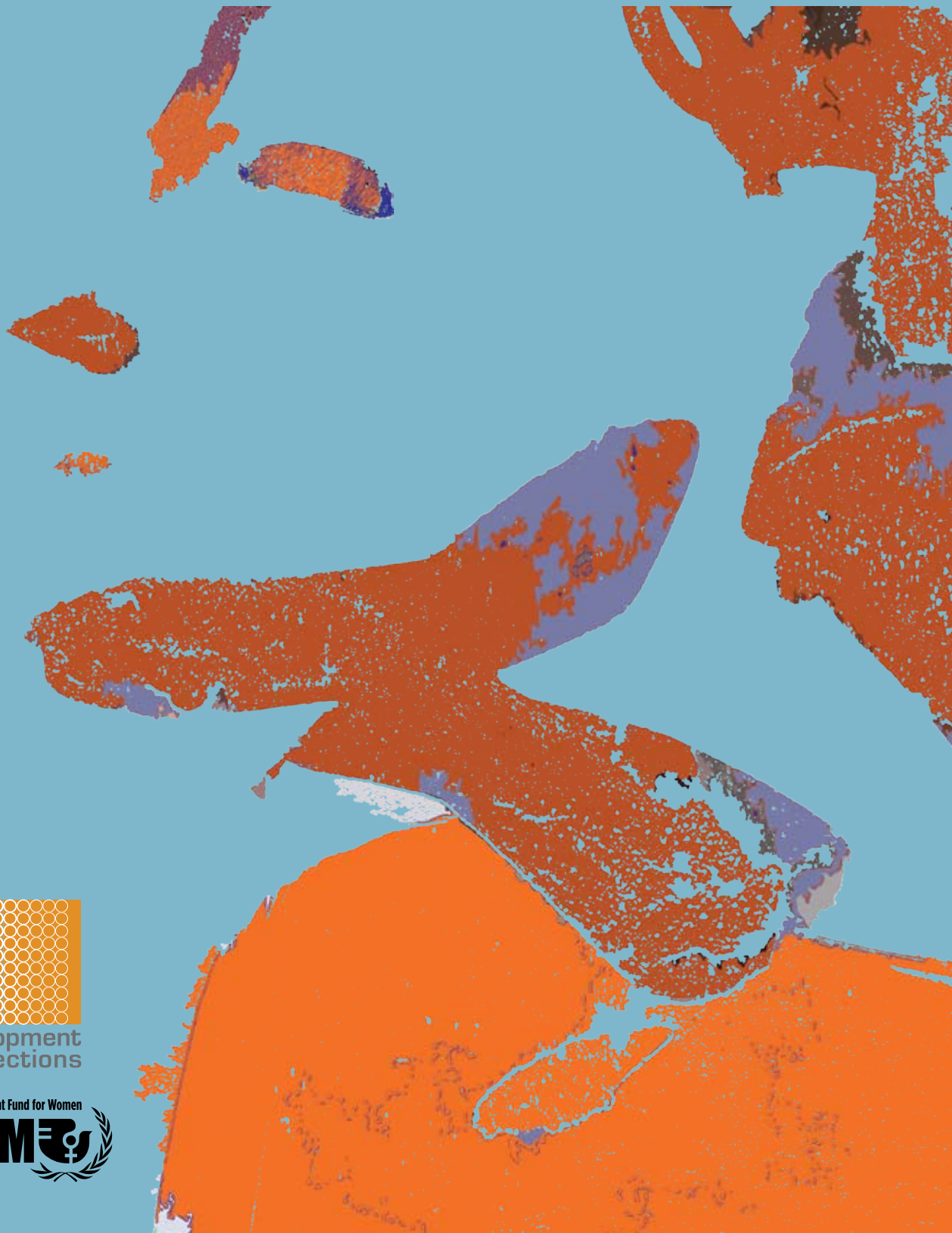
Development Connections

A Manual for Integrating the Programmes and Services of HIV and Violence Against Women

Dinys Luciano Ferdinand



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United Nations Development Fund for Women

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Dinys Luciano Ferdinand

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
CAFRA	Caribbean Association for Feminist Research and Action
CDC	Centers for Disease Prevention and Control (USA)
CIM/OAS	Inter-American Commission of Women/Organization of American States
DVCN	Development Connections
FCI	Family Care International
HIV	Human Immunodeficiency Virus
ICW	International Community of Women Living with HIV
IDU	Injected Drug User
IPV	Intimate partner violence
LACWHN	Latin American and Caribbean Women's Health Network
M & E	Monitoring and Evaluation
MSM	Men who have sex with men
NGO	Non-Governmental Organization
PAHO	Pan American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infections
SV	Survivor of violence
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
VAW	Violence against Women
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WLHA	Women Living with HIV/AIDS

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PRESENTATION

During the past decade international organizations, civil society groups and governments worldwide have intensified their efforts to describe the intersections between HIV and violence against women (VAW) and to identify the best method for integrating policies and programmes addressing both pandemics. Due to methodological limitations as well as the short time in which these intersections have been studied as yet, information is limited regarding the ways in which both problems interact in their causes, outcomes and social responses. In spite of these limitations, we can affirm that the evidence is sufficient to justify an integrated approach to HIV and VAW, even as new data is produced and as we continue to learn from the interchange of experiences and practices in different countries.

There is no single model for the integration of HIV and VAW interventions because the dynamics and characteristics of both problems, as well as the available resources, vary from one part of the world to another, among countries and within each country. Based on this premise, in 2007, Development Connections (DVCN) designed a course entitled "Empowerment, HIV and VAW" that incorporates a conceptual framework and practical tools for stakeholders to develop integrated HIV/VAW programmes and services tailored to their particular context and needs. During the period 2007-2008, four editions of the course were implemented in Latin America and the Caribbean, in collaboration with national agencies, regional networks and international organizations such as: the Caribbean Association for Feminist Research and Action (CAFRA), Colectiva Mujer y Salud, Diakonia, Family Care International, the Inter-American Commission of Women (CIM/OAS), the International Community of Women Living with HIV/AIDS (ICW), Isis International, Margaret Sanger Center, the Presidential Council on AIDS in the Dominican Republic, UNFPA/Dominican Republic, UNIFEM, and the Latin American and Caribbean Women's Health Network (LACWHN).

This manual summarizes the conceptual framework and some of the tools used in the four editions of the course. Also it includes the contribution of nine articles that were commissioned to be used as a complementary source in the elaboration of this manual:

- Exploring the Economic and Social Implications of HIV and VAW – María Antonia Remenyi
- Lack of Empowerment: A Driving Force Behind the HIV and VAW Epidemics – Anda Samson
- Interpreting VAW from the Experiences of Women Living with HIV/AIDS – Nizarindandi Picasso
- Intersections between HIV and Violence against Adolescent and Young Women – Florencia Aranda
- HIV and VAW in Women Deprived of Freedom – Carlos Güida Leskevicius
- HIV and Violence against Indigenous Women – Silvia Galán
- HIV and Violence: Implications for Elderly Women – Liliana Bilevich de Gastrón
- Migration, HIV and VAW – Jenny López
- HIV, VAW, and Natural Disasters: The Case of the 2007 Earthquake in Peru – Teresa Ojeda

ACKNOWLEDGEMENTS

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1. ABOUT THIS MANUAL

Objectives

The aim of this manual is to support government agencies, NGOs and inter-institutional networks in the development of processes for integrating HIV and VAW interventions in the specific areas of prevention, VCT, PMTCT, care, support and treatment. Also it can be applied to the analysis of emerging public policy issues regarding HIV and VAW. Its specific objectives are:

- To support the design of a conceptual framework, from a gender and human rights perspective, on the intersections between HIV and VAW in integration initiatives at the regional, national, local and institutional levels.
- To examine the strategic and practical implications of integrating HIV and VAW interventions in prevention, VCT, PMTCT, care, support and treatment.
- To socialize tools for carrying out processes of integration of HIV and VAW interventions at institutional and inter-sectoral levels.

Target Audience

The manual is directed at authorities, human resources and organizations working on HIV and VAW at the international, national and local levels. It can be used in any context irrespective of its epidemiological scenario regarding HIV and/or VAW. The manual is designed for those who work on both issues but it is hoped that it may also be useful to program managers and practitioners in other sectors, since both VAW and HIV are related to numerous key development issues: health, education, employment, justice administration, migration, natural disasters, and armed conflicts, among others.

Structure of the Manual

The manual is divided into five sections, beginning with this introduction. The second section addresses the conceptual aspects upon which the manual is based, analyzing the structural determinants, the intermediary factors and the social, economic and health outcomes associated with HIV and VAW, and assuming gender inequalities to be a crosscutting determinant of the intersections between both problems. Section three presents the operational framework of the integration process: the definition of integration, the rationale, guiding principles, steps and potential levels for integrating HIV and VAW programmes and/or services.

The fourth section identifies some considerations for integrating HIV and VAW in specific interventions: prevention, VCT, PMTCT and care, support and treatment. The fifth section includes fourteen tools selected from those used or developed in the four editions of the course "Empowerment, HIV and VAW in Latin America and the Caribbean."

The theoretical framework and the tools shared in this manual will continue to be adapted and expanded in new editions of the course and to be put into practice in local initiatives. Users of the manual are invited to send their observations and suggestions for improving it to Development Connections at: info@dvcn.org.

2. SOCIAL DETERMINANTS OF HIV AND VAW[1]

HIV and VAW are two mutually reinforcing pandemics that affect the health and development of millions of women, families and communities worldwide. According to UNAIDS, at the global level, an estimated 33 million [30–36 million] people were living with HIV in 2007. Although the proportion of women among people living with HIV has remained stable (at 50%) for several years, in many countries women's share of infections is increasing (1).

Gender and HIV

"Gender comprises widely held beliefs, expectations, customs and practices within a society that define 'masculine' and 'feminine' attributes, behaviors and roles and responsibilities. Gender is an integral factor in determining an individual's vulnerability to HIV infection, his or her ability to access care, support or treatment, and the ability to cope when infected or affected by HIV."

UNAIDS. Gender (3).

For its part, VAW is a pervasive human rights and development problem around the world. According to the WHO Multi-Country Study on Women's Health and Domestic Violence against Women (2005) carried out in 15 sites in 10 countries, the lifetime prevalence of physical violence by partners ranged from 13% (urban Japan) to 61% (provincial Peru), with most sites falling between 23% and 49%. Likewise, the lifetime prevalence of sexual violence by partners ranged between 6% (urban Japan, Serbia and Montenegro) and 59% (provincial Ethiopia), with most sites falling between 10% and 50%. Finally, the proportion of women reporting physical and/or sexual violence by a partner ranged from 15% (urban Japan) to 71% (provincial Ethiopia), with most sites falling between 29% and 62% (2). Also, the WHO (2002) has indicated that women and girls are the principal victims in the majority of sexual assault cases (4).

HIV and VAW share a complex network of structural and intermediary factors as well as development and health outcomes at the individual, family and community levels, with a common basis in gender inequalities, intersected with other sources of discrimination such as ethnicity, age, level of education, socio-economic status, area of residence, sexual orientation, among others. These social markers combine through various

Definition of violence against women

"Violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Violence against women shall be understood to encompass, but not be limited to, the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

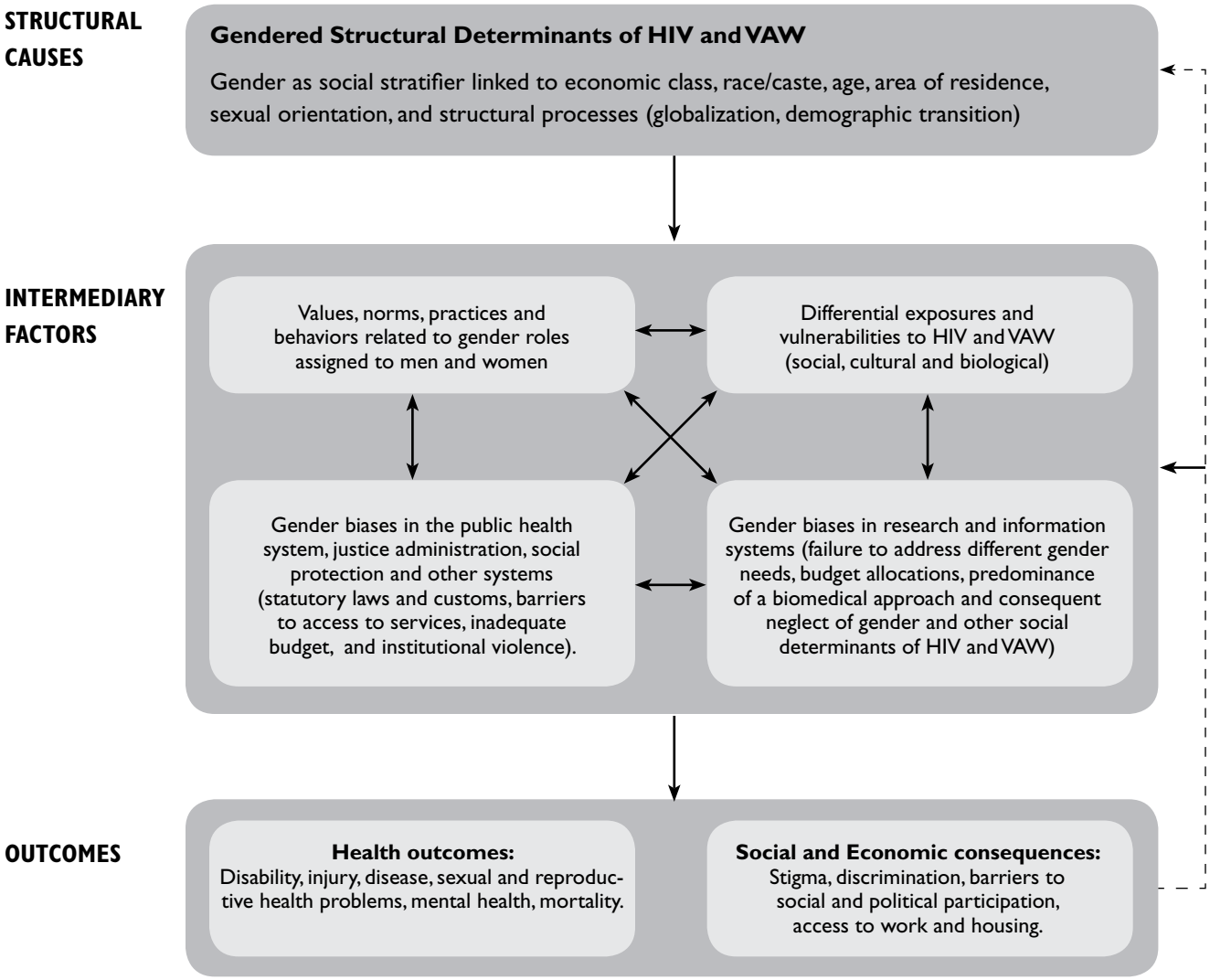
Declaration on the Elimination of Violence against Women (1993) (5)

1 In the absence of a universal consensus regarding the categories for describing interventions, for the purposes of this manual the concept "integration of programmes and services" will be used to refer to an ample range of initiatives including projects.

routes and in diverse contexts, increasing women's vulnerability and risks to HIV and VAW. At the same time, insofar as the prevalence and incidence of HIV and VAW increases, discrimination and social exclusion of women also increase.

The intersections between HIV and VAW can be grouped into three categories: a) structural causes, b) intermediary factors and c) health outcomes, social and economic consequences. These categories were developed in the model for analyzing gender inequity in health published by the Women and Gender Equity Knowledge Network (Gita Sen, Piroska Östlin and Asha George, 2007) *(6)*.

Figure 1: Conceptual framework for analyzing linkages between HIV and VAW causes, intermediary factors and outcomes/consequences



Adapted from: Gita Sen, Piroska Östlin and Asha George. *Unequal, Unfair, Ineffective and Inefficient – Gender Inequity in Health: Why it exists and how we can change it.* Women and Gender Equity Knowledge Network. 2007.

2.1 STRUCTURAL FACTORS ASSOCIATED WITH THE LINKAGES BETWEEN HIV AND VAW

Gender is a social stratifier[2] that interacts with other sources of discrimination such as economic class, race, caste, age, level of education, place of residence (urban vs. rural), and legal status, which combine to function as social determinants of HIV and VAW. These driving factors create a context of vulnerability to HIV and VAW that increases individual risk and compromises women's ability to protect themselves against both problems (7). These determinants are not static and can vary over time. As these two epidemics advance, institutional responses change and social transformations occur within communities and on an individual level. In this sense, there is no single HIV epidemic but many, even within the same country; also, the dimensions and characteristics of VAW vary depending on the interaction of social conditions in women's lifetimes.

Challenges to operationalize the concept of "Gender" in international HIV cooperation

"The issue of how best to define 'gender' has been somewhat complicated. There is also a concern that splitting gender issues off from the other issues affecting groups, such as stigma, political commitment, etc, is confusing. This concern underscores the need for discussion to identify the best platform for action, i.e., should issues be framed around gender or around key audiences (women, men, men who have sex with men, etc.)"

Fleischman, Janet. *An analysis of the Gender Policies of the Three Major AIDS Financing Institutions: The Global Fund to Fight AIDS, Tuberculosis and Malaria, The World Bank and the President's Emergency Plan for AIDS Relief.* 2008 ***(8)***.

Diverse studies show that certain forms of violence disproportionately affect women and that structural factors play a key role in their characteristics. The World Report on Violence and Health (PAHO, 2002) indicates that although intimate partner violence (IPV) occurs in all countries and all cultures, and at all levels of society without exception, some populations are more likely to report IPV than others (for example, low income groups and women with low level of education) (4).

Also, HIV has affected some parts of the world more than others. Over 68% of all HIV-infected adults live in Sub-Saharan Africa, and 76% of deaths from AIDS have occurred in this region, which also has the highest prevalence of AIDS in adults (5%). According to information published by the World Bank, the same region holds 63% of the countries with the lowest per capita income (US$875 or less) (9). Of the 48 countries located in Sub-Saharan Africa, 34 (70%) are classified as low-income countries (10). That is to say, the poorest region in the world is the most affected by HIV.

However, the association between economic status and vulnerability to HIV is complex and can vary according to the context. As Geeta Rao Gupta, et al (2008), point out, "Research suggests that the relation between poverty and HIV/AIDS is not straightforward. For example, within sub-Saharan Africa, the wealthiest nations are the most affected by HIV/AIDS" (11). Nonetheless, socioeconomic status at the individual level can play an important role regarding intermediary factors such as access to services, care, treatment, and social support, as well as in the economic and social consequences.

Ethnicity, Gender, HIV and VAW

The intersections between race and gender influence the dynamics of the HIV epidemic in some countries. Although race and ethnicity, by themselves, are not risk factors for HIV infection, the social conditions determined by them can constitute underlying factors of vulnerability to the epidemic. For example, in the USA (2006), the HIV prevalence rate for African-American women (1,122.4 per 100,000; CI = 1,002.2 – 1,242.5) was nearly 18 times the rate for white women (62.7 per 100,000; CI = 54.7 – 70.7), and the rate for Hispanic women (263.0 per 100,000; CI = 231.6 – 294.4) was more than four times the rate for white women. The HIV prevalence

2 Gita Sen, Piroska Östlin and Asha George (2007) use the term "stratifier" to refer to the dimensions along which societies are layered into hierarchies of power and control.

Rights-based approaches to HIV

a. A focus on the vulnerable and marginalized in the HIV epidemic (e.g., women, youths, people living with HIV, orphans, men who have sex with men, drug users, sex workers, migrant populations, ethnic and indigenous groups, and refugees);

b. Equality and non-discrimination in expenditure on HIV programs and applications;

c. Programs to empower those vulnerable to, or living with, HIV, including law reform, legal aid, human rights education, social mobilization, social change communication, and support for civil society;

d. Programs designed to achieve human rights standards relevant to HIV (e.g., protection from sexual violence, gender equality, education, information, health, employment, access to scientific progress);

e. Informed, active, free, and meaningful participation by those affected by HIV in HIV-related program design, implementation, monitoring, and evaluation; and

f. Accountability mechanisms for governments, intergovernmental organizations, donors, and the private sector (e.g., UNGASS and the "Three Ones" principles).

UNAIDS, 2008 *(1)*.

rate for African-American women was greater than the rate for all other groups, except for African-American men (12). Although according to the 2000 census, African-Americans make up approximately 13% of the US population, in 2005, they accounted for 18,121 (49%) of the estimated 37,331 new HIV/AIDS diagnoses in the 33 US states with long-term, confidential, name-based HIV reporting. African-American women are most likely to be infected with HIV as a result of sex with men who are infected with HIV and they may not be aware of their male partners' possible risk factors for HIV infection, such as unprotected sex with multiple partners, bisexuality, or injected drug use. The African-American men and women at greatest risk to contract HIV are those who: a) do not know the risk factors of their partner, b) have an STI, and c) are living in poverty (this last category includes 25 percent of all African-Americans). According to data from the 33 states (2005), of the 126,964 females (adults and adolescents) living with HIV/AIDS, 64 percent were African-American (13).

