together we must...

End violence against women and girls and HIV & AIDS

A review of promising practices in addressing the intersection

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Executive summary

Violence against women and girls (VAWG) and HIV&AIDS represent two of the greatest dangers to the health, well-being and productivity of women worldwide. Threats and violence limit women's ability to negotiate safer sex and to control the terms of their sexual encounters. Women and girls are two to four times more likely to contract HIV during unprotected sex than men because their sexual physiology places them at a higher risk of injury, and because they are more likely to experience violent or coercive sexual intercourse.[1]

Similarly, because HIV-related prejudice may manifest itself in the form of violence, HIV-positive women may experience violence at higher rates than other women.[2] Indeed, a woman's decision about whether to be tested for HIV, and whether to disclose the results, may be influenced by actual or perceived threats to her safety. Fear of violence, discrimination, abandonment and loss of economic support are commonly cited factors that keep women from learning their HIV status. This lack of knowledge also hinders women living with HIV from receiving treatment, care and support.

Because violence against women and HIV&AIDS are mutually reinforcing pandemics, the need and the opportunity for integrated approaches addressing their intersection is increasingly evident. To date, however, such strategies have not been implemented on a widespread scale. Advocates and communities working on HIV&AIDS and VAWG are just beginning to come together to explore common strategies. This report highlights key elements to consider in such strategies, by profiling organizations that employ human rights and gender-sensitive approaches to the dual pandemics; that empower marginalized sectors of society; that promote community ownership; that build the capacity of civil society; that encourage cross-sectoral integration; and that facilitate linkages between advocates and activists within the HIV&AIDS and VAWG movements.

Together We Must! is organized around four broad-based strategies for tackling the intersection: community mobilization to transform harmful gender norms; engagement of marginalized groups that are often more vulnerable to the twin pandemics; development of integrated approaches to support and care; and advocacy for greater accountability among funding agencies and policy makers. Together, these strategies offer valuable lessons and promising practices for other organizations and highlight the need for formal evaluations of initiatives to better understand and enhance their impact.

Gideon Mendel/Corbis/ActionAid Country: Nigeria

HIV-positive educator Aderonke Afolabi conducts an AIDS education workshop for teachers in Lagos. She is one of the few openly HIV-positive people in Nigeria where HIV prevalence has soared to over 5% of the adult population.

The first strategic approach is to involve community groups to change harmful gender norms. The report profiles Sonke Gender Justice from South Africa, India's MILANA and Equal Access Nepal, which actively engage target communities to recognize their roles in sustaining or even encouraging the spread of both violence and HIV&AIDS. By emphasizing the proactive roles of all community members in ending the pandemics, the organizations foster communities in which violence is not tolerated, and women and girls living with HIV&AIDS are supported to live safe, productive lives.

The second approach in the report focuses on how women's vulnerability to violence and HIV&AIDS is rooted not only in gender inequalities, but in social disparities based on race, class, ethnicity, age, sexual orientation and other factors. Working with groups disproportionately affected by both pandemics, organizations including Brazil's Criola, Women of Color United USA and Nigeria's Girls Power Initiative tackle the multiple forms of marginalization that make women and girls vulnerable both to violence and HIV&AIDS.

The third strategy focuses on the creation of integrated approaches, linking health responses to violence and

> “Violence plays a crucial role in increasing women and girls’ vulnerability to HIV infection.”

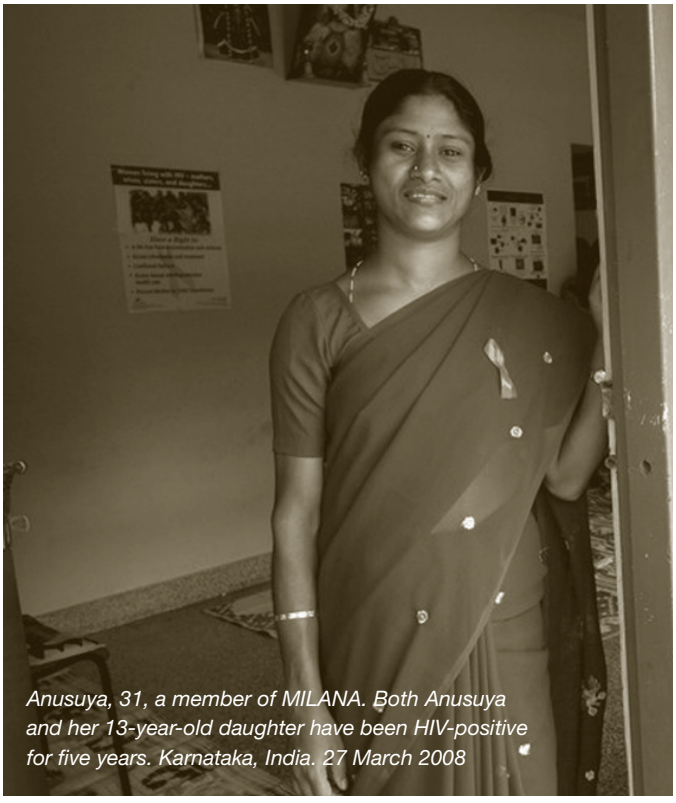
HIV&AIDS to comprehensive social services. Nairobi Women’s Hospital, a ‘one-stop shop’ for survivors of sexual violence, illustrates a rights-based approach to health care and provides women free treatment and support after they experience violence and potential exposure to HIV, including assistance in reporting their case to law enforcement and accessing longer-term care. In Argentina, the Fundación para Estudio e Investigación de la Mujer (FEIM) integrates protocols around VAWG and HIV&AIDS into standard medical practice. Both organizations use health care as an entry point to comprehensively address the two pandemics as they affect poor women and girls.

The last strategy highlights the importance of holding policy makers accountable for their efforts to address the linkages between the pandemics. Whether through research, documentation or rights-based training for HIV-positive women, profiled organizations including the global Women Won’t Wait campaign and CIRDDOC of Nigeria promote gender-sensitive HIV&AIDS policies at all levels of decision-making. They also push for adequate funding and participation of women’s organizations in the design and implementation of programmes to address the intersection of VAWG and HIV&AIDS.

Together We Must! represents an initial effort to draw attention to the knowledge, institutional capacity and resources needed to comprehensively address the intersection between HIV&AIDS and VAWG. It aims to stimulate debate and collaboration among practitioners and advocates around how to identify and promote policies and practices that are effective and can be adapted to various contexts. Of the multiple suggestions that could be drawn from the ‘promising practices’ profiled here, the report prioritizes five key recommendations.

