in the Web: <http://khatati.igp.gob.pe/cns/reportes/2007/sism_150807.pdf>

BERNAL, Isabel. (2007) Las escalas de magnitud y el terremoto de Pisco del 15/08/07. In: INSTITUTO GEOFÍSICO DEL PERÚ. The Earthquake of Pisco of 15 August 2007 –Special Volume (Preliminary Version) Available in the Web: <<http://khatati.igp.gob.pe/Webs/cns06/pisco2007/articulo04.pdf>>

BERNAL, Isabel; ROOMS, Henry, and TAVERA, Hernando. (2007) El Terremoto de Pisco del 15 de agosto de 2007: Aspectos Sismológicos. In: INSTITUTO GEOFÍSICO DEL PERÚ. The Earthquake of Pisco of 15 August 2007–Special Volume (Preliminary Version) Available in the Web: <<http://khatati.igp.gob.pe/Webs/cns06/pisco2007/articulo03.pdf>>

INSTITUTO NACIONAL DE ESTADÍSTICA E INFORMÁTICA–INEI. (2007) Census of the areas affected by the Earthquake in the South. Press Release No. 180. Lima, Peru Available in the Web: <http://economia.unmsm.edu.pe/Servicios/Banco%20Estad%C3%ADstico/Datos/INEI_NP_10.07_180.pdf>

Diario La República, 18/08/07. Available in the Web: <<http://www.larepublica.com.pe/content/view/172823/36/>>

Pan American Health Organization (2001) Gender and natural disasters. Data Sheet of the Women, Health and Development Program. PAHO, Washington, D.C. February 2001. Available in the Web: <<http://www.paho.org/Spanish/AD/GE/genderdisasterssp.PDF>>

CLARAMUNT, María Cecilia (2002) Sexual Violence Based on Gender and Health. Introductory Systematization of the Workshop: Sexual Violence and Health. PAHO, Women, Health and Development Program. Gender and Public Health Series, No. 13. San José, Costa Rica.

CARCEDO Cabañas, Ana (2001). Violence against Women, A problem of power. Available in the Web: <<http://www.isis.cl/temas/vi/reflex17.htm>>

CHEJTER, Silvia and RUFFA, Beatriz (2002) Mujeres víctimas de violencia sexual. Proteger, recuperar, reparar. Centro de Encuentros Cultura y Mujer–CECYM. Buenos Aires, Argentina.

HEISE, L., PITANGUY, J., GERMAIN, A. (1994) Violence against Women. The Hidden Health Burden. PAHO, Women, Health and Development Program. Washington, D.C., USA.

WORLD HEALTH ORGANIZATION/PAN AMERICAN HEALTH ORGANIZATION (1998). “Violence against women. A priority health subject”. Family and Reproductive Health Division, WHO, and the Health and Human Development Division, Women, Health and Development Program, PAHO, Washington, D.C.

UNITED NATIONS POPULATION FUND - UNFPA (1999) Violence against Girls and Women. Public Health Priority. New York, USA.

Pan American Health Organization (2003) World Report on Violence and Health. Pan American Health Organization, Pan American Sanitary Bureau, Regional Office of the World Health Organization, Washington DC.

PATH. 2006. Violencia contra la mujer, el VIH y los microbicidas. Technical Note #10. Campana Global por los Microbicidas.

<[http://www.global-campaign.org/clientfiles/F&s10_Violencia\(E\).doc](http://www.global-campaign.org/clientfiles/F&s10_Violencia(E).doc)>

UNAIDS. Violence against women and AIDS. World Coalition on Women and AIDS. Available in: <http://data.unaids.org/GCWA/gcwa_bg_violence_es.pdf>

Luciano, Diny. 2007. Empowerment, HIV, and Violence against Women in Latin America and the Caribbean. Development Connections. Washington D.C. Available in: <<http://www.dvcn.org/Documents/Intersecciones-VIHVCM2.pdf>>

Human Rights Commission. 61st Session. Integración de los derechos humanos de la mujer y la perspectiva de género: violencia contra la mujer. INTERRELATIONSHIPS BETWEEN VIOLENCE AGAINST WOMEN AND HIV/AIDS. Report of the Special Rapporteur on violence against women, and its causes and consequences, Yakin Ertürk. 2005. <http://www.unfpa.org/derechos/documents/relatora_violencia_2005.pdf>

HEISE, L.; ELLSBERG, M.; GOTTEMOELLER, M. (1999) Para acabar con la violencia contra la mujer. Population

Reports 27, No. 4. L Series, Number 11. Center for Communication Programs, The Johns Hopkins University School of Public Health and CHANGE. Maryland, USA. Available in the Web:

< <http://www.jhuccp.org/pr/prs/sll1edsum.shtml>>

HIV Dimensions in Latin America - UNAIDS. Available in: http://data.unaids.org/pub/epiReport/2006/08-Latin_America_2006_EpiUpdate_Es.pdf

UNIFEM, UNFPA, UNAIDS. La mujer y el VIH/SIDA: enfrentar la crisis.

< <http://www.unfpa.org/hiv/docs/women-aids-sum-spa.pdf>>

Convention on the Elimination of All Forms of Discrimination against Women, 1979 (ECOSOC) Available in the Web: <<http://www.undp.org/rblac/gender/campaign-spanish/cedaw.htm>>

Convention of Belém Do Pará, 1994. Available in the Web:

< <http://www.oas.org/CIM/Spanish/ConvencionViolencia.htm>>

UNITED NATIONS. Action Program of the International Conference on Population and Development, Cairo, 1994.

UNITED NATIONS. Declaration and Action Platform of the Fourth World Conference on Women, Beijing, 1995.