As to VAW, IPV rates in the United States show differences related to race/ethnicity. The results from the National Violence against Women Survey (U.S. Department of Justice and CDC, 2000) show that when data on African-American, Asian/Pacific Islander, American Indian/Alaska Native, and mixed-race respondents are combined, non-white women and men report significantly higher rates of intimate partner violence than do their white counterparts (14). The proportion of women that reported having been victimized (rape, physical assault and stalking) by an intimate partner during their lifetime was: white (24.8%), African-American (29.1%), American Indian/Alaska Native (37.5%) and mixed race (30.2 %) (14).

HIV and VAW share common characteristics across ethnic minority groups, but there are also differences. In Central Australia, in a sample of 24 native women between 18 and 38 years of age it was found that they had a

Action areas to address women's vulnerability to HIV – Global Coalition on Women and AIDS

a. Preventing HIV infection among young women and girls, focusing on improved reproductive health-care;

b. Reducing violence against women;

c. Protecting the property and inheritance rights of women and girls;

d. Ensuring equal access by women and girls to care and treatment;

e. Supporting improved community-based care with special focus on women and girls;

f. Promoting access to existing prevention options including the female condom, and research into new prevention technologies such as microbicides;

g. Supporting ongoing efforts toward universal education for girls.

UNAIDS, 2005 *(17)*.

poor understanding of modes of HIV transmission, and limited access to and use of condoms in spite of a high level of risk perception. The most significant themes associated with the cultural context in relation to HIV and VAW were alcohol abuse by the partner, infidelity, sexual abuse and the shame of acquiring an STI (15).

Some indigenous women face difficulties to leave their home in case of mistreatment or abuse by their partners, since separation could lead to situations in which violence is threatened, and also signifies an uprooting from their community and religious surroundings and a consequent loss of identity. Those who do make this separation are then faced with the challenge of forced assimilation and the consequent discrimination which increases their risks to HIV and various forms of violence (16).

Age

Age also plays an important role in the current trends of HIV transmission. According to UNAIDS (2008) estimates, young people aged 15–24 account for 45% of new HIV infections worldwide (1). Globally, the rate of young women (15 to 24 years) living with HIV/AIDS in 2007 was 0.6, compared with 0.4 for men in the same age group. Nevertheless, significant differences were found among regions. In some regions, such as Sub-Saharan Africa, the proportion of infected young women is three times that of their male counterparts, reaching 3.2% and 1.1%, respectively (1). The following table presents the percentage rate of young women and men living with HIV worldwide.

Rate (%) of young women and men (15 to 24 years) living with HIV by region (2007)

Region	Women	Men
Sub-Saharan Africa	3.2	1.1
North Africa and the Middle East	0.3	0.1
East Asia	<0.1	<0.1
Oceania	0.2	0.3
South and South-East Asia	0.5	0.3
Eastern Europe and Central Asia	0.1	0.9
Western and Central Europe	0.2	0.2
North America (Canada and the USA)	0.7	0.6
Caribbean	0.4	0.5
Latin America	0.2	0.7

Source: Author's own work based on HIV and AIDS estimates and data, 2007 and 2001. UNAIDS. 2008 (1).

In many countries worldwide, young women are exposed to various forms of violence placing them at elevated risk to HIV. A national survey conducted among high school students in Kenya found that 40 percent of girls who reporting having had sexual relations, indicated that their first experience was either forced or they were deceived into having sex (18). In the Caribbean, 47 percent of the adolescents who have had sex report that their sexual initiation was forced (19). According to the WHO Multi-Country Study on Women's Health and Domestic Violence against Women (2005), in over half of the settings, around 30 percent of women whose first sexual relations occurred before the age of 15 declared it to have been forced (2).

On the other hand, women over 50 face significant risks that have been barely explored. Safe sex messages do not address post-menopausal women who, erroneously, are considered at low risk to HIV and VAW. Several authors have indicated that older women are in fact more susceptible to STIs, including HIV, since estrogen deficiency causes vaginal tissue and the cervix to become more fragile, which can result in injuries that lead to a greater susceptibility to HIV transmission (20).

Formal education

In a systematic review of studies published between 1990 and 2006 in Eastern, Southern and Central Africa, it was found that during the initial stage of the HIV epidemic (before 1995), women with higher levels of education were more vulnerable to HIV than women with fewer years of formal education. Possibly this situation is associated with the fact that women who had achieved a higher level of education also enjoyed a more favorable economic situation, which allowed them greater flexibility with regard to lifestyle decisions such as territorial mobility and number of partners. This group was also more likely to live in urban areas, where HIV prevalence was higher (21). Nevertheless, as the HIV epidemic evolved, this pattern changed, and currently educated women are more likely to negotiate safe sex. Education can influence girls' and women's vulnerability to HIV in different ways: i) it exposes girls to information on HIV, which helps to prevent it, ii) it provides psychological benefits insofar as it elevates their self-esteem and enhances their ability to make decisions/act, iii) it can lead to a more favorable economic situation, which in turn can influence life styles that determine vulnerabilities to HIV, iv) it influences power in sexual relations, and v) it impacts their social and sexual networks (21).

Regarding VAW, the WHO Multi-Country Study on Women's Health and Domestic Violence against Women (2005) found an inverse relation between formal education and level of violence, that is to say, women with higher levels of education reported lower levels of violence. In some settings (urban areas in Brazil, Namibia, Peru, Thailand and the United Republic of Tanzania) it was found that education can function as a protective factor that seems to begin when women's education goes beyond secondary school, corroborating the findings of previous studies indicating that education has a protective effect for women regardless of their income and age (2).

Education can not only increase personal safety as a factor associated with participation in the labor market and a better income, but also in the utilization of HIV prevention and care services. For example, in the Dominican Republic (2002), among women aged 15 -49 years who had experienced IPV, 58.2% of those with a college education had tested for HIV, while only 36.3% of those without a formal education had been tested (22).

Structural processes

Globalization and other structural processes can increase women's vulnerability to HIV and violence, as in the case of migrant workers, trafficked women, and those displaced by emergencies (armed conflict, natural disasters). Regarding migrant women, a study in China found that the rate of casual and commercial sex among temporary migrant women was substantially higher than that for non-migrant women, while the incidence of these practices among migrant men was no greater than for non-migrant men (23).

In the case of trafficked women and girls, among those who had been subjected to sexual exploitation and then repatriated to Nepal, the prevalence of HIV was 38 percent, while up to half of those trafficked to Mumbai, India, and tested for HIV were found to be HIV-positive (24).

Also, in refugee camps, vulnerability to HIV is directly associated with discrimination and abuse of authority as well as to the ruptures in families and communities (25). Emergencies generate important changes in several of the determining factors for HIV transmission, including exposure to the virus through situations characterized by an imbalance of power and an inability to exercise individual rights, which find expression in high levels of sexual violence (26, 27). Food insecurity can increase girls' and women's HIV risk through practices such as unprotected sex to obtain food and money. When food is scarce, many women face challenges to feed

themselves and their families, making them more vulnerable to sexual exploitation, even by humanitarian personnel. The intersections between HIV and displacement can be affected by different factors that vary among refugee populations, such as the degree of interaction with the receiving communities.

A study carried out in Botswana and Swaziland (2007) found that food insufficiency (not having enough food to eat during the previous 12 months) can be an important HIV risk factor increasing risk behaviors in women. Among 1,050 women interviewed in both countries, controlling for characteristics such as income, education, knowledge of HIV and alcohol use, food insufficiency was associated with an inconsistent use of condoms with non-primary sexual partners, intergenerational sex, sexual interchange, and lack of control in sexual relations. The association between food insufficiency and sexual risk behaviors were more attenuated among men (28).

Also, in contexts of armed conflict, cases of mass rape can increase women's HIV risk. AVEGA estimates that almost 70 percent of the women raped during the genocide in Rwanda contracted HIV, and that 80.9 percent of those who survived the violence during the genocide are still traumatized. Although all the cases of HIV among rape victims cannot be attributed to these acts of sexual violence, AVEGA considers that the mass rapes that occurred in 1994 contributed significantly to HIV propagation in Rwanda (29).

However, a systematic review in seven countries of Sub-Saharan Africa on HIV prevalence in countries affected by conflicts and displaced people (Democratic Republic of Congo, Southern Sudan, Rwanda, Uganda, Sierra Leone, Somalia and Burundi), using data from surveys on HIV prevalence including sentinel surveillance in prenatal services, did not show an increase in HIV prevalence during periods of armed conflict independent of the HIV prevalence at the beginning of the conflict. The prevalence in urban areas affected by conflict decreased in Burundi, Rwanda and Uganda to rates similar to those of urban areas not affected by the conflict in their respective countries (30).

2.2. INTERMEDIARY FACTORS

Intermediary factors in the linkages between HIV and VAW are present at various levels and include the laws, norms, values and practices, differential exposures to risks and vulnerabilities, and biases in care, prevention and protection systems as well as in research and information systems on both issues.

2.2.1. Laws, norms, values and practices on HIV and VAW

The behaviors considered normal within a particular community or organization are molded by common values and practices and determined by the structure of existing social relations, including power relations (6). Norms are crucial determinants of social stratification and increasingly the evidence shows that gender norms (social expectations of men's and women's roles considered culturally appropriate) are directly related to women's risks and vulnerabilities to HIV and VAW.

The cultural norms assigned to each gender are the basis for practices within couples, families, communities and institutions. HIV and VAW share common cultural barriers which undermine prevention efforts: harmful practices related to women's sexuality, partner relations and reproduction, obstacles to women's and girls' education, lack of access to care and information and lack of control over economic, social, legal and political resources. Also, in many of the countries most affected by HIV, laws and customs restrict the right of women

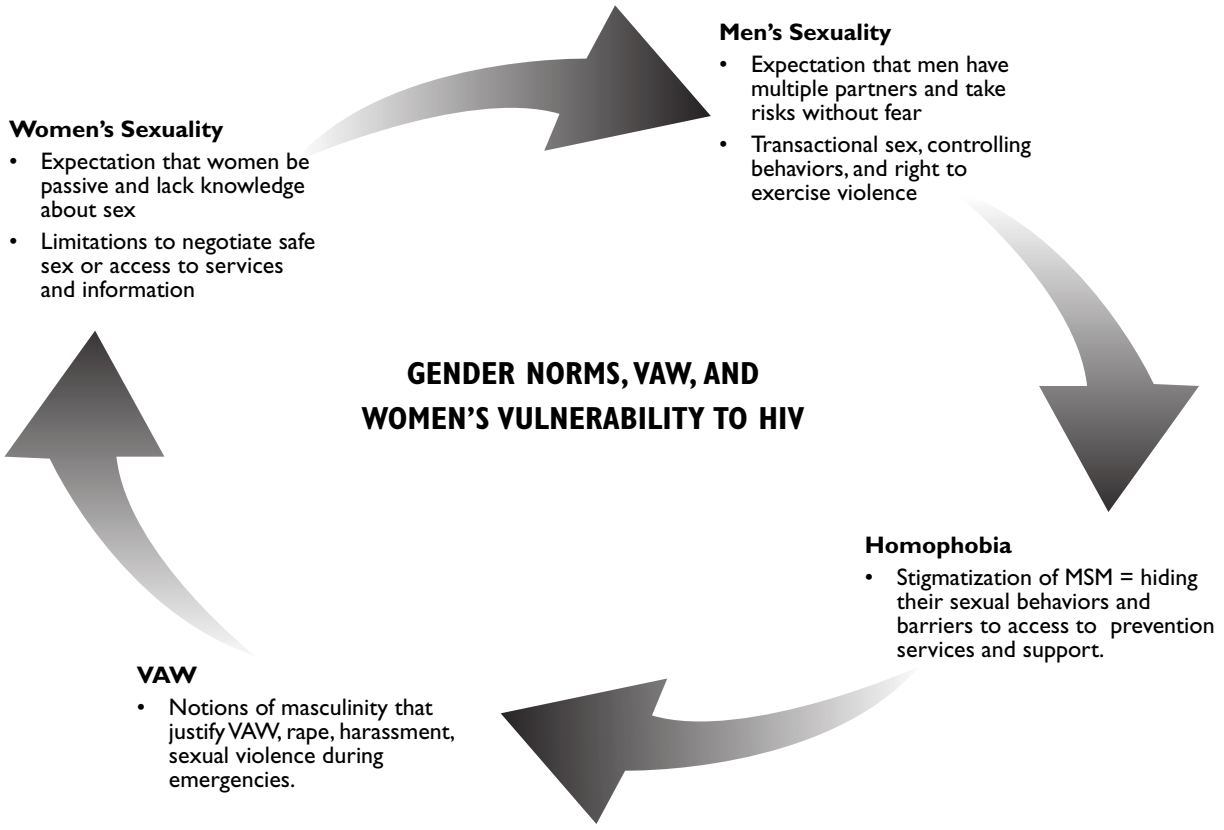
to own or inherit property, including land. In some communities widows are forced to marry a male relative of the deceased (31). 'Widow cleansing' implies unprotected sex for thousands of women. In many countries, genital mutilation exposes women to greater vulnerability to HIV (32).

Regarding gender norms and HIV, a systematic review of 246 scientific articles and 22 books published between 1990 and 2004 (Marson, C. and King, E., 2006) on the sexual behavior of young people of both genders, found that social norms related to perceptions such as whether the partner was "clean" generally play a very important role in decisions and sexual behaviors. Condoms are stigmatized and condom use is associated with a "lack of trust" and social expectations limit communication regarding sex (33). Studies in South Africa show how gender inequality contributes to and reinforces sexual risk behaviors, since girls' adherence to traditional norms limits their ability to discuss sexuality and negotiate safe sex with their partners. Traditional roles are cross-cutting issues within discussions on sexual initiation, decision making, forced sex and condom use (34). Practices also based on gender norms such as child marriage and cross-generational sex put girls at a greater risk of HIV.

Masculinities, HIV and VAW

VAW is a consequence of unequal power relations between men and women and data from surveys using standardized scales of attitudes show that men and boys who embrace more rigid views on masculinity (such as men need to have more sex than women, men must dominate women, etc.) are more likely to report having used violence against a partner, having an STI, having been arrested or having used controlled substances (35). In India (2004) a strong correlation was found between men who had self-reported STI symptoms (an important HIV risk factor) and those who had perpetrated violence against their partners (36).

Figure 2: Gender norms, VAW and women's vulnerability to HIV



With regard to men's acceptance/justification of VAW, research indicates a relation to women's transgression of behaviors assigned to them, especially partner relations and motherhood. In a study carried out in Central America (Belize, Costa Rica, El Salvador, Honduras, Nicaragua and Panama), the proportion of men who condone VAW in different situations oscillates between 2.3 percent and 13.3 percent. Nevertheless, the highest rate of men's justification of physical violence against women was 37 percent, in Belize, (if the woman does not take good care of the children and/or she betrays her partner) (OPS/OMS, 2005) (37).

2.2.2. Exposures, risks and vulnerability to HIV and violence

The relationship between HIV and VAW is a bi-directional one in which, directly and indirectly, they affect each other in an intricate network of causes and consequences. HIV transmission is associated with social conditions that increase risk and vulnerability, including gender inequality and the lack of empowerment of women and girls, stigma and discrimination, and social marginalization, which have been addressed with little effectiveness in the majority of countries around the world (1).

UNAIDS (2005) defines risk is as the probability that a person may acquire HIV infection and indicates that some behaviors can create, enhance and perpetuate risk, such as: unprotected sex with a partner whose HIV status is unknown; multiple unprotected sexual partnerships; injecting drug use with contaminated needles and syringes. Vulnerability is associated with multiple factors that lessen the ability of individuals and communities to avoid HIV infection and –either alone or in combination – may even create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV (39).

Research shows that the probability of reporting IPV is higher among women living with HIV than among those who do not live with the virus (40). Also, direct and indirect ways have been identified through which VAW increases women's risks and vulnerabilities to HIV such as forced sex, IPV, violence in childhood and its relation to risk behaviors in adulthood (41). The violence and power relations that take place within the different modalities of transactional sex also pose a risk factor (40).

Reinterpreting violence from the perspective of women living with HIV – Nizarindandi Picasso (ICW/Latina)

- **HIV, violence and women's life cycle**: many women living with HIV have faced diverse forms of violence throughout their lives and all of these should be addressed as a continuum.
- **Partner violence and HIV transmission**: a partner may know his serostatus and still engage in unprotected sex. Violence following disclosure of an HIV positive diagnosis. VAW poses a barrier to negotiating safe sex.
- **Violence within the family and at the community level**: rejection, leaving our community to flee from violence and therefore losing our assets, violence against our children including expulsion from school.
- **Self-inflicted violence:** hurting ourselves as a means to cope with previous and current experiences of violence. Blaming ourselves for being HIV-positive, punishing ourselves by not accepting and/or adhering to treatment.
- **Intra-gender and among peers:** rejection, placing the responsibility of the HIV transmission on us, discrimination based on sexual orientation.
- **Violence in health services:** violation of confidentially regulations, aggressive and discriminatory treatment, negligence regarding our health needs, forced contraception and abortion.
- **Corporate/business practices:** restrictions to employment, HIV testing without consent, forcing us to resign from our jobs.
- **Lack of social protection mechanisms.**

Nizarindandi Picasso, 2008 *(38)*.

a. Forced sex

Sexual violence is a risk factor for HIV since forced sex with a PLWHA is a channel for transmission of HIV and other STIs. The biological risk in episodes of sexual violence is determined by the type of sexual contact (anal, vaginal or oral); and women who have been forced into sex without protection are exposed to HIV due to injuries to vaginal and anal tissue (42). The Pan American Health Organization (OPS/OMS, 2002) indicates that women's risk to HIV increases because physiologically they are two to four times more susceptible to HIV because they have a greater area of mucous surface where microscopic injuries can appear (42). Forced sex causes bleeding and tearing of the genital area, creating passageways for HIV to enter the bloodstream. Young women and adolescents, whose reproductive apparatus is still developing, are more susceptible to HIV and other STIs. Also, women's risk to HIV increases in the presence of other untreated STIs (42). The Global Coalition on Women and AIDS and WHO have recognized the methodological difficulties to establish a direct link between sexual violence and HIV transmission. Two studies from the USA suggest that while women who are raped are at high risk for pre-existing STI, sexual assault itself presents a small but substantial additional risk of acquiring an STI (43).

b. Intimate partner violence and HIV/STI

Women's vulnerability to HIV is heightened by experiences of physical violence by the intimate partner. In Nairobi, Kenya, among 520 women visiting an STI clinic it was found that WLHA were almost twice as likely to declare lifetime IPV and women with more risk behaviors such as early sex, multiple sexual partners, history of condom use and STI, had experienced more IPV (44). Also, in Connecticut, USA, a study of 3,156 HIV-negative incarcerated women found a strong association between an experience of violence, particularly physical violence, and unprotected sex with the primary male partner (45). Also, women who experience violence are more likely to have a partner at higher risk for HIV (46).

A study of 56 urban, adolescent African-American and Hispanic women found that those experiencing higher levels of IPV had a greater probability of reporting inconsistent condom use. Their sense of control over their sexuality was not directly associated with inconsistent condom use (47).

c. Sexual violence in childhood and sexual risk behaviors

Research shows that sexual violence during childhood is associated with high risk behaviors in adolescence and adulthood, such as unprotected sex and multiple partners. In the Dominican Republic, a study carried out by the Margaret Sanger Center, UNFPA and UNICEF (2007) found that women who were victims of emotional and physical violence in their childhood were more likely to have unprotected sex (without a condom) with a stable partner (fiancé) than those not reporting these experiences (48). The same study also revealed that women who experienced physical violence by a regular partner, were more likely to be exposed to the following risk factors: a) greater number of sexual relations with different partners, b) greater consumption of alcohol, and c) fear regarding the revelation of their serostatus (48). A study of 409 adolescent girls in a multi-ethnic secondary school in Manhattan, New York, revealed that those with a history of sexual abuse during childhood or who had witnessed family violence had up to four times greater probability of reporting sex without a condom, sex after drug use or sex with multiple partners (49). In another study performed in the United States with 357 men and women living with HIV, 68 percent of the women and 35 percent of the men affirmed to having experienced sexual abuse from the age of 15 years. Those with a history of sexual

abuse reported a greater amount of recent unprotected sex than those who had not experienced sexual abuse during childhood (50).

d. Transactional sex, violence and HIV protection

Transactional/compensated sex includes multiple variants, from the traditionally denominated sex work, to interchange of sex for goods, drugs, food, or personal security and even group identity. In Karnataka, India, the HIV prevalence among female sex workers varied depending on the setting, as follows: 16% among those who operated within their own homes, 26% among those who worked in the streets, and 47% among those laboring in brothels (51). The links among sex work, violence and HIV can also overlap with other factors such as drug abuse and migration. In the Virgin Islands (USA), it was found that the sex workers who had used illegal drugs were significantly more likely to report unprotected sex, violence from clients and STI, in addition to having performed sex work in a greater number of countries (52).