The first is to encourage more research to identify and evaluate effective strategies for addressing the intersection and to document the lessons learned. Secondly, to facilitate such research, the report calls for increased collection and dissemination of national and global data on violence against women and girls, HIV&AIDS, and the connections between them. Advocates should concentrate on the strategic use of such research, data and protocols as a means to hold policy makers accountable for the effectiveness of programmes to address the intersection. Thirdly, since hospitals and health facilities are important sources of data on both pandemics, expanded use of standardized protocols and training for health care personnel would be valuable for raising awareness and capacity to address the connections between VAWG and HIV & AIDS. Fourthly, advocates working on the intersection between HIV&AIDS and violence must make efforts to engage excluded population groups, including racial and sexual minorities and young women in the places where they live, work and play.

The report’s final recommendation emphasizes the importance of community mobilization. Given their marginalized status, such women and girls are often the most vulnerable to HIV, yet the least likely to be reached through existing prevention, treatment, care and support services. The engagement of strategic groups from the broader community, from men to families to traditional and religious leaders to local authorities, is critical for the above-mentioned strategies to be effective. Community buy-in from a broad range of stakeholders is essential to confronting the widespread stigma and discrimination associated with VAWG and HIV&AIDS.



Anusuya, 31, a member of MILANA. Both Anusuya and her 13-year-old daughter have been HIV-positive for five years. Karnataka, India. 27 March 2008

Srikanth Kolari/ActionAid Date original created: 27 March 08 Country: India

Introduction:

Confronting the intersecting pandemics of HIV&AIDS and violence against women and girls

Around the world, women and girls are confronting the devastating combination of violence and HIV&AIDS. Either of these threats alone is challenging enough, but in many cases they go hand in hand. Whether in the private or public sphere, in times of peace or conflict, in situations of generalized or concentrated epidemics,[3] violence plays a crucial role in increasing women and girls' vulnerability to HIV infection. Violence against women and girls (VAWG) and HIV&AIDS are among the most important threats to the health, well-being and productivity of women worldwide.

The circumstances underlying the correlation between VAWG and HIV&AIDS include a complex intermingling of social, cultural and biological conditions. Women and girls are two to four times more likely to contract HIV during unprotected sex than men because their sexual physiology places them at a higher risk of injury, and because they are more likely to be at the receiving end of violent or coercive sexual intercourse.[4] Violence, along with threats of violence, limits women and girls' ability to negotiate safer sex and to control the terms of their sexual encounters. This is especially true within the context of marriage. Indeed, for too many women around the world, the greatest risk of HIV infection comes from marital sex with partners who contracted the virus before or outside the marital context.[5]

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Amuda and Anusuya, 31, both from MILANA, counselling Neelaamma, 30, who is HIV-positive. Karnataka, India. 27 March 2008

A network of people living with HIV, MILANA is a unique initiative enabling women affected by HIV to access their rights and lead a life of dignity by battling social stigma against HIV-positive people.

Violence against young women and girls in particular contributes to a vicious cycle: Sexual abuse and violence suffered during childhood may lead to increased sexual risk-taking in adolescence and adulthood.[6] In many cultures, paradigms of femininity promote innocence and ignorance, discouraging girls from seeking out information on sex or from taking control of their sexual lives. Power imbalances encouraged by practices such as forced or child marriage leave young women and girls with little or no say in the timing or circumstance of their sexual initiation. These practices may also increase their vulnerability to HIV: On average, husbands of child brides are older than sexual partners of unmarried girls of the same age and are more likely to be sexually experienced, with the power to negotiate sexual relations that increase a child bride's risk of exposure to HIV&AIDS.[7]

Stigmas attached to HIV—and their increasing prevalence when the disease progresses into AIDS—mean that HIV-positive women may experience violence at higher rates than the general population.[8] Indeed, a woman's decision about whether or not to be tested, and then whether to disclose the results, may be influenced by the actual or perceived threat of violence from her partner. Fears of violence, abandonment and loss of economic support are commonly cited factors that keep women from making their HIV-positive status public.[9]

Because women tend to use health services in greater numbers than men, particularly during prenatal and perinatal care, they are more likely to know their HIV status than their male partners. The potential risk for HIV transmission during pregnancy, childbirth and breastfeeding feeds a pattern of societal blame in which women are viewed as solely responsible for infecting their children. In many instances, women's disclosure of their positive status encourages the perception that they are vectors of the disease. Women are often blamed for bringing the virus into the family or community. Disclosing their positive HIV status with partners or third parties may increase the risk of violence, stigma and discrimi-

Gideon Mendel/Corbis/ActionAid Date original created:01 January 05 Country:Nigeria

HIV-positive educator Aderonke Afolabi wearing the T-shirt bearing the logo of the support organization she founded called Potter Cares. She is one of the few openly HIV-positive people in Nigeria where HIV prevalence has soared to over 5% of the adult population.Young people march in a street protest against an alleged child abuser in the poor Lagos neighbourhood of Ajeromi. They had been attending a youth education meeting held as part of the 'Make we talk' project, where they heard reports that a man with AIDS was paying young girls to have sex without a condom.

nation by partners, relatives and community members.[10] HIV-positive women have been thrown out of their households and communities, stripped of their possessions and in some instances criminally charged with transmitting HIV.[11] While criminalization is often meant to protect women who unwittingly contract HIV from their partners, such legislation may actually compound women's exposure to violence and stigma. Not only do these laws result in disproportionate targeting of women, but in some cases they encourage prosecution for mother-to-child transmission of the virus.[12]

Women and girls' vulnerability to violence and HIV&AIDS also has particular implications for efforts to achieve universal access to prevention, treatment, care and support.[13] While increased information, education and communication on HIV prevention options may help stem transmission of the virus, women may also experience a violent backlash as more of them are tested and treated. Advocates from the movements to end VAWG and to confront HIV&AIDS therefore need to be more aware of the intersection of the pandemics, and of appropriate, effective and culturally sensitive ways of addressing their linkages.

The context of this report

This brief introduction highlights a few of the complex ways in which VAWG and HIV&AIDS are both cause and consequence of one another.[14] Less is known, however, about effective ways of addressing this intersection. While the need and the opportunity for integrated approaches is evident, to date they have not been implemented on a widespread scale. So far, efforts to bring VAWG advocates together with HIV activists to explore areas of intersection and to create strategies for mutually strengthening research, policy and programming efforts have been modest.[15]

Institutional and political responses to HIV&AIDS have included some focus on gender equality and on addressing violence against women. But within the community addressing VAWG, attention to HIV&AIDS is a relatively recent phenomenon, and more work is needed to identify successful strategies that can be replicated or scaled up. Such efforts are particularly important because of the lack of clear and consistent global guidance on effective ways of addressing the links between VAWG and HIV&AIDS. According to the Women Won't Wait campaign profiled in this report, "the agencies responsible for promoting universal access, as well as those offering technical assistance at the national level, are often themselves still insufficiently addressing the intersection of HIV&AIDS and violence against women and girls."[16] The limited knowledge about effective strategies is exacerbated by separate funding streams; programmatic efforts to address violence against women on the one hand and HIV&AIDS on the other are still the norm, at least among the largest multilateral donors.[17]

ActionAid and UNIFEM decided to collaborate on this report as a first step toward strengthening the evidence base for linking VAWG and HIV&AIDS prevention programmes. The two organizations share a common commitment to building connections between work on HIV&AIDS and VAWG, including through the production of accessible informational tools that highlight the human rights dimensions of the twin pandemics. *Together We Must!* is an initial effort to draw attention to promising practices and to build support for the increased knowledge, institutional capacity and resources that are needed for a more comprehensive response.

The report explores how certain organizations are developing strategies to address the twin pandemics, and identifies certain commonalities in their approaches that can provide the basis for the development of more systematic, measurable and replicable practices. The profiled organizations were identified through the partner networks of ActionAid and UNIFEM, and therefore represent only a

sample of the excellent work in progress around the world. Their strategies should be situated alongside complementary approaches that have been described and applied elsewhere.[18] By highlighting these organizational approaches, ActionAid and UNIFEM aim to encourage further research and more rigorous analysis of strategies that are effective at both reducing the incidence of violence against women and girls and their exposure to HIV&AIDS. This report should thus be understood as a call to action to the international community to move beyond the 'promise' of these approaches towards a comprehensive response to the intersection of VAWG and HIV&AIDS.

Structure of the report

This report is divided into five sections. The first chapter explores the concept of a 'promising' practice for addressing the intersection between VAWG and HIV&AIDS. Because the highlighted organizations vary in the degree to which they incorporate monitoring and evaluation into their programming efforts, we refer to the strategies they employ as 'promising' rather than 'proven' practices. While these organizations engage in a wider array of activities than those featured here, the report focuses on six key elements of their work to address the linkages and drivers of both pandemics. These elements could be considered as criteria to inform efforts in other contexts to address VAWG and HIV&AIDS.

The remaining chapters lay out four broad strategies for confronting the intersection of VAWG and HIV&AIDS that emerge from the profiles. Chapter 2 illustrates the importance of involving multiple stakeholders, from men and boys to families and social networks, in strategies to confront the twin pandemics as a means of fostering community mobilization and support. Chapter 3 focuses on the importance of involving marginalized groups in and throughout the programme cycle, from design and implementation to monitoring and evaluation, and examines the ways in which organizations are addressing the impacts of race, class, sexual orientation and age in their work at the intersection of the dual pandemics. Chapter 4 looks at innovative models of health care that integrate sociocultural factors in their care and support, while Chapter 5 examines strategies for using research, advocacy and documentation to hold policy makers accountable. The report closes with five recommendations that emerge from the promising strategies profiled. These recommendations are aimed at governments, civil society groups, individuals and others who might consider similar strategies in their own programming efforts to confront the intersection between VAWG and HIV&AIDS.

Jodie Bieber/ActionAid Date original created: 26 January 09
Country: South Africa

Pretty was a good friend of Eudy Simelane. Eudy was murdered because of her sexual preference. Pretty now spends a lot of time with Eudy's mother.

"By highlighting these organizational approaches, ActionAid and UNIFEM aim to encourage further research and more rigorous analysis of strategies that are effective at both reducing the incidence of violence against women and girls and their exposure to HIV&AIDS."

What makes a practice 'promising' in addressing the intersection?

As ActionAid and UNIFEM began reviewing initiatives to be profiled in *Together We Must!*, a list of characteristics emerged from our combined experience in programming, policy analysis and advocacy on the intersection of VAWG and HIV&AIDS. First and foremost, both organizations agree that promising practices must be rooted in a human rights framework, focused on promoting, protecting and fulfilling the rights of women and girls. Such practices must of course contribute to gender equality by breaking new ground in women's empowerment, either on an individual, programmatic, institutional or policy level. They must also be evidence-based, building on and contributing to the current knowledge and recommended practices in the fields of HIV&AIDS and VAWG prevention. It is equally critical for initiatives to be sustainable, by supporting local capacity development, institutionalization of practices and identifying opportunities for ongoing funding. Ideally, the practices will also be replicable, serving as models for partner organizations hoping to employ similar strategies for the situation or population they serve.

While not all of the practices selected here have been formally evaluated or screened for their impact, they have all demonstrated a pioneering approach to cross-cutting issues at the intersection of VAWG and HIV&AIDS. They meet the needs of heretofore underserved populations, and offer valuable lessons for partner organizations. Beyond these attributes, ActionAid and UNIFEM have identified six criteria that can be considered in assessing efforts to confront the intersection of the twin pandemics. Each of the practices profiled meets one or more of the following standards, as referenced throughout the report:

1) Promising practices address the root causes of both pandemics

Gender inequalities lie at the intersection of the two pandemics. Unequal power relations both perpetuate and sustain violence against women and girls. They also play a role in influencing sexual behavior and HIV risk. For example, studies in Botswana and Swaziland demonstrate that individuals with gender discriminatory attitudes are more likely to have engaged in unprotected sex with a non-marital partner or partners.[19] In the context of the dual pandemics, such norms are harmful to both sexes. Women's subordinate status not only undermines their sexual autonomy, decisions and rights, but may also limit their access to the economic and educational opportunities that would otherwise decrease their vulnerability to both violence and HIV. Traditional norms of masculinity may encourage men to perpetuate violence as a means of proving their manhood or to participate in a range of risky sexual behaviors, including unprotected intercourse and engagement with multiple sexual partners.

Promising practices acknowledge that women and girls' empowerment cannot occur in a vacuum: In order to be successful, interventions must engage men and boys, families and larger communities. This includes a focus on the social construction of 'masculinity', and on challenging larger sociocultural norms that encourage or tolerate violence against women within the public and private sphere. Such practices, at the intersection of the two pandemics, also acknowledge particular kinds of violence, discrimination and barriers experienced by HIV-positive women and girls.

2) Promising practices empower excluded sectors of society

'Nothing about us without us' is a popular refrain among HIV&AIDS activists. It speaks to the importance of involving marginalized groups in policy, programme and practice. While both VAWG and HIV&AIDS affect women and girls from all walks of society, particular populations such as sex workers, migrant workers, young women, ethnic or racial minorities and disabled women are especially vulnerable to these interrelated pandemics. Effective strategies can address the intersection by being inclusive, acceptable and accessible, especially to marginalized groups. In keeping with the principle of Meaningful Involvement of People with AIDS (MIPA), effective strategies acknowledge how race, class, ethnicity, sexual orientation, age, religion and other factors impact women and girls' vulnerability to violence and to HIV&AIDS. Such approaches are attentive to how these factors affect women's ability to access services when they are affected by one or both pandemics. They also take steps to involve marginalized groups in every level of policy and programme development, from design, planning and implementation to monitoring and evaluation.