Within transactional sex relationships, the man is generally the one who decides on practices such as condom use and/or contraceptives. A study of young men in South Africa (rural area of Eastern Cape) showed a strong association between the perpetration of violence on the one hand, and the giving and receiving of material goods from women on the other hand, which suggests that transactional sex with primary and occasional partners must be seen within the broad continuum of the exercise of power and control by men (53). In Mexico (2004), a study of youths (15- 25 years of age) living in Cuernavaca, Morelos, found that in order to conceal the fact that they were using sex as a means to obtain social and economic benefits, girls would operate within an "engagement/courtship" relationship which subjected them to rules that limited condom use and exposed them to HIV and other STIs. The authors concluded that although transactional sex itself did not necessarily constitute a risk practice, the context in which that type of "engagement" is developed pushes girls to adopt risky behaviors (54).

Another modality of transactional/compensated sex occurs in rituals for the reaffirmation of a group identity. Within the ambit of adolescent males' social activities, is the practice of having sex with one or more girls for the purpose of showing that they (the boys) are not virgins, while for adolescent girls engaging in such a practice is a way to demonstrate friendship with the group of boys. The benefit for boys and girls is acceptance as a member or peer of a certain group (55).

Women WON'T Wait

Women WON'T Wait is an international coalition of organizations and networks from the global South and North. We are committed to women's health and human rights in the struggle to address HIV and AIDS and end all forms of violence against women and girls (56).

2.2.3. Biases within care and protection systems (health, justice or others)

The institutional responses to HIV have been characterized by the predominance of a biomedical and individualized approach that has relegated the role of gender and other pushing social factors in the dynamics of transmission of the virus to secondary status. Other biases are expressed in the inadequate level of investment from governmental and international cooperation to effectively address gender inequalities, stigma and discrimination, and to improve the levels of participation of WLHA and women's groups in the design, implementation and evaluation of HIV policies and programmes. Also, some laws can increase women's vulnerability to violence and HIV. In some countries the current legal framework does not typify certain crimes such as rape in marriage, sexual harassment or trafficking in women and girls. Also, victims of violence face limitations

Budget and national policy responses to gender inequality

More than 80% of national governments report a focus on women as part of their multisectoral strategy for HIV, but only 52% report having a dedicated budget allocation for programs addressing women's issues (UNGASS Country Progress Reports, 2008). The largest proportions of countries with reported budgets for such efforts are in Asia (69%) and sub-Saharan Africa (68%).

UNAIDS, 2008 *(1)*.

to access to justice due to geographic, economic and cultural barriers, gender biases in the justice administration system and lack of legal advice and counseling. Besides, in some countries, cases of domestic violence and even rape are conciliated which can put women at greater risk due to the imbalance of power between men and women that restrict a fair agreement and its fulfillment.

Other laws and norms relating to HIV, women's economic and social rights, migration, drug use, sex work, sexual and reproductive health, among others, can exacerbate women's vulnerability to IPV as well as institutional violence (health, justice, police) and violence within the community, thereby impeding them from adequate access to care, prevention and protection.

Another example of biases in the health system's response to the specific needs of women in relation to HIV is the low priority assigned to female condoms, even though it is the only available technology for the prevention of HIV transmission that is controlled by women. Research on the female condom indicates high levels of acceptance by women and an increased number of protected sex acts. At the same time, it is a cost-effective method when provided together with male condoms (57). Nevertheless, women still do not have broad access to female condoms, and other new technologies controlled by women, such as microbicides, will not be available for several years.

Regarding VAW, several studies have shown barriers to access to services, such as insufficient budgetary allocation, low quality of care, poor resolution capacity of services to fit women's needs, providers' attitudes (stigma, discrimination), deficient institutional mechanisms for ensuring women's safety, concentration of services in urban areas, and the high cost of care and treatment, among others (58, 59). In the WHO Multi-Country Study on Women's Health and Domestic Violence against Women (2005), women were asked whether they had ever sought official public sector services or contacted people in positions of authority for help (police, health services, legal advice, shelter, women's nongovernmental organizations, local leaders, and religious leaders). It was found that in all sites, a majority (between 55% and 95%) of physically-abused women reported that they had never gone to any of these types of agencies (2). Usually, abused women do not seek institutional help due to the lack of available services, but even in places where such services are close at hand, stigma, discrimination, and fear of losing their children prevent women from using them.

The deficiencies in the institutional responses to the physical, psychological, economic and social consequences of VAW and HIV have produced a domestic care overload for the women usually responsible for this work within families and communities. Research undertaken in Sub-Saharan African countries points out that 90 percent of the care to PLWHA is given in the household, usually by older women, and more than 60 percent of orphaned boys and girls in highly affected countries live in households headed by grandmothers. Households headed by older women are twice as likely to include orphans as those headed by older men (60).

2.2.4. Biases in researching HIV and VAW

Ever since the first HIV cases were identified, various authors have pointed out the significance of social stratifiers and inequalities as pushing factors of HIV transmission and have foreseen the feminization of the epidemic. Paul Farmer (1999) and Bill Rodriguez (1997), among others, have criticized the predominance of a biomedical approach to HIV, in which women are characterized not as subjects but objects related to their partners' risk behaviors or as vectors of the virus, transmitting it to their partners and babies *(61, 62)*. Nevertheless, there has been a consistent lack of analysis of social determinants within the first and second generation HIV epidemiological surveillance systems, constituting a serious barrier to analysis of the social, political and historical construction of the virus. Whenever HIV was associated with sexual activity and stigmatized groups (homosexuals, IDU, sex workers, Haitians) it became a problem of "at-risk populations." Although HIV is a biological entity, the driving social factors determining the dynamics of its transmission—social, economic and political—have been barely addressed.

Regarding VAW, although significant progress has been made in terms of policies and care programs and, to a lesser extent, primary prevention, the development of research and information systems is still meager. Also, diverse authors are increasingly producing information focused on showing that IPV and other types of violence are not a power/control issue and that they affect equally both men and women. The information intended to show symmetries between women and men in terms of the magnitude, severity, intentions, contexts and consequences of violence is growing in volume, although some data exists which contradicts such evidence and questions its validity and reliability *(63)*.

2.3. Social, economic, and health consequences

HIV and VAW share a number of health and development consequences affecting women, families and communities. HIV has a severe impact on people living with the virus while increasing the demand for social services, reducing productivity and increasing levels of dependency. HIV has brought about the greatest single reverse in human development (UNDP, 2005). In the most affected countries, the HIV epidemic has reduced life expectancy, deepened poverty in households and communities, decimated populations, undermined national systems and weakened institutional structures. The epidemic's effects have been more muted, although still considerable, in regions where HIV prevalence is lower than in sub-Saharan Africa. In Asia, for example, HIV has lowered life expectancy by 3 years in Cambodia and by 1.7 years in Myanmar (Commission on AIDS in Asia, 2008) (1).

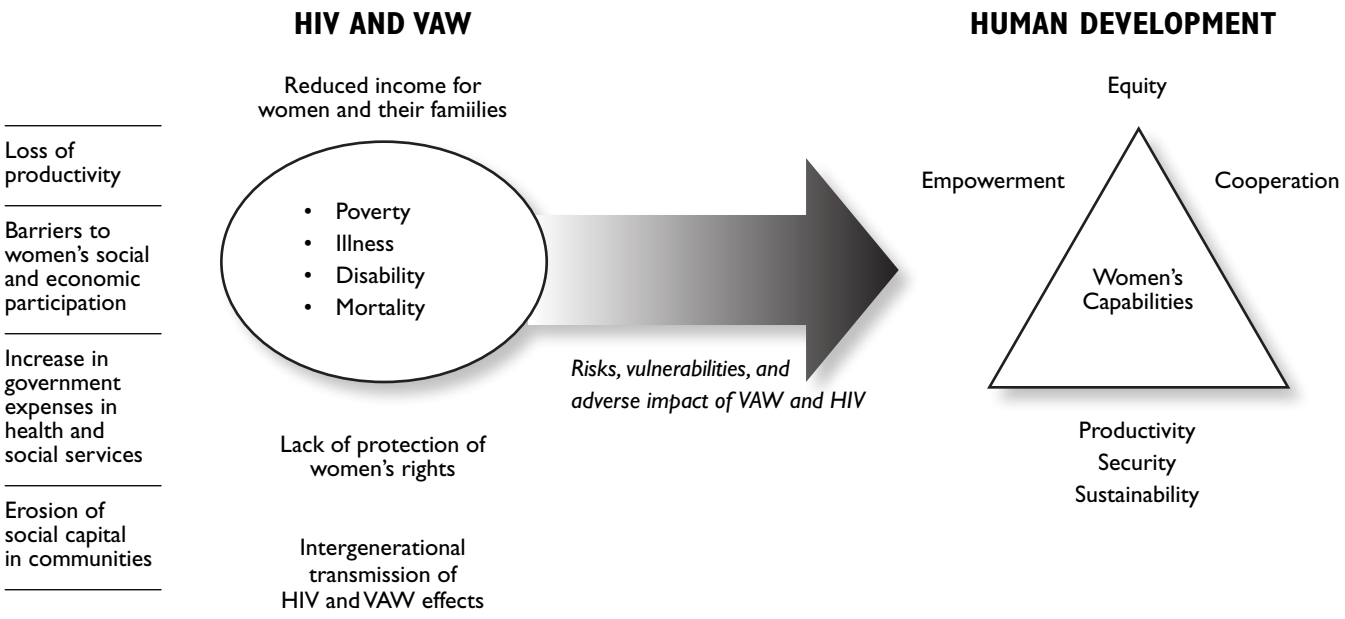
Although in recent years access to treatment has increased, helping to reduce the number of deaths associated with HIV, it is still one of the leading causes of death worldwide. In 2007 alone, 33 million [30 million–36 million] people were living with HIV, 2.7 million [2.2 million–3.2 million] people became infected with the virus, and 2 million [1.8 million–2.3 million] people died of HIV-related causes (1). The consequences of HIV on women have occurred at varying paces but with some common characteristics such as: deterioration of health; increase of social exclusion expressed through the reduction of social interaction with relatives and neighbors, fellow workers and friends; lack of access to resources such as housing and transport; loss of businesses and livelihoods; and low self-esteem (64). On the other hand, women are the primary caretakers of PLWHA, and are more likely to abandon school, experience violence, lose their properties and live in poverty (57).

In relation to the consequences of VAW, an international group of experts estimated that the disability-adjusted life years (DALY) caused by domestic violence and rape in women of reproductive age reached 5

percent in developing countries and 19 percent in the developed ones. The differences can be associated to a gender bias and underestimation of these causes in developing countries (65). Maria Antonia Remenyi (2008) analyzed the relationship among VAW, the Human Development Index and Gender Development Index and found that 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. It means that the lower the human development and the lower the gender development, the greater the VAW. However, the relation is not very strong since VAW affects women of all social strata and in all countries around the world (10).

Research at the international level shows multiple effects of IPV including homicide, suicide, maternal mortality, injuries, functional alterations, chronic pain, mental health problems (post-traumatic stress, depression, drug abuse), sexual and reproductive health problems (unwanted pregnancies, STI, gynecological problems, abortions, pregnancy complications, and pelvic inflammatory disease). IPV also influences women's perceptions of their future, limits their access to education, employment, and social participation generating absenteeism, reduction of productivity, and lowering income (66).

Figure 3: Linkages of HIV, VAW and human development



3. INTEGRATING PROGRAMMES OF HIV AND VAW

3.1. Definition of HIV/VAW integration

Traditionally, HIV and VAW programs have been separate. Depending on the epidemiological scenario, in many countries HIV interventions are concentrated in the so- called key and/or at-risk populations, whereas many of the VAW services work mainly with women at reproductive age, children and adolescents. Although some domestic and sexual violence care protocols include interventions on STI/HIV, only rarely are these incorporated in practice and where post exposure prophylaxis programs for rape cases are in place, they generally work in isolation from traditional programs of HIV and VAW. A study on medico-legal and health services for victims of sexual violence in Central America found that 70 percent of the centers reported offering HIV counseling, 66 percent HIV testing and only 25 percent provide HIV treatment (67).

The concept of integration varies across organizations and countries and can be implemented at different levels (macro, sectoral, institutional and community). According to WHO (2008), integration of health services implies the reorganization and reorientation of health systems to ensure the delivery of a set of essential interventions as part of a continuum of care, in a more efficient and coherent way in terms of costs, results, impact and use (acceptability) (68).

Other authors define the integration of services/programs from an operational point of view: "Integration in the health sector has been defined as offering two or more services at the same facility during the same operating hours, with the provider of one service actively encouraging clients to consider using the other services during the same visit, in order to make those services more convenient and efficient" (Foreit KGF, Hardee K., Agarwal, K. 2002) (69).

International instruments and tools for integrating HIV and VAW programs and services.

- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- The Millennium Declaration
- United Nations General Assembly Declaration of Commitment on HIV/AIDS
- Political Declaration on HIV/AIDS
- Regional HIV/STI Plan for the Health Sector 2006-2015 (PAHO/WHO)
- V World Conference on Women – Plan of Action
- United Nations General Assembly Declaration on Violence Against Women
- Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women.
- Declaration of San Salvador on Gender, Violence and HIV (CIM/OAS)
- Call to Action on Family Planning and HIV/AIDS in Women and Children
- The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health.

Regardless of the definition, approach or model adopted, HIV/VAW integration is a two-way process in which HIV programs incorporate VAW interventions and VAW services incorporate HIV interventions. In several countries there are opportunities and enabling conditions to carry out the HIV/VAW integration:

- The required infrastructure within some HIV programs already exists to offer VAW services (counseling, crisis management, referrals, places for distribution of educational materials, community outreach, etc.). On the other side, VAW services in some countries would possibly have to make

bigger changes, particularly those that are situated within programs with no linkage to sexual and reproductive health and/or STIs. But other programs might not require significant changes in their infrastructure when integrating HIV components, such as those for legal counseling, microfinance and community education for VAW prevention.

- Many human resources working on HIV and/or VAW have professional skills in counseling and orientation, which constitutes an important basis upon which to build up comprehensive competencies on HIV/VAW integration.

- The logistical system of HIV/STI care and prevention can be used to carry out activities on VAW. Health programs addressing VAW generally do not include: supplies such as HIV test kits, ART and non-antiretroviral drugs (antiviral, antibiotics, etc.); condom distribution (masculine and feminine); HIV tests or viral load count. However, this does not constitute a significant barrier since integration permits complementary resources, assuring access to them through an efficient system of referral and follow-up.

- The community outreach activities on both subjects can be integrated through multiple routes. For example, the legal promoters working on VAW can develop interventions on the promotion of rights and access to justice including specificities of HIV and WLHA, whereas the community educators on HIV/STI can inform the communities on HIV/VAW intersections regarding their causes and consequences.

HIV/VAW integration also can imply important institutional challenges such as the need for additional human and financial resources, which can also reduce the availability of those resources from other services. In this sense, HIV/VAW integration must be done without affecting the quality of other services. For example, in countries in which the investment in VAW prevention and care relies heavily on funds from international agencies, it can be difficult for managers to define a strategy to expand those services and include new interventions, although this can also be an opportunity to mobilize resources from other sources and strengthen their current interventions. On the other hand, the work overload on human resources working in HIV/VAW integration can affect not only the quality of the services but also the physical and emotional state of the providers, so self-care strategies must be in place. Similarly, political support can be scarce if decision makers do not perceive HIV/VAW integration as a cost-effective strategy.

3.2. Why invest in the integration of HIV and VAW programs and services?

a. Personal, familiar and social dimensions and implications of both problems. A significant proportion of WLHA experience violence while many survivors of violence (SV) are highly vulnerable to HIV/STI. The intersections between HIV and VAW increase social inequality and women's discrimination, generating disease, disability, death and high personal, family and social costs. HIV/VAW integration has the potential to produce important changes not only in the prevalence and incidence of both problems, but also in basic indicators of development such as life expectancy, the morbi-mortality profile, in education, access to work, social participation, exercise and protection of human rights.

b. HIV/VAW integration can increase social fairness and access to HIV and VAW services as well as reduce risks, vulnerabilities and discrimination associated with both problems. In spite of the importance of access to information and services in the elimination of both problems, very few SV use the existing services of prevention and support. In order to reduce the prevalence and incidence of VAW and HIV it is necessary to increase the access to integral services of attention and prevention.

Also, HIV/VAW integration has the potential to lessen health and life risks to women, while helping to eliminate the stigma and discrimination related to both epidemics.

c. Missed opportunities and efficiency of interventions. HIV/VAW integration may be one of the most efficient ways to reduce gaps in access to information and services enabling a process of empowerment that allows women to get the services they need. Isolated or vertical programs contribute to missed opportunities to take care of women's needs regarding HIV and VAW.

d. Cost and effectiveness of interventions. Integration can be financially viable and the investment can have important benefits and returns for systems in charge of the HIV and VAW institutional response. A suitable integration has the potential to increase the impact of current interventions and make them more cost effective.

f. Improve skills of human resources. HIV/VAW integration requires staff to have the proper skills and attitudes to evaluate and diagnose, to support women's empowerment and to carry out referrals in a comprehensive manner, which is why human resources must be suitably prepared and have the appropriate supplies, tools and managerial support and self-care programs in place. Integration can constitute an opportunity to develop new skills in human resources and a means to improve the quality of care.

Costs of HIV and VAW

- For women and their families: out-of-pocket expenses including treatment, medicaments, recovery for physical and psychological damage, time invested in home care. HIV and VAW decrease family income due to work absenteeism, job loss, mortality, and additional costs for the caring of orphans.
- Costs for care and prevention systems: long term treatment, emotional support, prevention and control programs, human resources, infrastructure.
- Direct and indirect costs for society as a whole: services for orphans, judicial and police services, barriers to access to education of girls, years of healthy life lost due to premature death and/or disease, loss of productivity.

Maria Antonia Remenyi, 2008 *(10)*.

g. HIV/VAW integration can improve the inter-sectoral response to both problems on different levels guided by shared basic principles. There is no single method or model for integrating HIV/VAW interventions. For this reason, the success of inter-institutional efforts will depend on the application of broad principles, adapted to the context and local needs.

h. HIV/VAW integration will strengthen public policies on both issues. The integration process can be more effective if it is supported by an integral framework of policies (laws, protocols, budget, plans) enabling connection of programs and services at the various levels, with the political will and support of decision makers and the adequate allocation of financial, human and technical resources.

i. Improve inter-sectoral and inter-programmatic coordination. Effective and efficient integration requires a coordinated network of services/interventions at different levels including care, prevention and social protection, complemented by the development of the key social systems such as health, justice, education, etc., supporting inter-sectoral and inter-programmatic work.

j. HIV/VAW integration will accelerate the achievement of international commitments on human development and gender equality established in the Millennium Declaration, UNGASS, United Nations General Assembly Declaration on Violence Against Women, Convention of Belem do Para, CEDAW, etc.

3.3. Guiding principles of HIV/VAW integration

a. Human rights and gender equality are cross-cutting values of HIV/VAW integration.

b. Policies and plans to sustain integration are necessary, although they do not ensure its success by themselves.

c. Advocacy and integrated interventions are essential to change social norms, attitudes and behaviors that work as pushing factors of HIV and VAW.

d. The integration process must be adapted to the epidemiological, economic, social and cultural context in each region, country and community in which it takes place.

e. Adequate and systematic training for ongoing skills development of providers (formal and informal) is needed and should be accompanied by self-care programs.

f. Women must have access to services and essential interventions for both problems under ethical standards of safety and quality of care.

g. The inter-sectoral collaboration and participation of all stakeholders involved, such as governmental agencies, NGOs, PLWHA, community leaders, volunteers and women's groups, are crucial to ensure the success of the integration process.

h. To consolidate approaches that are more likely to have a greater impact on human development, health and exercise of human rights, while increasing the effectiveness and efficacy of existing programs. Integration must add value to the current interventions and avoid duplication.

i. A basis in scientific evidence. HIV/VAW integration should be based on the information available on both issues and an evaluation of lessons learned of experiences in different contexts.