3) Promising practices promote community ownership

Promising practices ensure community involvement in efforts to address the intersection of VAWG and HIV&AIDS. They engage community leadership and hold communities accountable for fostering a climate that respects and defends women's rights. In order to ensure community 'buy-in', interventions must also be culturally appropriate and responsive to the population and circumstances being addressed. Given the role of community in creating and perpetuating gender norms, effective practices may have to balance respect for so-called 'traditional values' with recognition and validation of women's rights. In many instances, strategies profiled in this report facilitate community-level dialogue to broaden the interpretations of culture to include more egalitarian perspectives, using communication tools such as media and entertainment to educate and raise community awareness.

4) Promising practices enable civil society groups to hold policy makers accountable

Those women most impacted by the dual pandemics are best placed to evaluate the effectiveness of programming efforts, and to advocate for responsive policies. A promising practice supports and strengthens the role of civil society—particularly women's organizations and HIV&AIDS groups—in monitoring implementation of local, national, regional and global level commitments. Whether through documenting instances of violence against women and girls, training women on the use of human rights instruments or tracking the HIV&AIDS funding streams of governments and international agencies, such practices facilitate civil society involvement in holding policy makers accountable.

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Meena, 35, has four children. She has been HIV-positive for 13 years. Meena became a member of MILANA five years ago, she says, "By extending psychosocial support, and nutritional and home-based counselling, we reach out to many positive women." Karnataka, India. 28 March 2008

5) Promising practices promote holistic responses

Promising practices address the rights of women and girls affected by violence and HIV&AIDS to comprehensive prevention, treatment, care and support. They promote cross-sectoral integration, involving stakeholders from a wide variety of fields, and focus on a multitude of needs expressed by women facing one or both pandemics. Effective strategies provide a continuum of care, or employ a well-coordinated referral system, to ensure that HIV-positive women and girls who are survivors of violence receive comprehensive assistance. This includes a focus not only on a client's physical needs, but also attention to her mental health and her physical and economic security. Holistic responses might include legal support and advice, referral to a clinic offering antiretroviral therapy, or psychosocial support.

6) Promising practices build bridges between the movements to address HIV&AIDS, and to stem the tide of violence against women and girls

While HIV&AIDS activists have been working to influence the global AIDS agenda since the disease was identified, and the movement to end VAWG has been increasingly gaining momentum and international recognition, only recently have the two movements joined forces in their advocacy efforts. AIDS was initially viewed as a disease affecting homosexual men, so women and girls were not considered a target group for interventions. At the same time, little was known about sexual violence as a high risk factor for HIV&AIDS.

However, in the last decade or so, activists in the women's movement have been advocating for the need to address gender issues, including violence against women, in the fight against HIV&AIDS. As more and more women and girls have contracted the disease and its sociocultural and human rights implications have became more widely known, awareness of the linkages between the pandemics has increased. Promising practices facilitate linkages between advocates and activists within the two movements, and strengthen their capacity to work together.

Creating communities of support

Like a pebble in a pool, HIV sends ripples to the edges of society, affecting first the family, then the community and then the nation as a whole.

—UNAIDS, 2007

Srikanth Kolari/ActionAid Date original created: 28 March 08 Country: India

Stepping Stone meeting at MILANA with Christy Abraham of ActionAid and Jyothi Kiran of MILANA. Karnataka, India. 27 March 2008

Gender is a crucial factor in the spread of both the VAWG and HIV&AIDS pandemics, and communities help create and perpetuate destructive gender norms. Cultural values and traditions in many societies encourage men and boys to engage in aggressive, even violent behaviours as a means of expressing their masculinity. In some instances these norms are manifested through the perpetuation of violence against women and girls, while in others they are demonstrated through male engagement in risky sexual behaviours. In many societies gender inequalities are not acknowledged as violations of women's rights—in fact, they are often considered natural and necessary.

Until communities acknowledge the prevalence of violence against women and the increased vulnerability of women and girls to HIV, it is almost impossible for community members to become part of the solution. The organizations profiled in this chapter actively engage targeted communities to recognize their roles in sustaining—and sometimes perpetrating—the spread of violence and HIV&AIDS. They employ diverse strategies that are implemented in varied cultural contexts from South Africa to South Asia, but they share some important similarities. Through frank discussion with specific populations, such as young men or families, their strategies cultivate empathy.

This sense of compassion and connection is critical because it is the very lack of empathy that encourages violence to occur in the first place.[20] Furthermore, by emphasizing the proactive roles all members of the community can play in ending the pandemics, these strategies empower individuals to take ownership of their behaviour. This encourages men to become allies rather than perpetrators, women and girls to become advocates whether or not they are also victims, and families and communities to become supporters rather than stigmatizers or passive witnesses who tolerate abuse.

The organizational strategies profiled here exemplify many of the characteristics and criteria described in Chapter One. By working with a range of actors whose attitudes and behaviours help shape societal norms, they encourage community ownership and buy-in from even the most sceptical of stakeholders. They further address the root causes of the pandemics and demonstrate that the intersection of violence and HIV is more than just a 'woman's issue'. Last but not least, by probing deeply held cultural beliefs, these practices promote a more inclusive understanding of local culture to create true communities of support.

Cultivating men as allies: Sonke Gender Justice, South Africa

In my work . . . we challenge young men's ideas about what men should be like. When they say, men should take risks because that's what being a man is all about, we point out that certain kinds of risks are not about being brave, they are about getting HIV. As a man I want to change the thinking of other men and boys about the roles they place in life as husbands, fathers, members of communities.[21]

—Tapiwa, Community Educator

Tapiwa is a young man who has made it his mission to speak out against violence against women and girls, and its

multitude of consequences, including HIV&AIDS. His personal pain in witnessing his father being violent towards his mother impelled him to join a burgeoning movement that seeks to redefine what it means to be a man.

In South Africa, where research has shown that every six hours a woman is killed by her intimate partner, Tapiwa's story has particular resonance.[22] Furthermore, "nearly 4 percent of sexually active women aged 15-24 [in South Africa] reported that they had been physically forced to have sex by their most recent partner (just under 10 percent reported ever having been physically forced to have sex)."[23] Violence against women following disclosure of HIV status is also far too common, affecting between 3.5 and 14.6 percent of HIV-positive women involved in 17 studies conducted in sub-Saharan Africa and south-east Asia.[24]

Tapiwa's story was recorded as a digital narrative by Sonke Gender Justice, an organization dedicated to challenging the gender inequalities that contribute to the rapid spread of HIV and AIDS. Sonke, which means 'all of us together', recognizes the importance of engaging men and boys in the struggle towards gender equality. The first part of the battle is often getting men to recognize that they have a role to play. As Tapiwa recounts, "For the boys, gender was about women's issues. It had nothing to do with being a man. This disturbed me because I knew from my own experience how gender-based violence affects both women and men."

Sonke's flagship programme, the 'One Man Can Campaign', was established in February of 2006 and supports men and boys in eight South African provinces as well as Burundi, Kenya, Malawi, Mozambique, Namibia and Uganda to take action to end domestic and sexual violence and to promote healthy, equal relationships.[25] Sonke's work is part of promising efforts to engage men and larger communities as allies, rather than perpetrators, in the fight for gender equality. Whereas risky behaviours such as violence or engaging in unprotected sex are more often associated with men than women, Sonke knows it cannot engage men and boys through guilt, accusations or name-calling.

Dean Peacock, co-founder of Sonke, reflects, "In our efforts to convey the urgency of addressing gender-based violence, we must guard against falling into the trap of depicting men in the Global South as automatically invested in patriarchy and inevitably violent and/or irresponsible. Sometimes depictions of men in the Global South in international AIDS discourses run the risk of reinforcing racist and neo-colonial stereotypes and this has to be named and challenged. It is counterproductive, engenders unnecessary resistance among some men and increases the likelihood that AIDS organizations will fail to consider strategies that might enlist men as critical allies in ensuring women's access to health and rights."

Instead, to address the root causes of behaviour that reinforces the twin pandemics, men and boys must question what it truly means to be a man. This includes examination of how masculine norms may be harmful to men themselves and the people close to them. Sonke's programmes teach men and boys that the same gender norms that condone violence against women also encourage men to act in ways that put their own health at risk. Whether through violence and aggression, the pursuit of multiple sexual partners or unprotected sex, norms around 'masculinity' and sexual prowess may expose men and boys to sexually transmitted infections such as HIV. Such norms are even more dangerous in the context of men's low utilization of HIV services. Whether out of fear of disclosure or stigma, the desire to continue multiple sexual relationships, or other factors, men in South Africa get tested and treated for HIV at significantly lower rates than women.

Sonke encourages men and boys to think about the impact of their actions on their own mothers, sisters and daughters, colleagues, fellow women activists and friends. Once men understand the vulnerabilities and impact of the twin pandemics upon women and girls they care about, they can be mobilized to change behaviours that drive the spread of VAWG and HIV&AIDS. Sonke also draws on traditional South African ideas of Ubuntu—the notion that people derive their humanity through their connections with others—to engage broader communities and encourage local leaders to support their efforts. Working with both traditional leaders and local governments helps them gain credibility and shift cultural norms. In one poor rural province, for example, Sonke collaborated with influential religious and traditional leaders, training them on the connections between VAWG, HIV&AIDS and men's roles and responsibilities in addressing them. As one leader remarked, "I always thought that issues like equality don't belong in the African way. But now I realize that I have to do something."[26]

Sonke attempts to secure the sustainability of its work by strengthening leadership and capacity at the local, provincial and national government levels, as well as coordinating with the national gender machinery to ensure that all government departments integrate a focus on men and gender transformation into their work. Their focus is on scaling up their efforts by getting larger, better-funded agencies to buy into their methodologies. According to Mr. Peacock, "We also work with local government to get them to take the work on—including training their own staff to implement

> “For the boys, gender was about women’s issues. It had nothing to do with being a man. This disturbed me because I knew from my own experience how gender-based violence affects both women and men.”

work with men—to make sure that the work doesn’t end when Sonke’s funding ends or when the organization shifts to another area. Government has to take this work on and finance and support local civil society organizations to carry on the work in their areas.”

In addition to supporting government Sonke also uses advocacy to hold government to its constitutionally mandated obligation to advance gender transformation. The organization recently sued a prominent official from the ruling party for misogynist comments he made in public. Sonke has also issued press statements and held public demonstrations to demand swift action from the criminal justice system on cases of rape and domestic violence that have occurred in their communities.

While the true impact of Sonke’s work may be difficult to gauge, evaluations indicate substantial shifts in male attitudes and knowledge around gender, sex and women’s rights. According to one impact assessment, participants indicated significant changes in short-term behaviour in the weeks following Sonke workshops, with 25 percent having accessed Voluntary Counselling and Testing (VCT), 50 percent having reported acts of gender-based violence and 61 percent having increased their own use of condoms.[27] Surveys demonstrate that a majority of men change their opinion after a Sonke workshop about their right to beat their partners or to demand sex, even if their partner is unwilling. It is this change in attitude, one man at a time, that creates a shift in community culture.

Creating support networks in India, family by family

MILANA is like family to me. Its members are like relatives. It saved me from death and gave me strength to face the world.

—MILANA member

In a society largely ignorant about AIDS, admitting one has HIV can feel like announcing one’s own death. But “for MILANA members, the act of sharing HIV-positive status with the family and community is seen as an assertion of identity, a way to break the silence and stigma that too often goes hand in hand with the virus.”[28]

MILANA is a support network of women living with HIV&AIDS and their families. What began as an informal group of five HIV-positive women in Bangalore, India in 2000 has bloomed into a vibrant network and critical resource. Whereas initially women were worried about exposing their status to neighbours or relatives, MILANA’s open door policy encouraged participants and their families to share their feelings in an atmosphere free of stigma and judgement. From the very beginning, MILANA, which means ‘coming together’ in a local language, served as a safe environment where families could share common experiences around dealing with HIV. Such spaces are rare in India, where there are many networks of HIV-positive people, but few family-focused support groups.

MILANA emphasizes developing personal relationships, and encourages women to share their grief. Families meet to share space and friendship around the common experience of one or more of their family members who are HIV-positive. The meetings are lively, spirited and, above all, cathartic. According to Jyothi Kiran, MILANA Project Coordinator, “The women cry a lot, and when the tears dry, we sit and talk. Group counselling helps, as women sharing similar experiences derive support and strength from each other. Learning and sharing helps develop confidence among fellow members.”

MILANA’s meetings help reduce isolation, physically and emotionally, while enhancing empowerment. For many, the group was the first place where they acknowledged their HIV status to another person or where they came face-to-face with other HIV-positive people. For others, bringing relatives to the meeting presents an important opportunity for their loved ones to better understand their challenges. For those without the benefit of a network of support, MILANA itself serves as an extended family.

Such support, within the family context, is particularly important in a country where married women and girls are

particularly vulnerable to HIV. According to one nationally representative survey, over 95 percent of HIV-positive married Indian women (out of nearly 125,000 respondents) report being monogamous.[29] This data from India mirrors global trends: While it is often the husband's extramarital affairs and unsafe behaviour that puts his partner at risk, women and girls are commonly the first household member to discover their HIV-positive status. The results, which often come out during an antenatal test, can generate blame, violence, rejection and abandonment by a woman's partner, family and the larger community. Such real and internalized stigmas, as well as lack of access to resources, can prevent women and girls from leaving abusive relationships, seeking treatment or accessing other services.