Linking Reproductive Health, Family Planning and HIV/AIDS programs in Africa – Key issues to consider when integrating HIV and VAW services

a. **Functional definition of integration:** Integration can have different meanings including integrating services and programs to allocate funds from one to another. Each alternative of integration has its specific problems (stigma, donors' policies, etc.) It is necessary to differentiate between "linkage" and "integration," especially when considering human resource capacity and training levels required of staff.

b. **Barriers related to public policies:** While service integration can happen operationally at the field level, program administration and policy factors can influence implementation, particularly in terms of access to and extent of budgetary resources. Family Health International (FHI) designed, implemented and evaluated various integrated service delivery models in Kenya, Zimbabwe, South Africa and Nigeria. These experiences have demonstrated that a supportive national policy environment is necessary but insufficient for integration to succeed. Integration requires dedicated funds and infrastructures at national, provincial, district and service delivery levels along with programmatic coordination between the family planning, reproductive health and HIV/AIDS units of the Ministries of Health. Services have to become client-centered, rather than product-centered. In order to avoid turf issues between donor-driven vertical programs, the roles and responsibilities of partners must be agreed upon and articulated prior to beginning the integration process.

c. **Burn-out of human resources:** Investigators noted that the biggest barrier to overcome in integrating services in Amhara is the high burnout rates experienced by health professionals, in part due to heavy workloads.

Department of Community Health, Addis Ababa University, Bill and Melinda Gates Institute for Population and Reproductive Health and Johns Hopkins Bloomberg School of Public Health. Ethiopia. 2008 (70).

j. To ensure a suitable financial and human resource allocation.

k. Information and M & E systems will allow monitoring and follow-up on the integration processes and their impact.

3.4. Levels of HIV/VAW integration

HIV/VAW integration must be based on multi-level strategies to ensure sustainability, regardless of the levels selected for a specific initiative.

- **Macro:** Actions at this level allow for development of the inter-sectoral alliances needed to design general directives, adapt the legal framework effectively to enable HIV/VAW integration, and ensure budgetary allocation at the central level. They also will provide a platform to reach agreements on the implementation of integrated programs with donors.

- **Sectoral:** The different sectors (health, justice, education, labor, women's and gender equality mechanisms, HIV commissions, emergency boards, etc.) will create tools (guides, protocols, norms or others) to jointly carry out their interventions, while they coordinate and administer the technical and managerial components of their own sectors. Also, integration implies processes of harmonization between the changes in the systems (management) and the direct interventions that each sector implements.

Principles of HIV/VAW integration

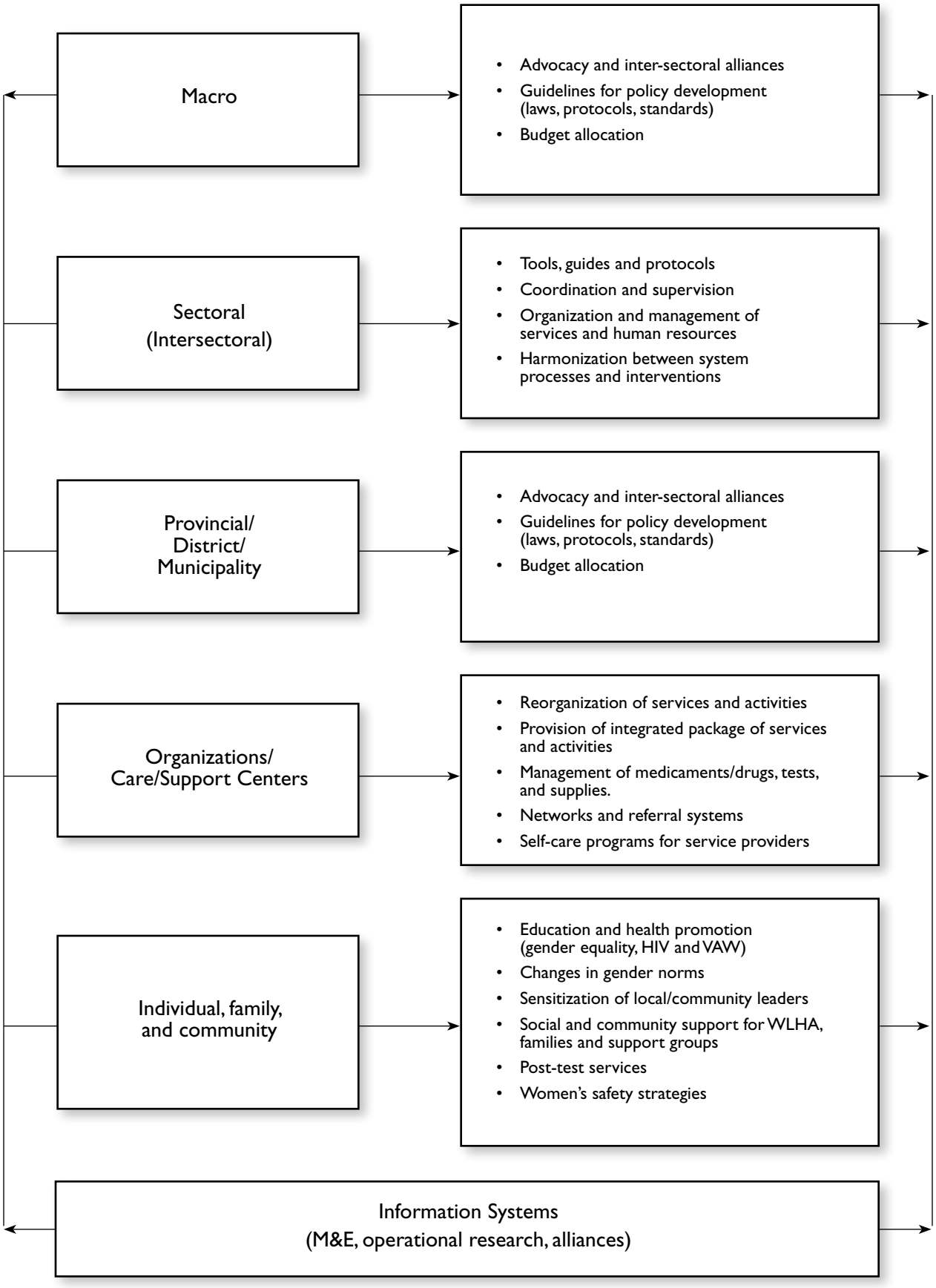
- Human rights and gender equality.
- Public policy enabling interventions in all levels.
- Changes in cultural norms, attitudes and behaviors related to HIV and VAW are critical.
- Integration should be tailored to context.
- Human resources development including self-care programs.
- Services and interventions based on ethical standards and women's safety.
- Social participation and inter-sectoral coordination.
- Promotion of synergies with ongoing initiatives.
- Based on scientific evidence.
- Adequate allocation of funds and human resources.
- M & E systems in place.

- **Provincial/District/Municipal:** Local levels play an important role in HIV/VAW integration, regardless of the type of decentralization in place within the countries. It is on this level where the necessary adaptations of tools, guidelines and protocols take place, the direct interventions aimed at different population groups are coordinated and where supplies and provisions are handled.

- **Institutional/organizational:** HIV/VAW integration implies internal changes within all the participant organizations and may include reorganization of services and activities, design of new packages of integrated services, drug supply chain management, tests and supplies, service networks and referral systems, as well as training and self-care programs for service providers (formal and informal).

- **Individual, family and community:** It includes working with the community to modify gender norms, carry out prevention activities and to create social support and women's safety mechanisms.

Figure 4: Levels and key activities for integrating HIV/VAW programs and services



3.5. Steps to develop processes of HIV/VAW integration

a. Situational analysis: To determine the needs and options of integration, it is necessary to evaluate the epidemiological scenario of HIV and VAW, the legal framework and other policies, sectoral responses (health, justice, work, education, etc.), the prevailing norms on sexuality, gender roles, risk factors and vulnerabilities, as well as existing local resources. In this sense, the situational analysis must be participatory and use several methods of data collection to respond to the following questions:

- What are the dimensions of HIV and VAW and through which routes do both problems intersect?
- What are the perspectives of key stakeholders in regard to HIV/VAW integration? What are women's perceptions in relation to HIV/VAW integration?
- What are the social, cultural, economic and political factors influencing both problems and the existing social responses?
- What are the services and programs available on HIV and VAW? Who are their main users/target populations? What key populations are not being reached by these programs and services? Do the existing services and programs have an empowerment approach that promotes human rights and gender equality?
- What type of integration is necessary and possible to develop in this specific context?
- What could be some of the strategic and logistic implications of HIV/VAW integration? Which are the implications in terms of human, financial and technical resources? Which are the strategic alliances? How can the meaningful participation of WLHA, SV and women's groups in general be guaranteed?

For developing the situational analysis it is recommended to use the following tools included in this manual:

- **Tool # 1:** Situational analysis of HIV and VAW
- **Tool # 2:** Evaluation of legal framework on HIV and VAW
- **Tool # 3:** Stakeholder mapping for integrating HIV and VAW programs and services

For cases in which integration is designed within emergency contexts after natural disasters, it is recommended to use:

- **Tool # 4:** Institutional mapping in emergency contexts after natural disasters.

b. Planning: Using the results of the situational analysis performed previously, the high-priority populations (specific groups and/or general population) and geographic areas are established. The participation of the personnel who will be involved in the integration process is crucial, as well as other service providers and decision makers. Next, it is necessary to identify viable interventions to be integrated, the need to adapt or to create protocols that respond to integration, as well as networks and referral systems. The integration plan must outline clearly the following components:

- Background and rationale: Magnitude (prevalence, incidence) of VAW and HIV, legal framework and other public policies, sectoral responses.
- Guiding principles, approach and technical structure of the integration initiative.
- Logic of the intervention: objectives, indicators, results, activities, assumptions and risks.

- Implementation: Functional structure of the integration initiative, implementing institutions and focalization, training and self-care programs for formal and informal providers of integrated services of HIV and VAW.
- Costs and efficacy: budget breakdown by expenditure lines, identifying sources of financing, as well as criteria to measure the efficacy and effectiveness of interventions.
- Monitoring and evaluation: M & E plan including methods for data collection and baseline.
- Sustainability and risk management strategies.

For the planning process, it is suggested to use the following tools:

- **Tool # 5:** Evaluation of the empowerment approach to programs and services on HIV and VAW.
- **Tool # 6:** Worksheet for prioritizing integrated HIV and VAW services.
- **Tool # 7:** Key components of self-care strategies for formal and informal service providers.

Using the information produced through these tools, the model of integration is designed with the participation of key organizations and stakeholders. The model of HIV/VAW integration in indigenous communities in South America presented in **Tool # 8** can illustrate an adopted option. Since it is anticipated that integrated initiatives will be scaled-up once they are proven and evaluated in pilot experiences, **Tool # 9** is also recommended to review the Strategic Approach for developing initiatives of integration of HIV and VAW.

c. Implementation: must be based on the interventions previously selected and sustained in protocols, women's safety measures, and with s uitable human resources and infrastructure.

The tools for working on the implementation will depend on the interventions selected, and may include the following:

- **Tool # 10:** The ecological approach applied to HIV/VAW integration.
- **Tool # 11:** Guide for designing an exit survey for HIV- and VAW-related needs at VCT sites.
- **Tool # 12:** Needs evaluation for integrating VAW into PMTCT services.

For designing a training plan for human resources working in HIV/VAW integration it is recommended to use **Tool # 13**: Planning competency development for human resources working in HIV/VAW integrated programs and services.

d. Monitoring and evaluation: It implies systematic collection of information and the analysis of progress, obstacles and achievements, costs, evaluation of integrated services from the user's perspective, and identification of lessons learned. In order to design the M&E system, it is recommended to review **Tool # 14**: Rapid assessment of data collection methods.

COMPONENT	ASPECTS TO CONSIDER
I. Infrastructure	Physical space for the prioritized services/interventions Space for support groups or educational activities Safe room for tests and storage of provisions Geographic accessibility
II. Materials	Educational materials for waiting rooms, community activities, social mobilization and advocacy Test kits (HIV and other STI), ART and other drugs Condoms (female and male) Safety plans for violence survivors Directory of resources on HIV and VAW Specific forms for data collection
III. Human resources	Human resources with adequate skills and motivation to implement integrated interventions of HIV and VAW. Supervision in place to support human resources working in HIV/VAW integration. Programs of self-care for formal and informal service providers.
IV. Alliances and inter-sectoral coordination	Networks or mechanisms of inter-sectoral and inter-programmatic coordination. Measures to ensure meaningful and consistent participation of WLHA, SV, women's groups and the community in general.
V. Budget	Budgetary allocation for HIV/VAW integration within the general planning of the participant organizations Strategies for financial sustainability of integrated services/activities Negotiation with financing sources (including donors) to assure support to HIV/VAW integration.
VI. Monitoring and evaluation	Baseline, methods of data collection for M&E, funds to ensure M&E.

UNIFEM The UN Trust Fund in Support of Actions to Eliminate Violence against Women

It was established by General Assembly resolution 50/166 in 1996 and is managed by the United Nations Development Fund for Women (UNIFEM) on behalf of the UN system.

HIV/AIDS Window – Addressing the linkages between violence against women and HIV and AIDS (2007)

1. **Renaissance Santé Bouaké**—Côte d'Ivoire, Africa

   Project Title: Prevention and women's protection against violence and support to HIV-infected women"

   Description: In post-conflict Bouaké, this project aims to sensitize public authorities, community members and traditional leaders on the impact of conflict on women, including HIV-infection. Local communities and State representatives will be trained on international women's rights conventions, violence against women and its intersection with HIV, with a view to reducing HIV-infection among women as well as discrimination and stigma among HIV-positive women. It will also provide psychological support to women who are survivors of violence or HIV-positive, and will advocate to increase women's role in the traditional leadership of Chefferie.

2. **Réseau National des ONGs Pour Le Développement de la Femme**—DRC, Africa

   Project Title: Supporting the reduction of the twin pandemics of HIV and AIDS and violence against women

   Description: In six sites in East DRC with a high prevalence of violence against women and HIV/AIDS (Goma, Bukavu, Uvira, Kindu, Kalemie, and Kisangani), the project will work to reduce the impact of the twin pandemics by training 400 stakeholders, including police, local women leaders, religious leaders and NGOs on women's human rights and providing support and legal redress for violence against women and HIV/AIDS. The project will support female survivors of violence infected or affected by HIV/AIDS through medical care and five psycho-social support houses. It will also contribute to their economic empowerment by setting up micro-finance initiatives benefiting women in 7 rural sites.

3. **Ethiopian Women Lawyers' Association (EWLA)**, Ethiopia, Africa

   Project Title: Reducing Gender-based Violence in Nazreth, Awassa and Bahir Dar

   Description: The project aims to reduce gender-based violence in three areas with high prevalence of HIV. In cooperation with the Gender Based Violence Taskforce, the project will develop the capacities of paralegals, police, judges and prosecutors to apply legal provisions addressing gender-based violence and HIV and to address the intersection of these pandemics. EWLA regional coordinators, legal counselors and survivors will be trained as trainers on survivors' self-representation. Capacities of health professionals in relation to the legal framework and their responsibilities with regard to women who have experienced gender-based violence will be developed. The project will also enhance cooperation among service providers at the regional and national levels. Emerging good practices will be disseminated and possibilities for replicating results and lessons learned in other cities will be explored.

4. **SidAlerte-Fria**, Guinea, Africa

   Project Title: Fighting sexual violence and HIV/AIDS among sex workers in Guinea's mining zones

   Description: SidAlerte-Fria, in partnership with the Association Guinéenne pour l'Implication des Femmes dans le Processus Electoral en Guinée (AGUIFPEG), will be working to reduce sexual violence and risk of HIV infection among sex workers in Guinea's mining zones. It will raise awareness among sex workers and mining workers who solicit sexual services, on the interrelation between sexual violence against women and HIV. The project will seek to empower sex workers to negotiate protected sexual intercourse and raise awareness of their human rights. The project will also support them to improve their physical security and facilitate the establishment of peer support groups. An advocacy component will work towards demanding State accountability for protecting sex workers' human rights.

5. **Forum Mulher,** Mozambique, Africa

   Project Title: Transforming Beliefs, Traditional Practices and Service Delivery to Redress Violence against Women and Reduce Women and Girl's Vulnerability to HIV-infection

   Description: Working in Chibuto and Xai-Xai, two districts of the southern Mozambique province of Gaza with high prevalence of HIV, this project will support the implementation of the National Plan on Advancement of Women (2007-2009) and the National Strategic Plan to Combat HIV/AIDS (2006-2009), in partnership with the government. The project aims to strengthen the access of female survivors of violence to services through developing standardized procedures of clinical, psychological, police and legal assistance. Community dialogue to transform harmful traditional beliefs and practices that increase women's and girls' risk of HIV infection will be strengthened through working with traditional and opinion leaders. A national men-to-men campaign will be launched to promote men's active participation in efforts to eradicate violence against women and girls and HIV.

6. **Doctors to Children**, Russia, Central and Eastern Europe and the CIS

   Description: In partnership with Doctors of the World-USA, St. Petersburg branch and the Administration of Kalininsky Rayon of St. Petersburg, Doctors to Children (DTC) will work to reduce discrimination and violence against HIV-positive women in St. Petersburg. Particular attention will be given to those who are pregnant or have young children, to prevent child abandonment and ensure their sustained access to treatment, care and support. To this end, the project will develop an inter-agency protocol to respond effectively to cases of violence against HIV-positive women and their children that will be piloted in one administrative district of St. Petersburg and then up-scaled city-wide. A service model will be developed to prevent violence against HIV-positive women and their children by addressing their needs. The project will also work to transform attitudes and behaviors of intimate partners, family members, and the larger community to reduce violence against HIV-positive women and their children resulting from stigma and discrimination.

7. **FEIM Argentina**, Argentina/Brazil/Chile/Uruguay, Latin America and the Caribbean

   Project Title: Two faces of the same reality: violence against women and HIV.

   Description: FEIM Argentina, with their partners GESTOS (Brazil), Mujer y Salud (Uruguay) and Educación Popular en Salud (Chile) will undertake research about the intersection of violence against women and HIV/AIDS, promoting integral public policies to fight both pandemics in the four countries. Qualitative and quantitative research will be conducted in each country, which will include interviews with women survivors of violence and public employees, civil society organizations and the academic community. The data collected will be used for the elaboration of national reports to be presented in each country in events with the media, government sector and women's networks. A regional report will be presented in the framework of the V Latin American and Caribbean Forum on HIV/AIDS and STDs in Peru in 2009. The project will also develop a communication strategy to disseminate its findings, including the creation of a website.

8. **Centro de la Mujer Peruana "Flora Tristán"** -Peru, Latin America and the Caribbean

   Project Title: Local and community based responses for prevention and care for HIV/AIDS and violence against women in the Villa El Salvador District

   Description: The project aims at promoting change in attitudes on HIV/AIDS among men and women, with a view to encouraging safe behavior and reducing stigma and discrimination related to women's HIV-positive status. The project will train women, youths, teachers and service providers to increase their knowledge and skills to identify and prevent high-risk situations. It will also advocate at the policy level to raise awareness of the stigma and discrimination faced by HIV-positive women, and to promote the inclusion of the twin pandemics in the district's development plans. Finally, the project will strengthen the capacities of two health centers providing care and treatment of women and youth at risk. Flora Tristàn will partner with women, youth, local elected officials, police, health workers and officials from Villa El Salvador District in the implementation of the project.

The Global Coalition on Women and AIDS recommended key actions to be developed by national governments to integrate strategies to reduce VAW into national AIDS plans, and to increase access to HIV services within VAW prevention efforts – and ensure adequate budget allocation to address those linkages. The recommendations are:

a. Supporting community-based training and information campaigns to change harmful norms and behaviors that perpetuate VAW and reinforce its social acceptability. This includes working with men and communities to address VAW, as well as engaging women's, faith-based, and other groups in preventing and coping with violence and its links to HIV.

b. Promoting economic opportunities for women through microfinance and skills training to give women the tools and economic independence they need to avoid or escape violence, and reduce their risk for HIV.

c. Ensure that HIV programs begin to address the realities of VAW as a barrier to HIV services by providing training for HIV service providers to recognize the signs of violence, to offer basic counseling and social support, and appropriate referrals for additional assistance, including legal services, where available.

d. Providing training to law enforcement officials and others who may encounter victims of violence about the risk of HIV and proper referrals to prevention information, medical treatment, and PEP, where appropriate, to reduce the immediate risk to HIV.

• Strengthen the legal and policy environment so that laws prohibiting VAW are enacted and enforced, that systems to report on the prevalence and acceptability of VAW are established and maintained, and that these monitoring mechanisms effectively feed into the design of national AIDS programs.

Inter-American Commission of Women (CIM/OAS)

This initiative aims to contribute to regional and national efforts to reduce the prevalence of HIV in Central America and, in particular, violence against women and its negative consequences on health and human development of the victims, their families, and their communities.

Participating countries: El Salvador, Guatemala, Honduras, and Panama.

Expected results

a. Four models of policies, one per country, describing the key components required to develop integrated policies and programs related to prevention, services, and treatment of HIV and VAW.

b. Four capacity-strengthening strategies developed in order to ensure the implementation of the integrated model through training, network strengthening, knowledge management, and technical tools for institutional development.

c. A set of measurements for safety and standards for service and prevention integrated in the organizations developed to assure the quality of priority interventions.

d. Implementation of pilot experiences, utilizing the integrated model of policies and programs and documenting and identifying lessons learned that will serve as a base for its adaptation in diverse contexts at the local and national level.

e. A network for information exchange, successful experiences, and technical cooperation at a sub-regional level.