MILANA's work lies at the intersection of the twin pandemics because of the challenges experienced by HIV-positive women in fighting both the virus and the social discrimination and violence that accompany it. Today MILANA helps not only through mutual support and fellowship, but by providing tools to empower HIV-positive women and their families. As a hybrid between a self-help group and a resource centre, MILANA helps participants learn from each other as well as from counsellors and experts in the field. The meetings are fully community-owned, as women themselves drive an agenda that might include navigating social and medical service systems, dealing with medication side effects or learning how to approach and demand their rights.

MILANA's reach also extends beyond group sharing. As part of a holistic approach to addressing the twin pandemics, peer counsellors present at meetings are available for home-based visits and care. There they raise HIV awareness among extended family members, offer advice on nutrition and care, and, when necessary, monitor and report on situations of violence. Furthermore, MILANA members use their power as a group to help hold policy makers accountable, through advocacy for government entitlements such as ration cards, medicines and bank accounts. When the Indian government introduced a drug with severe side effects as part of a free treatment programme, MILANA women were at the forefront of the protest. While the drug manufacturer chose the MILANA meeting as the site to defend its product, ultimately the drug was withdrawn from the programme due to the women's advocacy efforts.[31]

There are now more than 300 families enrolled in MILANA, all of whom joined through word of mouth. Almost half of the HIV-positive women are widows, mostly under thirty-five years of age. Eight percent are grandparents taking care of children. Many come from marginalized castes, younger or older age categories, or other vulnerable groups. Without the support of MILANA, many never would have had the knowledge or confidence to fight for their rights.

Broadcasting to change community culture: Equal Access Nepal

I belong to the Chaudari [ethnic minority] community and here there is very little support if people get infected from HIV&AIDS. Now I know that people should support and care for infected people.

—Community radio listener,
after listening to 'VOICES' programme

Sometimes the voices of the most marginalized groups can incite a powerful call to action. In Nepal, a country with high illiteracy rates and where the majority of the population lacks access to telephones, television or even electricity, radio remains an effective means of reaching out to the masses. The oral tradition is strong in this impoverished nation that is still reeling from 10 years of civil war. Women and girls have suffered greatly in the internal conflict. In this context, Equal Access Nepal perceived an opportunity to strengthen women's voices through radio. This was a natural progression for Equal Access Nepal, which produces radio programmes to address pressing and often controversial topics. According to Country Director Nirmal Rijal, "radio is the medium that is used to shift thinking and encourage dialogue about difficult social issues."

With 118 laws on the books in Nepal that discriminate against women and girls, there is a great need to encourage dialogue on gender relations. Exploring difficult issues on the radio and through community discussions helps break taboos and encourages safer, more empowering behaviours. Equal Access has addressed both HIV and VAWG through targeted programming since 2003. The Safe Migration Radio and Outreach Programme, for example, focuses on migrant laborers who are exposed to the intersection of the two pandemics in Nepal and elsewhere. It has been estimated that more than 41 percent of seasonal labor migrants returning home from India to Nepal are HIV-positive.[32] Many of these men engage in unprotected sex during their travels, potentially exposing their wives and partners to the risk of HIV infection upon their return.

Safe Migration programming profiles the adventures of Narendra, a young Nepali migrant to India. Through the use of satellite radio, migrant workers are targeted both in

sending communities in Nepal and receiving communities abroad. Equal Access encourages current and returned migrants and their families to listen to the broadcasts together and participate in facilitated discussions. The programme has also stirred strong emotions in female listeners, some of whom are now working to encourage safer sex practices in their communities.

'VOICE', Equal Access' new broadcast addressing linkages between violence and HIV, takes the concept of outreach and community involvement further. Created in response to community feedback and numerous listener letters, 'VOICE' uses audio diaries, interviews, songs and other features to create personal testimonies from HIV-positive women and survivors of violence. The stories broadcast are poignant and hard-hitting because they are told through the eyes of excluded and often voiceless groups. Equal Access trains groups of marginalized women such as sex workers, HIV-positive women, prisoners and wives of migrant workers in reporting and interviewing. Many of these women have witnessed domestic violence, or belong to families affected by HIV, conflict, internal displacement or migration. In their role as 'Community Reporters', women themselves create news and facilitate discussions both on the air and in smaller community forums. Their work serves as a critical outlet for voices that would not otherwise be heard. As part of their reporting, more than 350 rural testimonies, mostly from women, have been collected and broadcast as interviews, vox pops, monologues and features.

Not only does such training encourage women to find their voice, but frank discussions through facilitated listening groups help reduce stigma against HIV-positive members of the community. Further training of women leaders and community members in legal literacy complements the on-air discussions and encourages women survivors of violence and HIV-positive women to know and exercise their rights. With the permission of the individuals involved, detailed evidence collected through the radio programmes is provided to NGOs, UN agencies and others involved in advocacy efforts.

Much like Safe Migration programming, Equal Access makes efforts to ensure that 'VOICE' reaches underserved communities. In addition to broadcasting in Nepal and among Nepali migrants in India, a tailored version of the radio programme is recorded on audio tapes that are distributed among transport workers, long-route bus drivers and for use at major transit points such as border crossings. Furthermore, as a means to strengthen community ownership and ensure sustainability, Equal Access partners with local NGOs to assist in outreach and monitoring of project sites. Partners are carefully chosen for their expertise on HIV&AIDS, VAWG or both. Equal Access also maintains strong ties with local communities, and employs beneficiaries who have been affected by one or both pandemics.

Sumitra Thami, 34, attends a rally against gender violence. Approximately 700 women took part in the rally and a song and dance competition held on Friday the 5th December 2008. The event, which took place in the village of Lapilang in Nepal's mountainous Dolakha District, was organized by HURATEC (Human Rights Awareness and Development Center) Nepal in coordination with ActionAid's HungerFREE campaign.

While it is early to gauge the effects of 'VOICE' programming in particular, community reporters have highlighted a significant reduction of stigma among their peers. According to one woman, "after the broadcast on July 18th of an interview that I recorded, there was an evident change in the way the community looked at me, and now people who ignored me before are my well-wishers, and this has encouraged me to do more for the women of my community." The project succeeded in creating a cadre of knowledgeable and empowered women inspired to initiate community discussion around the impact and linkages between violence and HIV&AIDS. In this way, the use of radio in Nepal shows great promise as a means for changing community attitudes about the dual pandemics.

Involving excluded groups

Gender-based discrimination intersects with discriminations based on other forms of 'otherness', such as race, ethnicity, religion and economic status, thus forcing the majority of the world's women into situations of double or triple marginalization.

—Radhika Coomerswarmy
Former Special Rapporteur on VAW, Its Causes and Consequences

In most regions of the world, significant differences exist in access to education, social and political opportunities and economic empowerment between those who belong to racial, ethnic and other kinds of minority groups, and those who do not. Women and girls' vulnerability both to violence and HIV&AIDS is rooted not only in gender inequalities but in social disparities based on race, class, ethnicity, age and sexual orientation, among other factors.

Such disparities can be seen across cultural contexts, from the North to the Global South. In Brazil, for example, research demonstrates that black and mulatto women experience greater rates of poverty, less access to basic health care, and higher rates of HIV than their white counterparts.[33] In the United States, while African-American and Latin American women represent 25 percent of the female population, they comprise 81 percent of women living with HIV.[34] Discrimination is not only manifest at the individual and community levels, but embedded in laws, policies and state structures themselves.

In the context of HIV&AIDS and violence against women and girls, discrimination based on gender and race may be compounded by sexual orientation. Although women who have sex with women (WSW) are perceived as having low risk of HIV, violence against lesbians in the form of 'corrective' rape may increase their chances of contracting HIV. In South Africa, for example, reports of rape targeting lesbians have been escalating,[35] particularly in black townships where they are seen as challenging male power. In other instances, WSW are forced into arranged marriages as a means to 'cure' their homosexual behaviour.[36]

Gendered disparities in HIV prevalence are also more extreme among young women. In addition to girls' greater biological vulnerability to HIV, their economic and social challenges make them susceptible to multiple forms of violence including trafficking, transactional sex, domestic violence, forced sexual initiation, forced marriage and marital rape. Intergenerational transactional relationships between young women and older men are increasingly common in HIV&AIDS-affected areas, whether through child marriage, sugar-daddy relations or other kinds of sexual arrangements. At least three studies show that the greater the age differential between an adolescent girl and her partner, the higher the chances of her contracting HIV.[37] Furthermore, risky sexual practices such as non-use of condoms and non-discussion of HIV with a partner are significantly linked to larger age differences between men and women partners.[38]

Promising practices for addressing the twin pandemics of VAWG and HIV&AIDS must be informed by the way in which these identities intersect to create multiple layers of discrimination. The strategies showcased in this chapter address different aspects of marginalization, yet share similarities. All organizations work in communities where conditions are often hostile towards their efforts to inform, educate and empower women and girls. But operating on the philosophy that knowledge is power, they support women and girls by building their self-esteem, offering them practical and life skills, and strengthening awareness of their rights. And they encourage women and girls themselves to serve as ambassadors for the cause by teaching other women what they have learned and advocating for their sisters to protect themselves from violence and HIV&AIDS.

Addressing women of colour in their own communities: Brazil's Criola

We need to put black women and girls at the center of our services and policy-making. There is not only one epidemic. There are very different experiences with HIV for different groups.

—Jerema Werneck, Criola Executive Director

As the first developing country to implement an HIV&AIDS plan, Brazil has become a model for addressing the pandemic. Numerous other countries have adopted Brazil's prevention and treatment guidelines, which have dramatically

reduced AIDS-related deaths. Despite its international reputation, however, government policies and programmes have one major shortcoming: Services are not readily accessible to Afro-Brazilian women and girls, the very populations that are especially vulnerable to HIV and violence.

Until recently, the impact of race on Brazil's AIDS strategies was not formally acknowledged. Data collection on HIV and race only began in 2000, and such statistics have not yet been incorporated into HIV&AIDS planning efforts. Nor has the interplay between racial and gender discrimination been addressed in any state-sponsored programmes. According to Jerema Werneck of Criola, which works to empower Afro-Brazilian women and girls, "The challenge lies at the root of how all of the policies around HIV&AIDS have been conceptualized from the beginning. The policy framework emerged from an approach based on the notion that HIV&AIDS was only affecting white [men who have sex with men] (MSM). The epidemiology was understood from that premise and the approach translated into use of condoms and medication to take at certain times. These narrow methodologies pose complications for other lives, especially for black women and girls."

The consequence is that vulnerability to HIV in Brazil is growing, especially among black women and girls.[39] Nowhere in Brazil is the relationship between race, gender, violence and HIV more prevalent than in the *favelas,* or slums. Living in communities rife with violence and crime, *favela* women and girls commonly suffer brutalities, including rape and sexual violence, at the hands of both criminals and the police. HIV-positive women themselves may be targeted by gangs, and in some cases are forced to take HIV tests.[40] Women who test positive have been forced to leave their communities or suffer other violent reprisals, even death.[41] The situation is so extreme that health care workers are often afraid to tell women their HIV status for fear of putting them in harm's way.

Working in those very communities of Rio de Janeiro since 1992, Ms. Werneck and her Criola colleagues themselves face situations of violence, shootings and gang warfare as an unfortunate backdrop to their skill-building and empowerment efforts. Yet Criola fills an important gap in access to services and information for many *favela* dwellers. Women and girls who are victims of violence in such communities and women living with HIV may not know how to seek out the necessary support or services. As Ms. Werneck describes it, "violence displaces women, both geographically when they flee unsafe situations, and emotionally when women are either in an ongoing violent situation or suffering post-traumatically and are thus unable to engage with society, external relationships and resources. Thus, there is a literal or figurative chasm between where they are geographically and/or emotionally and access to HIV&AIDS prevention and treatment services and information."

ActionAid/UK branded image
Date original created: 29 April 09 Country: Brazil

Gabriele, 10, with her cousin Marcio Eduardo (1 year and 5 months old) at her home in São João de Meriti in Brazil.

Criola breaks this chasm by bringing such services to women where they live. In fact, Criola's practices can be considered promising specifically because they operate in areas where the state refuses to tread. Stigma and discrimination hinder the government from allocating adequate resources for *favela* dwellers. Fear of violence and crime further prevent the limited resources for services from being delivered. According to Ms. Werneck, "The government has a house-to-house visitation programme, but they don't go to the communities where black women and girls live. State actors who do home visitation are concerned about security … and thus they avoid these areas." In contrast, Criola's work in the *favela* itself gives poor and marginalized women a sense of security and belonging, especially in areas wracked by drugs and crime.

Criola was created to address the multiple kinds of marginalization suffered by *favela* women. Recognizing that such women need to "confront the racism, sexism and homophobia that is current in Brazilian society," Criola develops tools to help women and girls deal with violence, raise their self-esteem, advocate for their rights and embrace their Afro-Brazilian heritage. In addition to practical skills, such as income generation or negotiation of safe sex, Criola builds a sense of pride among *favela* women. Led by black women of a variety of backgrounds, staff members serve as role models for young girls who know little outside of *favela* life. Training materials incorporate elements of

traditional Afro-Brazilian culture and religion to strengthen self-respect among girls and women often disconnected from both mainstream Brazilian culture as well as their own African heritage.