CIM/OAS, 2008 (73).

- Ensure that organizations, particularly those with experience addressing violence against women, are represented on national AIDS councils and other relevant fora to help ensure that the link between violence against women and HIV is effectively addressed within the design and implementation of national AIDS programs *(72)*.

Pan American Health Organization (PAHO/WHO)

National studies on domestic and sexual violence and HIV in Central America

In 2006, PAHO developed country studies in Belize, Honduras and Nicaragua on the linkages between two specific types of violence (IPV and sexual violence) and HIV to estimate the incidence of HIV on women users of VAW services and violence history in WLHA. The studies also explored attitudes on gender roles, impact of VAW and coping strategies as well as knowledge, attitudes and practices regarding HIV/STI.

PAHO, 2005 (74).

4. INTEGRATION OF KEY COMPONENTS OF PROGRAMS OF HIV AND VAW

4.1. HIV and VAW prevention

In the majority of countries around the world, HIV policies have been dominated by a biomedical and individualized approach which has translated into a low investment in primary prevention. UNAIDS (2008) has pointed out that the rate of new HIV infections has fallen in several countries, but globally these favorable trends are at least partially offset by increases in new infections in other countries (1). Also, although VAW prevention strategies have produced important advances in the level of knowledge on the problem in several countries, violence against women and girls continues to be a widely-accepted practice, particularly when it is to preserve traditional gender roles assigned to women.

From a public health approach, all types of prevention (primary, secondary and tertiary) are intimately connected and are mutually reinforced, since early diagnosis of HIV and VAW can help to stop the cycle of violence and to offer the care needed on both problems, as treatments to curtail deaths or to palliate their effects can prevent new HIV infections and/or new cases of violence. The experience in prevention on both problems has shown that multi-level interventions (individual, interpersonal, community, sectoral and macro) are required and that knowledge itself is not a sufficient condition to produce behavioral changes in a sustainable manner.

Prevention approaches which focus on so-called high risk populations constitute a palliative and temporary strategy inasmuch as they do not seek to alter the underlying causes of these problems but to identify the individuals who are particularly susceptible to those causes (75).

Even recognizing the importance of preventative measures for so-called "bridge populations" to reduce HIV transmission, given women's condition of discrimination, violence and lack of access to resources of protection, these approaches do not address their specific vulnerabilities, and therefore the feminization of the HIV epidemic in many countries is not surprising.

Structural approaches to HIV prevention

a. Sustained progress in HIV prevention will require a structural approaches rather than continuing to address individual-level factors.

b. Structural factors are defined as physical, social, cultural, organizational, community, economic, legal, or policy aspects of the environment that facilitate or impede efforts to avoid HIV infection. These factors operate at different levels and affect individual risk and vulnerability to HIV.

c. When implementing a structural approach, there is no single blueprint that will work in all contexts. Instead, strategy should be relevant to the particular needs of the population being served.

d. Assessing the effectiveness of structural approaches may be challenging. Improving assessments of structural approaches also means recognizing the limitations of random controlled trials for investigating complex structural factors. These trials are the gold standard of evidence for some public-health issues, but are most appropriate where the intervention being tested is proximate to the risk behavior that it is seeking to change.

Rao Gupta, Geeta et al. 2008 (10).

a. Women and HIV prevention

The HIV prevention choices for women are still very limited. An integral HIV prevention strategy requires a combination of structural approaches, biomedical interventions, behavioral change, women's empowerment, elimination of VAW, strengthening of social justice and protection of human rights.

The scant importance assigned to environmental risk factors such as poverty and gender inequalities has resulted in HIV prevention strategies directed to people who possess a certain level of individual control and autonomy in decision making over their sexuality and other spheres of their life, which does not take into consideration the situation of women and girls (Krishnan et al, 2007) (76). A case that exemplifies this situation is the ABC strategy (abstinence, be faithful and condoms) used for HIV prevention, which does not address the needs of women or the realities of relations between men and women, and which therefore ignores the fundamental pushing factors of the epidemic (77). This approach is not a viable answer for many women who are subject to rape or sexual coercion by partners or strangers, or who are limited by violence to negotiate the use of a condom (78). Among young women interviewed in Harare (Zimbabwe), Durban, and Soweto (South Africa), 66 percent reported having had a single partner in their lifetime and 79 percent abstained from sex at least until the age of 17 years. Nevertheless, 40 percent of these women were living with HIV (79).

Men's sexual behaviors and their risk perception on HIV/STI transmission, increase women's vulnerability to HIV. For example, a study on extramarital sex in Mexican men and the HIV/STI risk of their partners, found that 15 percent reported sexual intercourse with someone other than their primary partner in the year previous to the survey, and of those, only 9 percent used a condom during their last sexual relation, and 80 percent did not perceive themselves at risk to HIV infection (80). Also, men's level of knowledge on HIV/STI varies across countries and within them. Although progress has been made regarding women's knowledge of ways to protect themselves from HIV/STI, important gaps persist in many countries. In India, the National Family Health Survey, 2006 (NFHS III), showed that women's awareness of HIV had increased to 57 percent, in comparison with 40 percent in the previous edition of the survey (NFHS II). Nevertheless, only 34.7 of them knew that the consistent use of a condom can reduce the probability of HIV transmission (81).

Managing Expectations Around Microbicides (PATH)

Timing of microbicide availability: Currently, three microbicide candidates are in the last stages of testing (which can take up to four years) to determine whether they are effective. We do not know yet whether these candidates will work. If one does work, it will take another 1 to 2 years for individual countries to go through their own regulatory processes and decide whether to approve the drug for marketing in their country.

Drug development: It is a long and complicated process. It can take 10 to 15 years between the discovery of a promising lead and its availability on the market.

Microbicide effectiviness: The early microbicide products are likely to reduce risk of transmission by no more than 40 to 60 percent. But even a partially effective microbicide can provide substantial protection from HIV, especially if used consistently. Even a 60% effective HIV/STI microbicide could avert 2.5 million HIV infections over 3 years, if introduced into 73 low-income nations, according to modelling by the London School of Hygiene and Tropical Medicine.

The prospect of a woman-initiated method means that the discussion on use can happen outside of the bedroom and women can take prevention into their own hands.

PATH. 2008 (82).

Technologies to prevent HIV infection – female condoms and microbicides

Some women prefer the female condom to the male condom, since it provides more flexibility in terms of when to wear or withdraw it. Nevertheless, some donors and policy makers remain skeptical as to whether there is sufficient demand for female condoms, although projects reveal a significant demand already in place. In this sense, the expansion of access to female condoms does not depend on the users, but on whether donors and governments are willing to invest in buying them, to develop programs supporting their distribution and use, as well as to make them affordable. At the worldwide level, in 2007, roughly 423 male condoms were produced for each female condom, and the unit cost of female condoms is 18 times that of a male condom. In 2007, total funding for female condoms is estimated to have been no more than 0.3 percent of the total funding for HIV responses (55). The new strategies and trends on HIV prevention aim towards the combination of behavioral interventions, biomedical and structural approaches.

b. VAW prevention

Systematic evaluation of VAW prevention programs reaffirms the findings regarding HIV prevention: knowledge does not necessarily translate into behavioral changes and when they do happen, it does not ensure that individual transformations endure over time. In this sense, provision of information is not sufficient to generate a positive and sustainable behavioral change (83). Also, attitudinal change and sensitization seem much easier than modification of violent behaviors (84). Some evaluations indicate that VAW prevention strategies can be more effective if they integrate interventions at different levels targeting cultural changes, laws to sanction violence and protect women, and to increase women's access to justice. Equally effective can be programs focused on women's empowerment, provision of services to prevent the occurrence of new episodes, harm reduction strategies, as well as efficient safety and support resources for the victims (85).

Some prevention programs addressing VAW from reproductive health and HIV sectors have included communication strategies for behavioral change at individual and community levels through alliances with other organizations and addressing an ample range of subjects such as HIV, gender equality, and micro-enterprises, among others. Some initiatives have measured changes in sensitization levels and attitudes, although challenges remain to evaluate changes in behaviors and practices (86).

Criminal prosecution for HIV transmission and VAW

- The fact that many women are first to acknowledge publicly that they are living with HIV, opens the door to accusations that they transmitted the virus to their partners, which could increase violence against them by their partners and/or relatives, or rejection in the community.
- Risks of economic violence and violence in the workplace: loss of employment, stigma and discrimination by coworkers and supervisors, loss of business and income, barriers to access to credit, and financial destitution.
- Violence in health and social services: discrimination, additional barriers related to confidentiality. Women will be unwilling to tell service providers if they are having difficulties avoiding unprotected sex.
- Disincentive to testing.
- The threat to confidentiality posed by criminal investigation may deter participation (or honesty) in sexual behavior research which provides an essential evidence base for HIV prevention.
- Female sex workers, injecting drug users and other population groups can face criminal prosecution.
- Research evidence on the public health impact of criminal prosecutions for reckless transmission of HIV is limited. Further research on its linkages with VAW is urgent.

Adapted from Ruth Lowbury and George R Kinghorn. Criminal prosecution for HIV transmission. BMJ 2006; 333; 666-667 (89).

A systematic review of IPV primary prevention programs targeting middle and high school students showed that all used a combination of the feminist theory and social learning theory and those having a measurable positive impact were ones that put together interventions at individual and community levels (87).

In some countries the interventions with men have shown changes in macho attitudes, including an increase in their participation in domestic activities and more solidarity behaviors toward women. Also, promising experiences on VAW prevention within reproductive health, HIV and life skills approaches for youth have been developed (84). Entertainment and education programs using mass media (radio and TV) such as Sexto Sentido in Nicaragua increase knowledge on VAW, favorable attitudes toward equitable distribution of domestic work and rejection of VAW (88).

The "Stepping Stones" workshops have been implemented in more than 40 countries focusing on modifying behaviors and cultural norms related to HIV, gender and relationships. This initiative has reduced the acceptance and the prevalence of VAW and promoted sensitization on HIV and condoms through community dialogues (90). Also, the Men as Partners project in South Africa, implemented by EngenderHealth, produced changes in men's perception regarding equal rights for men and women, showing that wife- beating was wrong (91). In Brazil, the Program H headed by Promundo improved attitudes of young men towards gender equality and produced reductions in risk of HIV and other STIs (92).

Microfinance, intimate-partner violence, and HIV (Limpopo, South Africa)

The IMAGE project study undertook a cluster of randomized trials to assess the combined intervention of microfinance and Sisters for Life which is an open-ended group program that uses workshops covering sexuality, HIV, and gender roles, to strengthen confidence, communication, and leadership among women. Providing business opportunities and developing social networks, the investigators anticipated that women would be more strongly placed, as economic contributors to their households, to challenge inappropriate sexual roles and behaviors. In addition to increased wealth and decreased violence, it was hoped that benefits would extend to participants' households and villages.

The authors show a dramatic reduction in intimate partner violence, which was halved after 2 years. Although participants' wealth increased, no benefits were seen at household and community levels for which follow-up was less complete, effect sizes were small, and confidence intervals wide. Particularly disappointing was the failure to increase school enrolment for household children, condom use for non-spousal partners, or to decrease HIV incidence in the community. Self-selecting participants and multiple interventions will make it difficult to generalize findings, but there is no doubt that for those individuals receiving interventions the program was a success.

The Lancet. Editorial. Vol 368 December 2, 2006.

UNIFEM (2003) proposed ethical considerations in strategies of communication on VAW applicable to HIV/ VAW prevention interventions (93):

- Recognize that gender inequality and discrimination are at the base of VAW and HIV and must be addressed.
- The messages and materials must make the safety and wellbeing of all women, individually and collective, the first priority.
- Use of direct and graphical messages, but never materials that exploit, stigmatize or reinforce stereotypes about women and men. They must reflect positive models, as well as positive interactions and behaviors in relation to HIV and VAW.

- Use of constructive and positive ways to involve men in HIV/VAW prevention without putting at risk women's safety and confidentiality.
- Linkages between primary, secondary and tertiary prevention strategies, to ensure a comprehensive response to care demands that can be generated through primary prevention interventions.

Efficacy of an HIV Prevention Program among Female Adolescents Experiencing Gender-Based Violence

The objective of this initiative was to examine the efficacy of an HIV prevention intervention among African American female adolescents reporting a history of gender-based violence. It was developed in Birmingham, Alabama over the course of a year, on the subset of 146 participants who reported a history of gender-based violence at the baseline assessment. The authors categorized young women who had ever been coerced into having intercourse against their will by their boyfriend or who had been physically abused (i.e., they had been kicked, slapped, hit, or pushed or had had something thrown at them) by their boyfriend as having experienced gender-based violence. Participants were randomly assigned to either a 4-session HIV prevention intervention or a 4-session general health promotion intervention. The HIV prevention intervention consisted of 4 interactive group sessions, 4 hours each in duration, conducted on consecutive Saturdays. Participants randomized to the general health promotion intervention also attended 4 interactive group sessions (4 hours in duration). These sessions focused on the importance of exercise and proper nutrition, provision of information on local venues for purchasing healthy foods, and the health consequences of a poor diet.

Over the entire 12-month period, participants in the HIV prevention intervention reported significantly fewer episodes of unprotected vaginal intercourse in the preceding 30 days than participants in the general health promotion intervention, as well as significantly fewer episodes of unprotected vaginal intercourse in the previous 6 months. Also, the percentage of condom-protected sexual episodes in the previous 30 days was significantly higher in the HIV prevention group. Finally, participants in the HIV prevention group reported a slightly higher (non-significant) percentage of condom-protected sex acts in the preceding 6 months.

In comparison with participants in the general health promotion intervention, participants in the HIV intervention had higher HIV prevention knowledge scores, had more favorable attitudes toward using condoms, reported fewer perceived partner-related condom barriers, demonstrated greater proficiency in applying condoms, and had higher condom use self-efficacy scores. The frequency with which they negotiated safe sex was not higher than the frequency observed among participants in the general health promotion intervention.

Wingood, Gina et al. 2006 (94).

4.2. Voluntary counseling and testing

WHO (2003) has indicated that in several countries women's fear of violence keeps them from using HIV testing and counseling services (95). Studies in Uganda show that women are scared to ask their husband for money or permission to visit a HIV center or to look for information, and in some cases, partners have explicitly prohibited women to be tested (96). In Tanzania, among female users of VCT services in Dar es Salaam, young women living with HIV (<30 years old) were ten times more likely to report violence by their current partner than women of the same age group who were not living with the virus (97).

In the United States of America, 4 of 20 studies reported that women experienced violence as a result of disclosure of the results of the HIV test, on average 8 percent; ranging from 3.2% to 24%. Some authors indicate that those women with a history of physical or sexual violence were more likely to face violence as a result of disclosing their serostatus (95).

Benefits of routinely asking women about VAW within VCT settings

- Increase the rates of VAW disclosure and benefits from intervention.
- Opportunities to reduce barriers to prevention, care, and treatment of HIV associated with VAW.
- Change the social and individual acceptance of VAW as natural , for WLHA as well as for those who test negative.
- It can be a means for changing service providers' attitudes toward VAW and help to reduce stigma and discrimination related to HIV and VAW.
- Helps ensure the safety of women, whether or not HIV-positive.

Some countries show variations in HIV testing rates and level of knowledge about where to get tested, depending on women's history of violence. In Haiti (2000) and Colombia (2004), the proportions of women that had experienced violence and knew where to get an HIV test were 23.7 and 49.9 percent respectively, whereas among those with no history of violence the proportions were 21.8 and 54.6 percent. Nevertheless, the proportion of women who had been tested, among victims of violence in both countries, was 3.6 and 20.4 percent, whereas among those who had not experienced violence the figures were 3.7 and 17.1 percent, respectively (22).

Sharing HIV test results with a partner can be beneficial to women since it can lead to an increase of preventive behaviors as well as improving access to treatment and care. According to WHO (2003), rates of disclosure to sexual partners are higher among women in the developed world (average 71%; range: 42%-100%) compared to women in the developing world (average 52%; range: 16%-86%) (95). Among the barriers to disclosure are fear of abandonment, rejection and/or discrimination, violence, upsetting family members, and fear of being accused of infidelity. A recent study using a US probability sample of HIV- positive patients in primary care found that 20.5% of women, 11.5% of MSM, and 7.5% of other men had experienced physical harm after their diagnosis (98).

In some countries, only 1 percent of adults has sought VCT and only one out of ten PLWHA knows his/her serostatus (UNAIDS, cited by Panos). VCT services are a suitable means to improve access to prevention, care and treatment of HIV and VAW. Nevertheless, several authors have raised concerns about strategies such as the "opt-out approach" since it implies the elimination of individual informed consent requiring clients to actively decline the HIV test after a pretest information session. Even though the benefits of increased access to HIV testing are known, other potential outcomes have been analyzed in relation to stigma, risk of violence or abandonment, possible psychological impact and the false sense of security that a negative test result might give if high risk behaviors persist (99). Women may be more affected by measures that eliminate individual informed consent due to their marginalized social status. The differences in status between pro-

viders and clients can influence the ability of women to make decisions on their own behalf. Due to gender norms women may be less likely than men to question providers' recommendations. Literacy and language barriers and the lack of tailored information in pre-test sessions may in the future exacerbate the problem for women (100).

Gender differences among sero-discordant couples should be taken into account. Home-based, voluntary counseling and testing has found that over 2% of cohabiting couples in the Bushenyi region of Uganda are sero-discordant for HIV. The men in these partnerships are more likely than the women to be HIV-positive, and condom use in these couples is very low (101).

Given the magnitude of the diverse forms of VAW, asking about these experiences during pre and post HIV testing could help to provide women with needed support and services. The social stigma surrounding VAW and HIV prevent women from talking about them or seeking help. A systematic review of IPV screening in health settings concluded that, although there is not sufficient evidence to recommend routine screening programs, health centers should aim to identify and support women facing violence (102). Some authors have stated that screening strategies in health settings increase referrals to other services and this strategy seems to be highly acceptable to women, whether abused or not (103).

Potential benefits of integrating VAW intervention in VCT services

WOMEN WHO TEST NEGATIVE FOR HIV	WOMEN LIVING WITH HIV	COMMUNITY
a. It can be a motivational factor to confront violence as a means to stay HIV negative. b. It enables informed decision-making and development of skills to negotiate protected sex. c. It provides an opportunity to identify cases of sexual violence and prevent high risk behaviors related to those experiences. d. It gives an opportunity to evaluate HIV/STI risk. e. It improves access to care and support of VAW through referral systems. f. May be an opportunity to increase access to HIV testing. g. Prevention of perinatal transmission.	a. Early access to support services to prevent or treat VAW sequels. b. It promotes behavioral change and provides support to prevent re-infection due forced sex or risk behaviors associated with previous experiences of sexual violence. c. Opportunity to evaluate risk to violence. d. It facilitates the development of a safety plan for SV. e. Identification of mental health problems as a result of VAW and effects of living with HIV. f. It supports adherence to treatment, reducing associated risks of abandonment due to VAW. g. Prevention of perinatal transmission.	a. Promotes knowledge regarding the linkages between HIV and VAW, and potentially, reduces VAW and other pushing factors related to HIV transmission. b. Changes women's risk perception. c. It enables a supportive social environment for VAW prevention. d. It promotes openness and reduces the fear and stigma associated with HIV. e. It encourages community responses for supporting WLHA and SV. f. It supports the protection and promotion of human rights in relation to HIV and VAW.

Practical considerations for professionals working in the fields of violence prevention and HIV care.

- **Stigma:** Although the CDC's recommendations are an attempt to "normalize" the process, HIV testing and diagnosis remain heavily stigmatized in many communities in the United States. The same is true for IPV. It is important to note that at-risk clients may also be battling internalized stigma surrounding either HIV or IPV or both, meaning that a person believes the negative stereotypes associated with HIV and IPV. This can have a substantial influence on whether a client is forthcoming about his/her own status, fears, or conditions. In addition, health care providers, counselors, and other professionals must be aware of their own beliefs regarding HIV and IPV. Their perceptions, beliefs, and discomfort can influence their behaviors which can convey a prejudice against a person in need of assistance. If this is the case, professionals may avoid asking the necessary questions to ascertain risk or they may ask the questions in a manner that inhibits the client from disclosing. Universal screening can address this stigma. For general health care providers, incorporating HIV testing and IPV screening into routine health visits for all patients may build trust and decrease the discomfort surrounding disclosure. Those providers working in reproductive health should routinely assess for IPV as well as HIV risk. In addition, those working in areas where HIV-related services are offered such as VCT, prenatal and postnatal care, and general HIV treatment, should incorporate violence screening and resource referrals into usual care for all.

- **Warning Signs of Overlap:** Health care practitioners and other professionals must be aware of the signs of potential overlap between HIV and IPV. If a client is engaging in HIV risk behaviors, is reluctant to get tested for HIV, and/or resists disclosing a positive test result to a partner, the client may have an underlying fear of abuse from that partner. If an HIV positive individual is having difficulty adhering to an HIV medication regime, there may also be underlying abuse issues. Additionally, if a client screens positively for IPV, this may indicate that they are at a higher risk for HIV. Domestic violence advocates who are aware of the overlap between IPV and HIV should encourage their clients to get tested. Health care professionals should also consider these possibilities when working with their clients and offer strategies to promote safer sexual practices.

- **Disclosure plans:** Special care must be taken when considering partner notification if abuse is present in the relationship. Not all victims are ready to leave the relationship and plans must be developed accordingly. Clients who experience abuse will need to develop safe disclosure plans if they are HIV positive. HIV counselors who incorporate IPV screening into their post-test counseling can help their clients develop safe disclosure plans with the understanding that the disclosure may result in an escalation of violence.

- **Trauma Histories:** Because there is often a history of trauma among those individuals who are HIV positive, HIV support group facilitators should address trauma histories as part of the counseling process.

- **Couples testing and counseling:** This relatively new approach to HIV testing and counseling has demonstrated promise in a few African countries, and was added to the VCT priorities of the President's Emergency Plan for AIDS Relief in 2006. However, a search of PubMed, Web of Science, and NLM Gateway databases was unsuccessful in locating any published studies or meeting abstracts describing its use in the United States.

Baty, Marguerite L. 2006. (*104*)

Considerations for integrating VAW interventions within VCT services

a. **Pre-test counseling:** some programs combine different modalities of counseling: individual, couples, family, and group counseling. All of them should address the links between HIV and VAW as well as the available options such as mediated counseling to support disclosure, access to care, treatment and support, prevention of perinatal transmission, self-care and care for WLHA. Strategic and practical considerations should include the potential implications related to the rapid test. Women should be consulted as to whether they prefer a longer wait time for receiving the test results, to allow them an opportunity to reflect on the topics addressed during the pre-test counseling session and the implications of partner involvement (105).

b. **Test:** The HIV test must be voluntary and confidential, and must be accompanied by counseling. For those with a positive result, medical and psychological care must be provided. The post-test follow-up should be ensured.

c. **Post-test counseling:** It includes referrals, support for disclosure through mediated counseling or other options for protecting women from violence. Those obtaining a negative result must receive counseling about staying HIV negative through empowerment to negotiate safe sex and communication with their partners about sexuality. Also, they should be advised on risk behaviors related to sexual violence through referrals and emotional support services.

Discussion on gender within VCT services for young people

a. Do girls have the right to refuse sex with a boy?
b. Are boys more manly if they have several girlfriends?
c. Do you think it is a good idea to have a "sugar daddy"?

Fischer, Suzanne et al. 2005 *(106)*.

AIDS counseling for survivors of domestic violence

If you are counseling a survivor of domestic violence who is HIV positive or fears that she is HIV positive, you will need to assess the needs and concerns related to her HIV status:

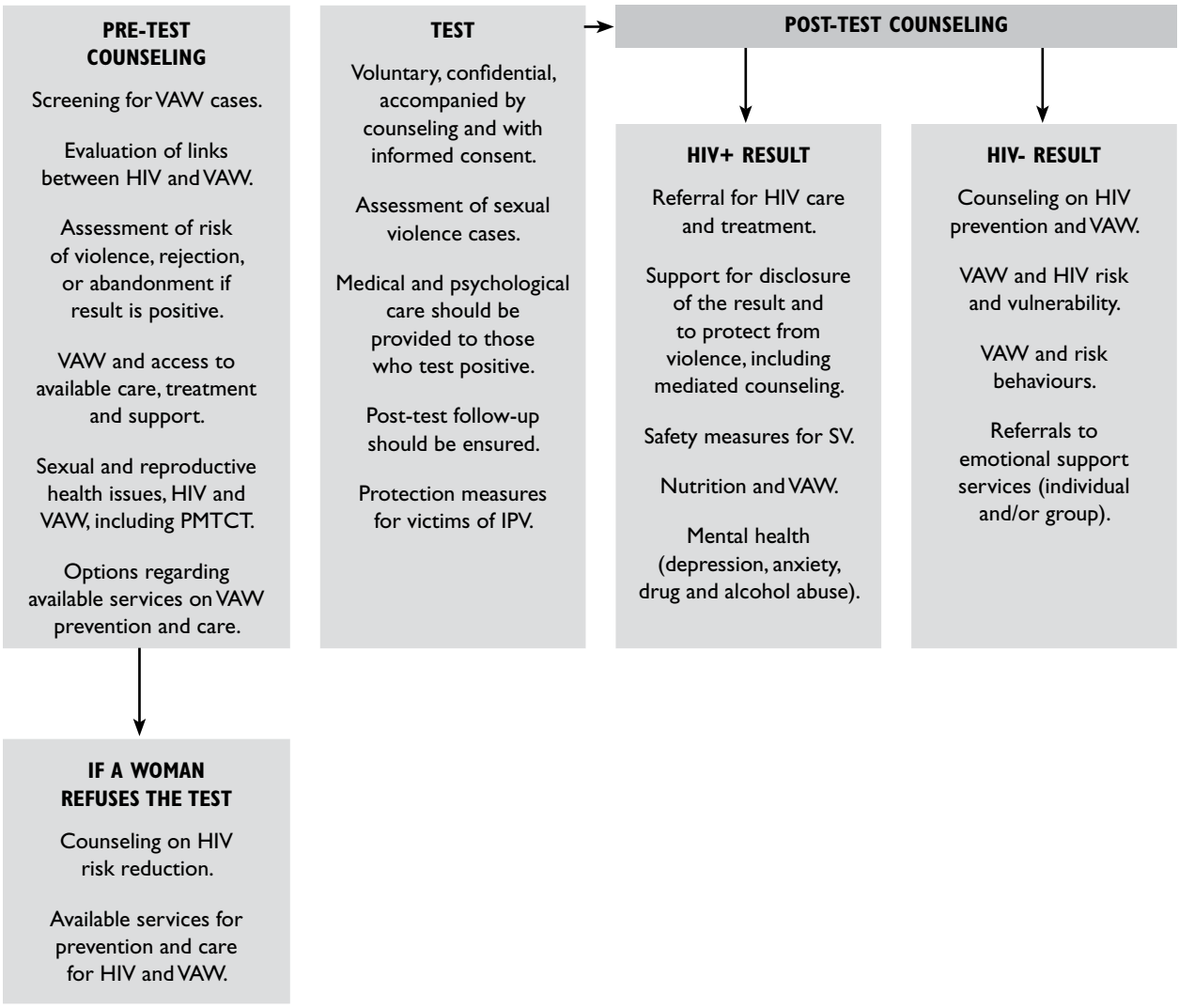
a. Explore your client's level of understanding of HIV and AIDS, her beliefs, attitudes, and possible misconceptions. Correct any wrong information she may have and be sure that she gains a more accurate understanding of HIV, its transmission, and its effects of causing AIDS.

b. If your client is concerned about being infected with HIV, explore the reasons for her concern. Help her identify risks of infection related to her lifestyle and ways to reduce the risks. Discuss the possibility of HIV testing and tell her about available counseling and testing services. Provide accurate referral information if she wishes to be tested.

c. If your client already knows that she is infected with HIV assist her to adjust emotionally. HIV infection is not a death sentence. Counsel her on techniques of positive living and about issues of disclosure. Tell her about support groups of people living with HIV. If she is interested, refer her to a group that is most appropriate to her needs.

The Southern African AIDS Trust. 2004 (107).

Integrated services of routine VCT and VAW



4.3. Prevention of HIV perinatal transmission and VAW

VAW is an issue of crucial importance for PMTCT since it can constitute a barrier to access to services and can generate results that affect the health and well-being of the mother and the fetus. Violence during pregnancy affects a significant proportion of women worldwide. According to the WHO Multi-Country Study on Women's Health and Domestic Violence against Women (2005), the proportion of women who had ever been pregnant and who reported having experienced physical violence during at least one pregnancy ranged from 1% in urban Japan to 28% in provincial Peru, with the majority of sites falling between 4% and 12% (2). The Centers for Disease Prevention and Control (CDC, 2005) reported that homicide was the leading cause of death among pregnant women, with higher risks for women under 20 years old and African-Americans (108). Violence during pregnancy can be associated to abortions and maternal death. PAHO/WHO (2005) indicated that pregnant women or post-partum mothers can die due to obstetrical complications produced by abdominal trauma, for example, hemorrhages or abruptio placentae (loosening of the placenta), which can cause the death of the fetus or the woman. Also, the stress and fear created by violence can trigger physiological responses (for example, hormonal responses) that lead to adverse obstetrical results. Similarly, when the capacity of women to make decisions or to relocate is jeopardized, by situations of control by the partner or economic limitations, women's ability to seek help in case of obstetrical complications is restricted (109).

VAW as a barrier to access to PMTCT

Some studies indicate that violence or the fear of it can prevent women from acceding to the HIV test and/or condoms offered in the prenatal care services. In a hospital in Mbale (Kampala, Uganda), a very low acceptance of prenatal VCT was reported. It was found in a sample of 457 women that 54 percent had suffered IPV in their lifetime and 14 percent had been physically abused during within the previous 12 months. Focal group results showed that women declined to be tested for HIV and to ask their partner to use condoms out of fear of IPV (110). Also, in Nairobi, it was found that a history of trauma can prevent women's participation in PMTCT programs (111).

The perception that disclosure of HIV test results can cause VAW is common among men and service providers. In Tanzania, the perceptions of men, women and of counselors on couple counseling and HIV in prenatal clinics was explored through focal groups. Several participants agreed to the importance of incorporating VCT within the prenatal services, while others expressed reservations due to the cultural beliefs that those services are only for women. In addition, many participants anticipated that disclosing the serostatus, whether positive or negative, to an HIV negative partner could lead to abandonment, divorce or VAW (112).

IPV can constitute a barrier of access to antenatal care (ANC), particularly in those countries where such care is not universal. Results from the demographic and health surveys in Cambodia, Colombia, Egypt, Haiti, India, Nicaragua, Peru, the Dominican Republic, and Zambia found that in the majority of the countries there was no significant difference in access to ANC among abused women and non-abused women; nevertheless, in Egypt, among those that were abused only 32 percent of births received prenatal care, in comparison with 41 percent of births in non-abused mothers. In India, the proportions were 58 and 67 percent, respectively. The authors indicated that the data suggests that the experience of violence is not an obstacle for accessing ANC in those countries in which it is nearly universal, but that it is a significant hurdle in countries where ANC is not universal (113).

It should be noted that the proportion of women who get tested and return to find out the results is low in many countries and that this can be associated with social factors. A study carried out by the Policy Project for USAID (2003) in 73 countries with more than 10,000 PLWHA, found that VCT, ART to prevent mother-to-child transmission, or counseling on nursing options for newborns had been offered to only one out of ten pregnant women (114). In a comparative study on opportunities of PMTCT among Hispanic and non-Hispanic women in California, it was found that Hispanics were less likely to receive timely access to ANC, to be offered an HIV test or to have taken the test (115). Also, women using ANC can face problems such as being tested without documented pre-test counseling, such as in the case of Barbados (2004), where the proportion of these cases reached 14.3 percent (116).

Opportunities to integrate VAW care and prevention within PMTCT programs

PMTCT programs can constitute a venue to address VAW, particularly within VCT, strategies on reduction of stigma and discrimination, nutrition and post-partum care. The integration of VAW interventions within PMTCT programs may be a way to achieve the following objectives:

- To prevent future unwanted pregnancies in WLHA.
- To promote men's participation in maternal health, communication between partners, and the use of condoms as dual protection tools (HIV and unwanted pregnancies).
- To extend the birth interval in WLHA and therefore to protect their health.
- To reduce maternal and child mortality associated with violence.
- To reduce other STIs which in some countries are more prevalent among abused women than non-abused women.
- To offer care for pregnancies due to rape, preventing HIV/STI and perinatal transmission.

Integration of VAW within PMTCT programs must take into account the needs and perspectives of users of those services and be accompanied by outreach activities at the community and family level to promote social support and reduce the stigma and discrimination related to pregnancy in WLHA.

4.4. Care, treatment and support of HIV and VAW

WLHA have an ample range of needs including psychological support, ART, treatment for opportunistic infections, non-antiretroviral drugs, support for enabling and promoting their social participation, integration in the labor market and the community. Nevertheless, the great majority of WLHA still do not have access to the services and support needed. This has not only an impact at the individual level, but a negative effect which extends to households, communities and businesses while limiting HIV prevention efforts. In an evaluation of the LifeLine program in South Africa, with a sample of 304 women who participated in a community project on HIV and VAW, it was found that care and support were less available to HIV negative women who experienced violence than for those living with HIV. The support for WLHA and WLHA experiencing violence was provided mainly by health centers (74%), whereas those facing violence, but not HIV, mentioned the police and social services most frequently (117).

ICW and the Global Coalition on Women and AIDS have stated that access to care, treatment and support implies the capacity of women to gain consistent access to all the existing services, considering the specific gender barriers, as well as women's particular needs (118). Among the services and high-priority interventions recommended are:

- Supportive environments in the home, community, work place, learning centers, public spaces and health services.
- Sensitization, information and treatment for diseases and specific gender problems.
- Information and orientation on prevention of perinatal transmission.
- When necessary, financial support to cover expenses of treatment and service fees.
- Policies in health centers and places of work, such as factories, stores, schools, banks, agriculture cooperatives, etc.
- Diagnosis and treatment for sexual and reproductive health problems, including STI.
- Pre and post test counseling.
- ART with advice and treatment for side effects or complications of medication.
- Prophylaxis and treatment for opportunistic infections with advice and treatment for side effects or complications of medication.
- Healthy pregnancy and motherhood.
- Continuous support through counseling.
- Home-based care and other care-in-the-community programs and palliative care initiatives.

Barriers to access to services and support

Institutional, economic, cultural and geographic barriers limit access to services needed by WLHA. In India (2007), WLHA indicated that they do not seek health care because of a lack of female medical personnel, the great distance required to travel to health centers and the high cost of services. Although women represent 40 percent of PLWHA, they make up less than 33 percent of the people under treatment (119). In Kenya, although public hospitals provide ART free of charge, service users must pay a registration fee equivalent to Kshs. 100 (US$ 1.50) (120). Women face severe financial and social restrictions associated with violence that can limit their access to care and treatment once diagnosed with the virus. Also, stigma and discrimination constitute substantial barriers to access to services and affect quality of care. In a study carried out in Mexico with 373 service providers, it was found that discriminatory practices such as isolation of PLWHA, indication of HIV in medical files of PLWHA, compulsory tests and delays in surgical procedures were habitual practices. Additionally, the perception that MSM and male and female sex workers decide their sexual behaviors established a division between innocent and guilty victims of HIV and influenced stigma and discrimination in the provision of services (121).

Sexual and reproductive health needs of WLHA and violence

WLHA have sexual and reproductive needs and aspirations. Those are central in their lives and must be recognized as human rights of PLWHA as they are for the rest of the population. Taking care of these needs must be a central component of the HIV prevention efforts, support and care of WLHA. Several obstacles related to the fragmentation of sexual and reproductive health systems, taboos regarding sexuality, gender inequality, stigma and discrimination limit the exercise of these rights (122).

It is also necessary to address the links between HIV, unwanted pregnancies and abortion (IPAS, 2008) since:

- The ICW has pointed out that WLHA have been forced or have felt pressured by health providers to abort.
- HIV can increase the risk of spontaneous abortion, and therefore post abortion care is required.
- WLHA can have unwanted pregnancies as a result of rape or incest, they may choose not to have children in a context IPV, or they may not possess the economic resources to sustain another child. Others are scared of rejection, of possible negative effects in their health and the health of the child, while others want to postpone pregnancy.
- Safe abortion has been denied to many WLHA or they have been asked to "consent" to be sterilized as a condition to obtain an abortion.
- Lack of clinical research on the provision of abortion services to WLHA (123).

Another aspect to consider is the implications for WLHA of the psychological stress produced by the burden of caring for children. Specific mental health and social support interventions should be provided for them and their children. Some studies link non-adherence to treatment and non-attendance to medical appointments with the role of parents in PLWHA (124). More research is needed on the links between domestic care of children, previous and current experiences of violence and the consistent access of women to care and treatment.

WLHA experiencing IPV

IPV can affect the follow-up visits of women to health centers. Also, the overload of domestic work or care of children and sick family-members can reduce the time available to WLHA for self-care, nutrition and rest. The lack of control over financial resources may constitute an obstacle to paying for expenses such as transport and other needs. IPV can also imply restrictions on visits to health centers, support groups and home visits on the part of community workers, while some partners control the use of medication or consume it themselves. Studies in diverse populations indicate that partner support can be associated to adherence to treatment (125).

Specific needs of orphans and vulnerable children

Violence prevention and care efforts must include sexual abuse in orphans (youth and adolescents). They must also establish strategies to reduce the burden of home care and domestic responsibilities of women (girls, adolescents and older women), who are often tasked with raising the orphans. Experiences from Botswana, South Africa and Zimbabwe (2007) show that the most effective and viable way to protect and support orphans and vulnerable children on agricultural farms is through developing life skills, capacities in the community, sustainable income generation sources, maintaining the parents alive and healthy, strengthening the psychological support system and developing resilience skills, more so than giving them informational materials (126).

Older women

Older women suffer physical violence by partners and many are forced to maintain sexual relations against their will. Also, they undergo economic violence and loss of rights when obliged to leave their jobs to respond to the demands of ill children and/or orphaned grandchildren without any type of compensation. In this group, it

is important to consider that symptoms of the HIV infection tend to be nonspecific, such as fatigue, anorexia, weight loss, lessened physical activity and deficient cognitive function. Opportunistic infections present in these patients tend to be: Pneumocistis carini pneumonia, tuberculosis, Mycobacterium avium complex, zoster herpes and cytomegalovirus. Certain dementia characteristics induced by the HIV may make it hard to distinguish from Alzheimer's disease. With regard to its association with tumors, Kaposi's sarcoma, lymphomas, multiple myeloma, and solid neoplasms have been described. There are also hematological disorders accompanied by thrombocytopenia or pancytopenia (60).

Women with depressive and anxiety symptoms: A history of trauma (sexual abuse in childhood, IPV, sexual exploitation, etc.) can produce psychological problems that may lead to forgetfulness or difficulties to take medications. Studies have shown an association between depression and adverse results in patients living with HIV. According to Lima, et al (2007), depression is common in individuals living with HIV, especially women and those who have a history of injection drug use, did not complete high school, or were non-adherent to their antiretroviral regimen. The investigators found that the combination of depressive symptoms and non-adherence was associated with an increased mortality rate (127). Also, anxiety disorders in WLHA can be associated to the post-traumatic stress produced by events involving serious threats to their life or physical injuries. WLHA that have experience of sexual violence can undergo psychiatric disorders (128). The rates of violence and abuse that WLHA face or have faced throughout their lives are very high (129).

Women who inject drugs: A study in the United States (2003) on adherence in IDUs found a lower rate of adherence to treatment in women than in men (18% in women and 25% in men) and also found that access to mental health care was associated with adherence in women (130).

5. TOOLS TO DESIGN INTEGRATED PROGRAMS AND SERVICES ON HIV AND VAW

5.1. Tool # 1: Situational analysis of HIV and VAW

The situational analysis is a fundamental step in the HIV/VAW integration process in that it permits:

a. A description of the general context of the country and/or the selected geographic area in which HIV/VAW integration will be carried out.

b. An analysis of the epidemiological scenarios of HIV and VAW and their impact on women's lives, families and communities.

c. An identification of the advances/strengths and gaps/weaknesses in the HIV and VAW response in national policies and programs as well as at the institutional level.

d. An evaluation of the practices or experiences on HIV and VAW in the selected geographic area and identification of the paths through which integration could strengthen the existing initiatives.

e. The identification of potential allies/partners and opportunities to make HIV/VAW integration more effective at the selected level(s).

LEVEL/INFORMATION NEEDED
Context of the country • Territorial extension • Total population • Total population disaggregated by gender, age, ethnicity/cast, urban/rural • Education and literacy (disaggregated by gender) • Employment (disaggregated by gender) • Access to basic services (electricity, drinking water, sanitary service, rubbish disposal, cooking fuel) • Durable goods and communication services (radio, TV, video/VHS, computer, Internet, residential telephone, cellular telephone) • Socioeconomic level (Index of wealth): quintiles of wealth according to area of residence • Position of the country in the Human Development Index and Gender–related Development Index.

LEVEL/INFORMATION NEEDED	
VAW **I. Spousal/partner violence** a. Percentage of women that have been married or in a partnership who have ever suffered emotional, physical, or sexual violence from their current or former spouse/ partner. b. Percentage of women that have been in a union/ partnership who report some type of violence by their partner in the last year. c. Percentage of women living with HIV/AIDS who report violence by their partner. d. Percentage of women who agree that female spouses/ partners may refuse to have sex with their male spouses/ partners for specific reasons (knowing he is infected with an STI, he engages in sex with other women; because she is not willing or does not want to have sexual relations with him). e. Among women that have ever been in a union/partnership, percentage who were subjected to control situations by their spouse/partner, disaggregated by age, marital status, education, employment status, and partner's education. **II. Sexual violence** a. Ratio of women who report sexual violence at least once in their life. b. Ratio of women who report sexual violence before age 15. c. Ratio of women who report sexual violence by their partner in the last year. Where available, include data on: Femicide, sexual harassment (at work, in the street, and at school), trafficking in women and girls, traditional practices (female genital mutilation, widow cleansing), and forms of VAW affecting specific populations such as women in gangs, immigrants, among others. Also include data on costs and outcomes of VAW at the individual, family, community and social levels.	HIV/STI **Incidence of STI/HIV** (in selected population groups) a. General population (disaggregated by gender) b. Pregnant women c. Sex workers d. Adolescents (age 10-19, disaggregated by gender) e. People deprived of freedom (imprisoned, disaggregated by gender) g. Migrants (disaggregated by gender) h. Sexual violence victims (incest, rape, sexual harassment, among others, disaggregated by gender) i. Injected drug users

LEVEL/INFORMATION NEEDED	
I. Macro level	
a. Policies and strategies on HIV and VAW (national plans, executive decrees, laws, regulations, budget, international commitments ratified by the country). b. Research and information systems: official statistics on HIV and VAW produced by key sectors (Health, Education, Justice Administration, Employment/Work, Social Protections) as well as research programs financed by the mentioned sectors. c. National coalitions, commissions, and committees addressing HIV and/or VAW.	
II. Sectoral level (Health, Education, Justice Administration, Employment/Work, others)	
a. Inclusion of HIV and VAW among the sectoral priorities and their placement within the sector's structure (organigram) b. Strategies of these sectors to address HIV and VAW within their policies. c. Existence of specific programs on HIV and VAW in each of these sectors. d. Inter-sectoral coalitions/coordination to address both issues.	
III. Provincial level	
a. Local policies and strategies related to HIV and VAW. c. Information systems and research on HIV and VAW at the local level. c. NGOs, groups of PLWHA, VAW survivors and women's organizations (areas of work, target population).	
IV. Institutional/organizational level	
a. Existing services and programs on HIV and VAW (focusing on their capacity to respond; also on the level of coordination between services within organizations and between organizations).	
VAW: Primary prevention, screening strategies, psychological support/care, counseling and first aid, legal support, judicial and police protection, medical care, shelters, support groups, rehabilitation of aggressors/batterers, or others.	HIV: Prevention, VCT, treatment and care, vulnerable and orphaned children, specific programs for key population groups, PMTCT, support groups, harm reduction initiatives, social protection and social services, or others.
b. Research and information systems: surveillance systems, standardized indicators for M&E, guides on data collection, evaluation of data quality, and strategy for use and dissemination of data.	
V. Community Level	
a. Attitudes, beliefs, knowledge and practices on HIV and VAW. b. NGOs, PLWHA, VAW survivors and women's groups. c. Gender norms, customs and traditions that increase women's risks and vulnerability to HIV and VAW. d. Women's participation at community level. e. Role of traditional health workers (midwives, delivery attendants) in relation to HIV and VAW.	

LEVEL/INFORMATION NEEDED

VI. Individual Level

a. Economic, social and political participation of women.

b. Decision-making in the household regarding sexuality and reproduction.

c. Attitudes about gender roles and VAW.

d. Controlling behaviors by intimate partners.

Knowledge on STI/HIV

a. Percentage of women who know 3 specific ways to prevent HIV, disaggregated by age, area of residence, and level of education.

b. Among women that have heard about HIV, percentage who know where to take an HIV test, disaggregated by area of residence and level of education.

c. Among women that have heard about HIV, percentage who know where a person living with HIV/AIDS (PLWHA) can receive aid, disaggregated by area of residence, income, and level of education.

Practices

a. Use of condom: Among women who engaged in sexual relations in the year preceding the survey, percentage that used a condom in their most recent relation with the spouse/partner, non-cohabiting partner, or any partner, disaggregated by age and area of residence.

b. Among women currently in a union/partnership, percentage who have discussed HIV/AIDS prevention with their spouse/partner at least once, disaggregated by age, area of residence, and level of education.

c. Percentage of women who suffered from any STI and/or related symptom in the 12 months preceding the survey, and of these women, the percentage who informed their partner about their condition, and the percentage who took any action to protect their partner from infection, disaggregated by STI/related symptom.

Perception of HIV risk

Women's perception of the risk of being infected with HIV (small, moderate, great, none, or lives with HIV), disaggregated by age, area of residence, and experience of domestic and extra-familiar sexual violence.

Sexual partners

a. Of women in a union/partnership, number of individuals with whom they had sexual relations in the last 12 months (disaggregated by age, marital status, area of residence and level of education).

b. Percentage of women who report that they had sexual relations or performed sexual acts in exchange for money, drugs or other benefits, disaggregated by age, area of residence, number of children, and level of education.

Use of services

a. Percentage of women who have taken the HIV test, disaggregated by age, area of residence, pregnancy status and marital status. Among women who *have* taken the HIV test, the percentage who have sought to know the result, disaggregated by age, area of residence, pregnancy status, and marital status.

b. Among those women who *have not* taken the HIV test, percentage who know where it can be taken, disaggregated by age, area of residence, and level of education.

c. Percentage of women who reported any type of violence, and among those who did, whether or not they sought help, for whom they sought it, the place where they sought it, according to the type of person who attacked them, and frequency of the attacks.

d. Percentage of women who reported any type of violence, and reasons that prevented them from seeking help, disaggregated by age, area of residence and level of education.

5.2. Tool # 2: Evaluation of the legal framework on HIV and VAW

From the list of existing laws and regulations in the country, state and/or province, analyze the contents and their implications for integrating HIV and VAW programs and services.

I. HIV/AIDS LAWS AND REGULATIONS	YES	NO	IMPLICATIONS FOR HIV/VAW INTEGRATION
Non discrimination			
• Uses the "risk group" concept?			
• Includes mandatory detection tests under certain circumstances (sex workers, women victims of human trafficking, among others)?			
• Includes women within vulnerable/key groups?			
• Does it allow HIV testing in personnel recruiting and selection processes without the consent of the job applicant?			
• Does it require the employee to notify the employer about her/his serostatus?			
• Does it allow health providers to refuse offering their services to a PLWHA?			
Right to Privacy			
• Does it allow tests for violence survivors and pregnant women without their consent?			
Right to Confidentiality			
• Does it require the consent of the service user to disclose information about her/his serostatus or any other clinical information?			
Disclosure to sexual or drug injection partners			
• Does it include measures that require people to notify their sexual or drug injection partners about their serostatus?			
• Does it include measures that authorize the service provider or sanitary authority to notify sexual and/or drug injection partners about the user's serostatus?			
• Does it include penalty measures for those who, through negligence or by intention, expose other people to HIV?			
Post-exposure prophylaxis (PEP) in cases of sexual violence			
• Does it include PEP measures for VAW cases?			
• Does it establish rights for people subjected to PEP?			
• Does it describe who would be subjected to the test and under what circumstances?			

I. HIV/AIDS LAWS AND REGULATIONS	YES	NO	IMPLICATIONS FOR HIV/VAW INTEGRATION
Access to condoms			
• Does it include any measure that restricts the marketing, sale, or access to condoms?			
Migration and travelling			
• Does it establish restrictions on PLWHA for entering the country?			
• Does it restrict access to prevention and treatment services for undocumented migrants?			
II. VAW			
• Does it include rape in marriage/couple relations?			
• Do VAW laws and regulations include provisions for STI/HIV?			
III. Other laws and regulations			
Sex work			
• Is sexual work penalized?			
• Are there regulations for sex work?			
Human Trafficking			
• Are there regulations that protect victims of human trafficking?			
Education			
• Do educational regulations restrict access to school for children living with HIV?			
• Do educational regulations pose a barrier for girls and women to have access to education?			
d. Economic Rights			
• Do statutory or customary laws prevent women from exercising the right to own or inherit property?			
e. Sexual and Reproductive Rights			
• Do laws or regulations exist to protect women's sexual and reproductive rights? Is HIV testing mandatory for pregnant women?			
f. Traditional practices			
• Is there any law or community norm that increases women's vulnerability to HIV, such as female genital mutilation, or "widow cleansing"?			

I. HIV/AIDS LAWS AND REGULATIONS	YES	NO	IMPLICATIONS FOR HIV/VAW INTEGRATION
g. Injecting drug use			
• Does any law or regulation prevent access to clean needles? Is there any measure preventing or prohibiting needle exchange programs or other policies?			

5.3. Tool # 3: Stakeholder mapping for integrating HIV and VAW programs and services

Stakeholder mapping permits:

- To identify the key institutions and sectors that will assure the viability of HIV/VAW integration within the selected levels.
- To analyze the institutional profile of key stakeholders (purpose, objectives, services, programs), their institutional capacity, experience of inter-sectoral coordination and attitudes/motivation about HIV/VAW integration.
- To explore the viability of the establishment of networks to carry out HIV/VAW integration processes.

Stakeholders are selected taking into account their role in the selected levels and may include government agencies, civil society groups (PLWHA, VAW survivors, women's groups), community leaders, international organizations, mass media, universities, among others.

VARIABLES	INDICATORS
Institutional profile	• Type of organization, mission, objectives; issues/problems on which it currently works.
Institutional capacity	• Activities and projects on HIV and/or VAW • Target population • Competencies of human resources on HIV/VAW integration • Integration of HIV and VAW in services and programs • Information systems and epidemiological surveillance on HIV and VAW.
Inter-institutional coordination	• Joint initiatives on HIV and VAW • Modalities/types of coordination.
Attitudes and motivation regarding HIV/VAW integration	• Perception on the relevance of HIV/VAW integration • Motivation to participate in a process of HIV/VAW integration • Perception on the logistic and strategic implications of HIV/VAW integration • High-priority organizations or groups with whom the interviewed organizations would prefer to coordinate integrated interventions on HIV and VAW. • Coordination strategies • Institutional commitments with HIV/VAW integration (institutional resources, political will, advocacy, etc.)

5.4. Tool # 4: Institutional mapping of HIV and VAW services in emergency contexts after natural disasters

The objective of this exercise is to assess the availability of HIV and VAW services in the selected geographic area in the event of a natural disaster. Using the results of this mapping exercise, the stakeholders involved will devise a course of action to ensure that HIV and VAW considerations are included in the emergency response.

Name of the person/organization completing this form: _____

Date: _____

Province/municipality: _____

I. *Socio-demographic information for the province/municipality*

Total population (disaggregated by gender, age, socioeconomic level, ethnicity, rural/urban)	
Fertility rate	
Level of education and illiteracy (disaggregated by gender)	
Access to basic services (water, sanitation, electricity, durable goods and communication; disaggregated by gender)	
VAW prevalence and incidence (domestic violence, sexual violence). Explore the dimensions of sexual violence among displaced population, trafficking in women and girls, practices of transactional sex, sexual harassment, violence against women living with HIV/AIDS.	
HIV prevalence and incidence	
Prevalence and incidence of STIs	
Population located in temporary shelters (disaggregated by gender, age and ethnicity)	
Number and type of shelters available (explore the actual capacity)	

Availability of HIV and VAW services after a natural disaster

SERVICES	*Current availabilty*		*Was it in place before the disaster?*		Comments/observations (include detailed information about the community organizations, governmental agencies, NGOs, international organizations offering those services. Also include any relevant information on key populations being served)
	Yes	No	Yes	No	
VAW					
a. Psychological support					
b. Medico-legal services					
c. Support groups					
d. Police stations and/or legal support for VAW cases					
e. VAW prevention interventions (including specific interventions in shelters)					
f. PEP for sexual violence cases					
g. Safety measures (including protection orders) for VAW survivors					
HIV/STI					
a. Diagnosis and treatment of STI (Syndromic approach or laboratory)					
b. VCT					
c. Prevention of opportunistic infections in PLWHA					
d. ART					
e. PMTCT programs					
f. Counseling for pregnant women living with HIV					
g. Family planning services for PLWHA					
h. Nutrition					
i. Community activities on HIV/VAW prevention including people placed in shelters.					
j. Networks of social support for PLWHA					
HIV/STI prevention programs for key populations (children, young people, migrants, refugees, ethnic groups, women at reproductive age, or others)					

5.5. Tool #5: Evaluation of the empowerment approach to programs and services on HIV and VAW

The following checklist permits the identification of: a) empowerment aspects that should be included in HIV and VAW programs and services, b) institutional areas that need strengthening, and c) training and/or awareness-building needs. Initially, this list may be used to evaluate the empowerment approach within the process of integrating HIV and VAW in some services, and eventually it can be used as a tool to monitor the progress in said process.

COMPONENTS	YES	NO
1. Participation		
a. Do users participate in the program design process?		
b. Are there mechanisms in place to receive suggestions and complaints from the services' users?		
c. Does it coordinate activities with groups of PLWHA, VAW survivors and/or women's groups?		
d. Are users' rights promoted?		
e. Do interventions for households and the community include contents related to gender equity and women's autonomy and participation?		
2. Voluntary Care		
a. In VAW services, is couple/family psychological assistance prioritized over the woman's individual needs?		
b. Is HIV testing voluntary?		
c. Are VAW services (support groups, psychological, legal, medical, and social assistance, support to children, referral) voluntary?		
3. Confidentiality		
a. Is a mandatory report filed with justice administration authorities for cases of domestic and sexual violence against adult women?		
b. Is the information received during counseling and other services shared with other people?		
c. Are HIV test results reported to other people, besides the user?		
4. Counseling and orientation		
a. In VAW services, is the HIV risk explored? Are harm and risk reduction methods discussed?		
b. In HIV services, is the VAW risk explored? Are safety measures and harm reduction methods addressed?		
c. Are the intersections between HIV and VAW (risks, outcomes) explored with all users?		
d. Is HIV information – such as transmission modes, prevention, test, access to services, and referral – provided?		
e. Is VAW information – such as causes, effects, self-esteem strengthening, service options including support groups and safety plans – provided?		
f. Is health and general well-being (work, education/training, participation, housing, stigma and discrimination, etc.) discussed with the users?		

COMPONENTS	YES	NO
5. Informed Consent		
a. Are HIV tests carried out with written consent?		
b. In VAW cases, are therapeutic agreements subscribed?		
6. Privacy		
a. Does the program's setting allow for private conversations with the users?		
b. Is the users' information kept in a private, secure location with restricted access?		
c. How are the users' identities protected? Are the collective values of the community regarding privacy prioritized over the individual right to privacy?		
7. Referral		
a. Are referrals sent to all available services based on the users' needs?		
b. Do referrals protect the users? (VAW and/or HIV referrals without placing the user at risk)		
c. Are the interventions/package of services coordinated with groups of PLWHA and VAW survivors?		
8. Monitoring and Evaluation		
a. Is service quality monitored from the users' perspective?		
b. Do PLWHA and/or VAW survivors participate in service monitoring and evaluation?		
c. Are the results of M&E used for policy/program planning and management?		

5.6. Tool # 6: Worksheet for prioritizing integrated HIV and VAW services

INTERVENTIONS	COMPONENTS	**CRITERIA** *[Rate each intervention from 1 (low priority) to 5 (high priority)].*					
		Resources available (human, technical and funding)	Potential impact (on HIV and VAW, selected populations, organizations involved, community, etc.)	Existing strengths and capacity (community and organizations)	Greatest needs	Implications for women's safety	**TOTAL** priority rating
Screening of VAW cases and HIV risk assessment	• Assessment of experiences of violence, controlling behaviors by partner(s) • Evaluation of risk behaviors/ situations (transactional sex, trafficking in persons, IDU).						
Counseling/ orientation	• Information on HIV • HIV risk assessment • Risk behaviors linked to previous experiences of violence • Information on HIV/STI services available • VAW and pregnancy, PMTCT.						
Crisis intervention	• HIV risk assessment • Considerations on violence patterns/controlling behaviors and potential HIV/STI linkages • Resources for protection from HIV • Managing emotional stability, depression and anxiety • Safety plans.						
Medical care	• VCT and ART • Care and treatment for HIV/ STI • Care and treatment for injuries and other health problems produced by violence • PEP adapted to the needs of specific age groups • VAW and PMTCT • Adherence to HIV and VAW treatment, including treatment for depression and/or anxiety symptoms • Nutrition						

Social support	• Services for women living with HIV/AIDS • Community networks working to reduce the stigma and discrimination associated with HIV or VAW and increase access to services • Adherence to treatment • Support to for social and economic participation						
Legal assistance	• Legal counsel and representation • Information about laws and other protection tools for PLWHA and VAW survivors • Available resources for legal assistance.						
Psychological/emotional support	• Strategies for increasing behavioral competencies and self-sufficiency • Managing anxiety and depression symptoms • Safety plans.						
Referral systems	• Networks of care, prevention and support • Safety and confidentiality regulations. • Participation of PLWHA and VAW survivors in care, prevention and social support strategies. • Incentives for referrals and case follow-up.						
Support groups	• Norms for integrating specific needs associated with HIV and VAW • Contents of group sessions including HIV and VAW • Formal collaboration with PLWHA, VAW survivors and women's groups.						

5.7. Tool #7: Key components of self-care programs for formal and informal HIV and VAW service providers[3]

Self-care programs for service providers must take into consideration informal caregivers (family, friends, neighbors), formal caregivers [ambulatory care, medical doctors, nurses, those working with orphans, social workers, psychologists, legal counselors, support groups facilitators, first aid workers, rescue teams (police, paramedical), emergency services, among others] and other providers caring for people affected by HIV and VAW.

AREAS TO BE ASSESSED

I. Assessments at the individual level

- ✓ Emotional situation (empathy, affective involvement, loss of confidence in relationships with others, feelings and emotions associated with work)
- ✓ Personal feelings and expectations as part of a team/working group (group resonance)
- ✓ Cognitive aspects (thoughts and ideas on HIV and VAW)
- ✓ Behaviors (behavior pattern—daily or habitual)
- ✓ Review and work of own personal history (experiences of violence and/or association with HIV)
- ✓ Personal experiences (related to violence and/or HIV) and their impact on task execution
- ✓ Attitudes toward offering care to PLWHA and/or survivors of violence
- ✓ Identification of sources of overwork and tension during the performance of the functions as a care provider
- ✓ Management of power in the development of tasks and in the relationships with service's users.

II. Individual and team practices related to self-care

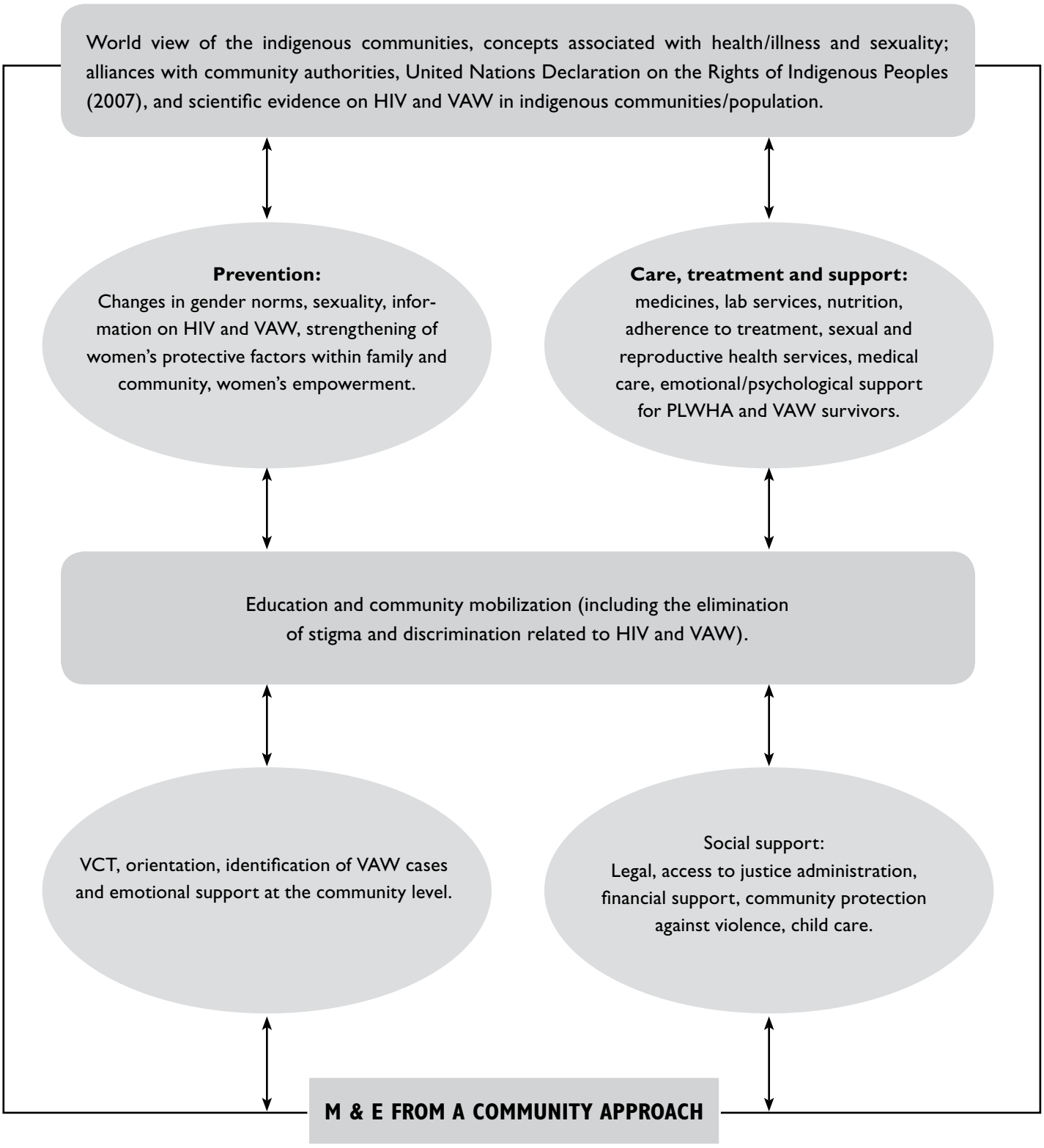
- ✓ Physical care
- ✓ Identification of acquired strengths and value of own work
- ✓ Identification of processes of burn-out
- ✓ Link between the ideals of the service provider and self-imposed expectation of fulfillment of her/his responsibilities
- ✓ Review of strengths and weaknesses in the functioning of the team.

III. Institutional and community responses to service providers' needs related to self-care

- ✓ Continuous training
- ✓ Interventions for relaxation and managing exhaustion
- ✓ Measures of support and emotional containment
- ✓ Supervision and support to the work team
- ✓ Strengthening of social and professional support networks of the caregivers
- ✓ Financing, M&E of self-care strategies.

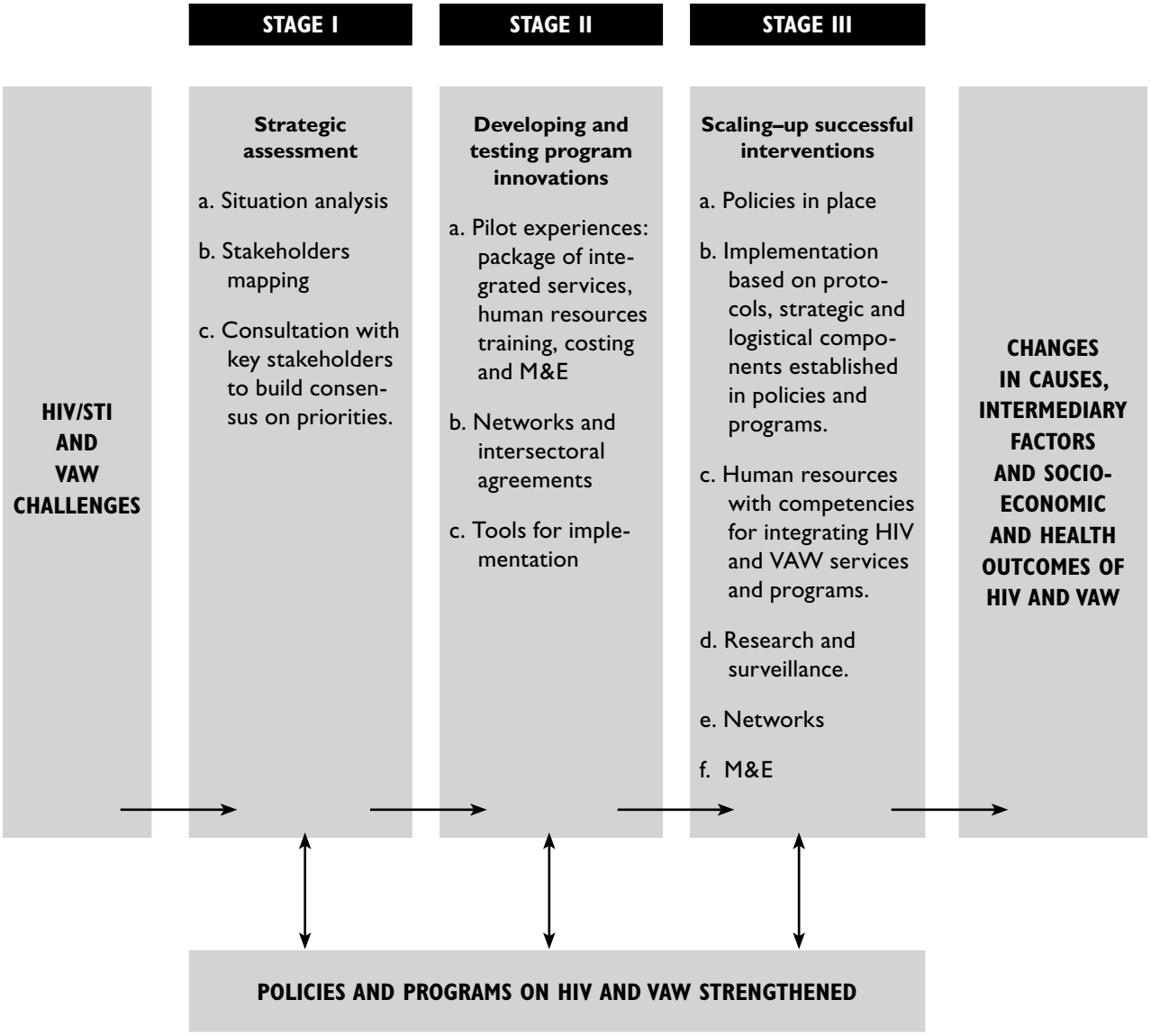
3 Adapted from: Ojeda, Teresa. *Las propuestas de autocuidado para prestadores de servicios que trabajan en el campo de la violencia contra las mujeres.* OPS/OMS. 2005 (Versión preliminar).

5.8. Tool # 8: Model of HIV/VAW integration in indigenous communities in South America



Source: Development Connections, Diakonia and Family Care International. Course "Empowerment, HIV and Violence against indigenous women in South America." Bolivia, 2008.

5.9. Tool # 9: The WHO strategic approach to strengthening the integration of HIV and VAW programs and services



Adapted from: WHO. *The WHO Strategic Approach to strengthening sexual and reproductive health policies and programs*. Geneva, 2007.

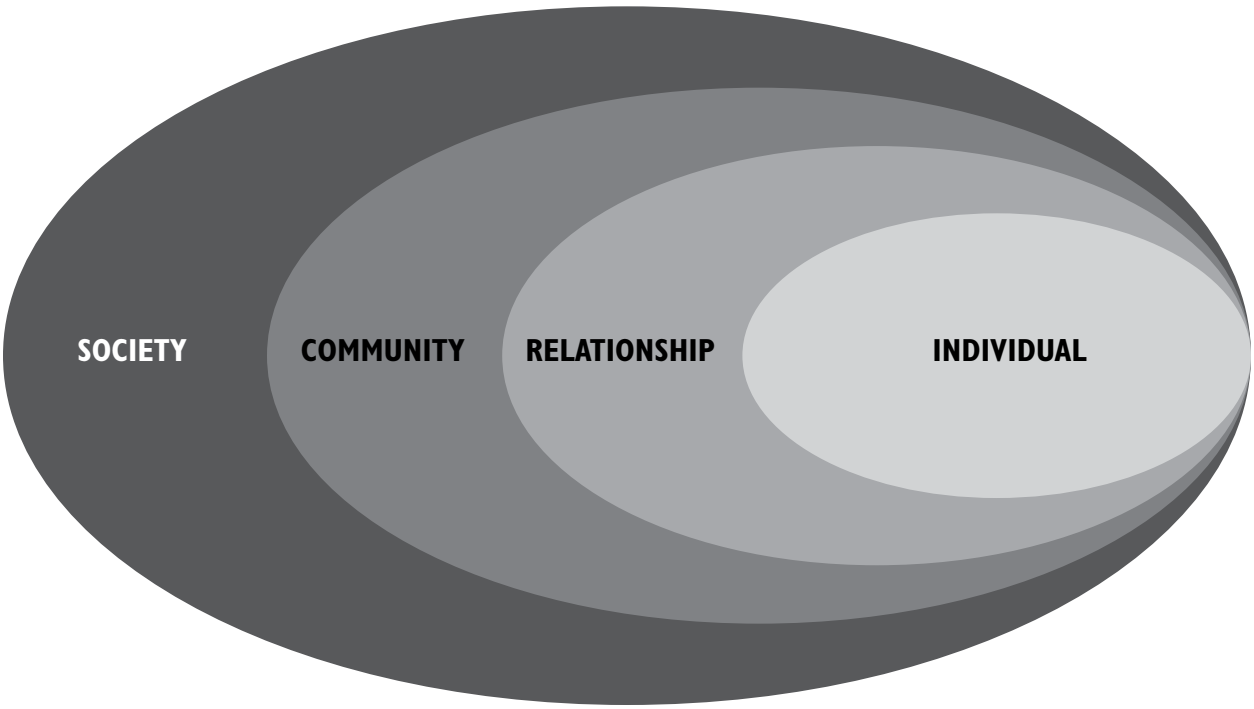
5.10. Tool # 10: The ecological approach for designing HIV/VAW prevention strategies

The causes, risks, and impact of the intersections between HIV and VAW are the result of diverse factors interacting on various levels. The World Health Organization (2005) proposed the ecological framework as the best tool to analyze the underpinning factors associated with interpersonal violence. In this manual, we propose to apply the ecological framework to the intersections between HIV and VAW. This framework establishes that violence is the result of linkages among factors concurring in four levels: society, community, relationship, and individual.

- **Society:** policies, cultural norms, social stratifications along economic, educational, age, gender, or ethnic lines, etc.
- **Community:** the contexts in which social relations are developed such as school, neighborhood, workplace or others.
- **Relationship:** family, friends, peers, partners, among others.
- **Individual:** personal history, biological factors influencing risks and vulnerabilities to HIV and VAW.

Using the following graph, please analyze the factors associated with the intersections between HIV and VAW in each one of the indicated levels.

Factors Associated with the Linkages Between HIV and VAW



Adapted from: Heise, Lori. 1998. *Violence against Women: An Integrated, Ecological Framework. In Violence against Women*, Vol. 4, No. 3, June 1998. 262-290. Sage Publications, Inc. USA.

Based on the factors described above, develop a prevention strategy proposal that includes the following:

a. **Objectives:** Taking into account the gender equality, empowerment and human rights promotion approach.

b. **Priority problems:** Those that the prevention strategy seeks to address.

c. **Audiences:** Based on the level of linkage to or influence on the identified priority problems.

d. **Prevention strategies:** Describe the selected activities, contents, messages.

e. **Intersectoral coordination:** Describe the institutions and individuals with whom alliances would be established to expand coverage of the selected priority strategies. Some of the criteria to establish collaboration priorities may be:

   - ✓ Institution's potential to reach specific audiences.
   - ✓ Credibility among priority population groups.
   - ✓ Interest in the selected contents/issues.
   - ✓ Existence of human, technical, financial and/or infrastructure resources to contribute to the selected strategies.

Evaluation: The evaluation of the strategies will be carried out using the defined objectives as a reference. Various information sources may be utilized, including surveys, administrative records of participating organizations, institutional audits, among others. Select at least three impact indicators per established objective.

Objective	**Impact Indicator**	**Information sources**
1.		
2.		
3.		

5.11. Tool # 11: Guide for designing an exit survey for HIV and VAW related needs at VCT sites

Presentation of the survey: a) the survey seeks to identify topics of interest to the users of the services, b) the results will help to improve the quality of services and to better attend to the users' needs, c) participation in the survey is voluntary, d) the answers are confidential, e) the users should feel free to share questions and doubts on the interview.

Date **Interview No.**

Place

Name of interviewer

I**. General information on the interviewee** (Age, marital status, area of residence, ethnicity, fertility, formal education, employment.) Also, specify the type of service that was used on the day of the interview (HIV/STI prevention, HIV test, delivery of HIV test results, issue arising subsequent to the taking of the test, other).

II. Perception on the services currently offered

a. Did the counselor explain everything the client hoped to know?

b. Did the client feel free and comfortable to speak on her worries and personal matters?

c. Did the client and counselor talk about sharing the test results with her intimate partner? If yes, did they discuss the possible reactions of the partner and the options for sharing the results?

d. Did the counselor talk with the client about risk behaviors or specific vulnerabilities? If yes, did the client and counselor talk about the risk associated to the partners' behaviors (multiple partners, sex with other men, violence, sexual coercion, controlling behaviors, etc.)?

e. Did the client and counselor talk about condom use, including barriers to access and/or limitations for negotiating their use?

III. Problems / issues of interest for the client and the reasons why

- ✓ Partner's controlling behaviors
- ✓ Decision making at home (use of services, sexuality and reproduction, others)
- ✓ Communication about sexuality and reproductive decisions
- ✓ Risk perception to HIV/STI
- ✓ Fear and doubts to speak with the partner about the HIV/STI test results
- ✓ Experiences of violence (intimate partner violence, violence during pregnancy, sexual violence by anyone else, or others – lifetime and in the previous 12 months)
- ✓ Partner's participation in the VCT services
- ✓ Gender norms within community and family
- ✓ Stigma and discrimination
- ✓ Alternatives for increasing the economic and social participation of women
- ✓ Referrals to other services
- ✓ Reproductive choices for women living with HIV
- ✓ Others

5.12. Tool # 12: Needs evaluation for integrating VAW into PMTCT programs

I. HIV and VAW epidemiological scenarios	a. HIV prevalence and incidence in women: in reproductive age and different population groups (adolescents, women in reproductive age, IDU, sex workers, immigrant workers, ethnic groups, or others). Is the HIV epidemiological scenario Concentrated, Generalized or Hyperendemic? b. Prevalence of intimate partner violence, sexual violence (lifetime and in the previous 12 months). Data on other types of violence prevalent in the selected country/geographic area should be included. c. Prevalence of violence by the intimate partner or any other person during pregnancy.
II. Access to HIV and VAW services	a. Proportion of women accessing pre and post natal services b. Proportion of institutional childbirths c. Does the geographic location of the services pose a barrier to pregnant women's access to pre and post natal care? d. Level of participation of community health providers (traditional birth attendants, midwives, etc.) in pregnancy care, delivery and post postpartum.
III. Existing resources	a. Resources available or accessible for integrating HIV and VAW interventions within the PMTCT programs already in place. b. Will HIV/VAW integration in PMTCT programs imply the creation of new infrastructure? c. Analyzing the level of financial resources and infrastructure available in the selected community, can the cost of HIV/VAW integration within PMTCT programs be absorbed by the existing resources or will it be necessary to mobilize new funds? d. What would be the best strategies for ensuring the consistent and meaningful participation of PLWHA, VAW survivors and women's groups?
IV. Needs for specific interventions	a. Which would be the high-priority populations and what are their specific needs? (adolescents, sex workers, immigrants, displaced/refugees) b. What approaches would be most appropriate for VAW prevention and care directed to pregnant women living with HIV? c. What strategies could be developed to prevent HIV/STI in pregnant women suffering violence? d. Who would be involved in these services? Partners, relatives, peers, others?
V. Changes in the organization of services, programs or interventions	a. What measures would be taken to ensure the quality of HIV/VAW integrated services within the PMTCT services? b. Can the participant organizations in HIV/VAW integration develop outreach activities at the community level to increase knowledge on human rights and change attitudes towards pregnant women living with HIV? c. How could actions be coordinated with community health workers (midwives, traditional birth attendants, etc.)? d. What measures will be developed to ensure that users' perspectives will be an integral part of the design, implementation, monitoring and evaluation of the programs?

5.13. Tool #13: Planning competency development for human resources working on HIV and VAW

I. Title of the position or activity:				
II. Main tasks of the position or activity a. b. c.				
III. Baseline (competencies already in place, broken down by type of personnel)				
IV. Learning plan				
Skills, knowledge and attitudes required (cross-sectional and specific competencies)	Learning objectives	Methods of evaluation of the selected competency (how, where and who will evaluate the competency)	Activities and learning resources (work guides, databases, glossary, bibliography, cases, program tours, forums, etc.)	Instructional approach (linkages between learning process and work, participant's autonomy, community of learning/practices)

Source: Adapted from the learning plan of the course "Empowerment, HIV and VAW." Development Connections, 2007/2008.

5.14. Tool # 14: Rapid assessment of data collection methods[4]

METHOD	CHARACTERISTICS	RATIONALE
DOCUMENT REVIEWS	***Periodic review of existing documents and reports, including:*** Statistics (administrative records from public health system, justice administration, education, police, as well as surveys) Reports from training programs on HIV and VAW of human resources from different sectors/organizations Performance evaluation of providers Evaluations of policies and programs on HIV and VAW Inventories of supplies, equipment, human resources and infrastructure. Budget reports (government, NGOs, coalitions and international organizations)	It permits the collection of data for quantifying the results of HIV/VAW integration. Depending on the quality of the data, it can be used to examine HIV and VAW trends and population groups most affected. Since the data is already available or collected on an ongoing basis, it can be continuously improved to provide better information on the HIV/VAW linkages.
MAPPING STAKEHOLDERS	***Help to establish:*** Profile of organizations and leaders influencing HIV and VAW policies, programs and services Attitudes and motivation of stakeholders on HIV/VAW integration Challenges and obstacles regarding HIV/VAW integration. Opportunities for inter-sectoral coordination.	It is appropriate when integration is developed based in inter-sectoral networks. The roles, powers and relationships among stakeholders could change in the future. Selection of high-priority interest indicators based on the needs of an ample range of stakeholders can be challenging for designing the integrated interventions and the M&E system.
INSTITUTIONAL MAPPING	Matrix to identify the existing HIV and VAW services in a selected geographic area. It can include a rapid qualitative evaluation of these services, and can be used in various contexts, including emergency/conflict settings. It incorporates a geographic mapping to identify the location of the evaluated services.	It is useful for collecting information on existing services and also for locating them geographically. It also helps to identify potential geographic barriers to access to those services.

4 Information on key informant interviews, focus-groups, direct observation and document reviews was adapted from: UNFPA and EngenderHealth. HIV Prevention in Maternal Health Services: Programming Guide. New York, 2004.

METHOD	CHARACTERISTICS	RATIONALE
FOCUS–GROUP DISCUSSION	A limited number of participants (12-15) with similar characteristics/backgrounds participate in a discussion of selected topics on HIV and VAW facilitated by a guide. A co-facilitator should take notes on the comments and observations of the debate. It should include the participants' consent and other ethical considerations.	It can be useful when human resources, time and financing are limited, and in-depth information of specific issues is required. The sensitive nature of the issues should be considered as well as the safety of the participants.
COST–EFFECTIVENESS ANALYSIS	Allows for the comparison of the potential impact of different integrated HIV/VAW interventions. It analyses the alternative allocations by type of intervention and population groups. It should include criteria such as equity, gender equality, fairness and human rights.	It is useful for advocating for budgetary allocation of integrated HIV/VAW programs that use a gender and human rights approach. It helps in measuring the direct and indirect costs of the interventions and can serve to show the effectiveness in key indicators such as behavior change, access to services, prevention, new HIV cases, etc.
DIRECT OBSERVATION	An observation guide is used to register what is seen and heard in a specific context (service, community activity, household, school, others). The information being collected can include current activities or interventions, processes among stakeholders, coordination activities, social interactions in different contexts, and observable results.	It is appropriate when the observation of organizations, groups, relationships among people in specific contexts (homes, communities, services, etc.) is required. It can be useful for measuring time and activities of home care of PLWHA and VAW survivors, interaction at VCT, PMTCT services , clinical procedures, support group, etc.
KEY INFORMANT INTERVIEW	Qualitative, in-depth semi-structured interviews with individuals selected for knowledge or experience in certain area of interest for HIV/VAW integration. It can be applied to decision makers, service providers, users of services, community leaders, etc.	It is appropriate when dealing with sensitive issues, or when time, budget and human resources are limited. It addresses a limited number of issues.
SURVEYS	Questionnaire structured with closed-ended questions (or open-ended questions which are later grouped by category), administered to a specific population with predetermined characteristics. Inclusion/exclusion criteria should be established as well as ethical considerations.	It can help to establish the weight of some associated factors regarding HIV/VAW intersections. It is important for quantifying results of the integration. It reduces the subjectivity/bias in responses generated when using other methods such as focal groups.

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