"In promoting health awareness, Criola draws upon the culture, knowledge, tradition and experience of African-Brazilian religions, which not only have a particular take on the notion of health and well-being, but are also a direct link with an African ancestral heritage. Criola utilizes African descendant cultures to restructure, reorganize and empower black women in their communities. Their tactics have emphasized the value and usefulness of African cultural legacy to understand these women's health conditions and to challenge the way health policies, care and practices are implemented in Brazil."[42]

In addition, Criola's work also serves a larger advocacy purpose. The organization uses its long history of working with Afro-Brazilian women to produce data on the disproportionate effects of HIV on blacks in Brazil. Their evidence is taken to policy makers and government health agencies to lobby for more resources for black women's health. A parallel strategy used is to facilitate the political participation of black women and girls. Criola's longer term goal is to encourage more black women politicians in the hope they can develop better policies to address the needs of their sisters.

Advocacy at home and sisterhood abroad: Women of Color United (WOCU) USA

There is no such thing as a single-issue struggle because we do not live single-issue lives.

—Audre Lorde, African-American poet and activist

Criola's experience working with women of colour in Brazil echoes that of groups engaging similar populations in the United States of America, where AIDS is the leading cause of mortality among African-American women. According to Dázon Dixon Diallo, founder of SisterLove, a member organization of Women of Color United (WOCU), "experiences of women of colour in the US often mirror what's happening with women in the Global South." Indeed, as research demonstrates, if black Americans made up their own country, it would rank just below Ivory Coast in numbers of people who are HIV-positive. [43]

Founded in 2007, Women of Color United (WOCU) is a trust of 70-plus women of colour organizations in the United States of America that collectively focus on strengthening the capacity of members and others to advocate for policies to address the intersection of violence against women and girls and HIV&AIDS on a global scale. WOCU recognizes that while not all communities of colour are alike, they do often share inequality in status, visibility and political power. Within the African-American community, for example, the very existence of the WOCU network is important because of the pervasive silence surrounding violence, HIV and the ways in which they are linked.

As Ms. Diallo explains, marginalization of African-American women is complicated by key behaviour patterns that can negatively impact communities of colour. These include women's lack of comfort with their bodies and their sexuality; lack of open discussion about sex and sexually transmitted diseases, including AIDS; and blind respect for medical providers, even when they are uninformed or biased. Whereas in the past, female elders might have shared their knowledge with younger women, such relationships are less common today. This culture of silence contributes to a tendency for women to hide both incidents of violence and their HIV-positive status.

WOCU works to support a diverse set of network members in their awareness-raising efforts. The network uses its collective strength to add to the evidence base and strengthen advocacy efforts, particularly in communities where awareness of the relationship between VAWG and HIV&AIDS is limited. One means of addressing the silence is to collect more data on the intersection of VAWG and HIV&AIDS within the United States of America. Whereas much of the current research on communities of colour in the US is qualitative and anecdotal, WOCU advocates for more quantitative research as a means to push for targeted policies and funding. By serving as a support system to help women of colour engage in the US political system, including through grass-roots voter registration efforts, WOCU aims to strengthen the role of marginalized members of society in holding policy makers accountable.

WOCU's efforts are important not just because of their work within the United States of America, but because of their connections with women's movements in the Global South. Members use their positioning within the United States to push for policy change abroad. Recognizing the key role of the US political system domestically and globally, WOCU lobbies policy makers to advance key global initiatives such as the International Violence against Women Act and foreign assistance reform to more effectively target VAWG and HIV&AIDS. The network is gaining members and plans to hold policy makers accountable at home and abroad.

Empowering youth: Nigerian girl power

Girls are trained to be submissive and humble. No one wants to hear them. No one expects that they have any rights to express themselves.

—Bene Madunagu, Executive Director, Girls Power Initiative

In the absence of a cure for HIV&AIDS, education has been called 'a social vaccine'. Research in a variety of settings suggests that educated girls are more likely to know the basic facts about HIV, more empowered to negotiate safe sex, more likely to delay sexual activity and are less likely to suffer from sexual and gender-based violence.[44] In Nigeria, where over 83 percent of girls report that they have had sex before the age of twenty,[45] Girls Power Initiative (GPI), established in 1993, uses the power of education to teach girls how to negotiate respectful relationships and protect themselves from unsafe sex. GPI forms partnerships with state governments with centres in four states as well as activity programmes in 28 schools.[46] They conduct sex education in these schools and advocate for the inclusion of educational materials on sex and sexuality in school libraries.

Such efforts are not always easy in religious and highly conservative communities. Because sex is not discussed in 'polite society' in Nigeria, GPI frequently encounters resistance to its efforts from families and others concerned that sexual education itself will encourage promiscuity. GPI promotes community ownership of their programmes by inviting parents and concerned community members to interactive forums where they explain their curriculum and overall goals. Parents who have already been convinced of the programme's value help explain its benefits to other families. By emphasizing how such education can protect girls from rape and unwanted sexual advances, they quell parents' fears and encourage community support for their programmes. These forums are complemented by radio and television shows in which girls, parents, GPI facilitators and school administrators share positive examples of the programme's impact.

GPI's model of comprehensive life skills and sex education prepares girls to deal with gender and power inequalities that lie at the intersection of VAWG and HIV&AIDS. Beginning with pre-adolescent ten-year-old girls, GPI focuses on such topics as self-esteem, body image and personal hygiene. The second level teaches the basics of sexuality, male and female anatomy, contraception, abortion and HIV&AIDS. During the final year, GPI supports the girls in their transition to womanhood, exploring personal decisions around sexuality and empowerment. Girls who know their rights at an early age develop the confidence, skills and ability to confront violence in their relationships and protect themselves from HIV. Those involved in relationships are taught that love doesn't have to include intercourse. Girls approached by an older man for sex learn to ask how he would feel if his daughter were in a similar situation.

GPI's model also has provisions for a multiplying effect. As a condition for graduation from the three-year comprehensive programme, the girls go through community service in a rural community where they teach other adolescents what they have learned. A needs assessment is conducted, focusing on health challenges for local girls and women. The girls conduct analysis, prepare educational materials and go back to their community to perform educational sessions, based on their newfound knowledge and skills.

According to Bene Madunagu, Executive Director of GPI, the level of empowerment has significantly increased as a result of GPI programmes. Girls who were shy at the beginning of the programme become confident and assertive by graduation. Through the education and skills they receive, girls choose when to enter relationships and ensure that their needs are met, including the need to be safe from violence and protect themselves against HIV. Indeed, none of the girls who have entered the programme HIV-negative have contracted the disease. They also have the tools and confidence to leave abusive partners.

GPI's programmes demonstrate the power of education in breaking the links between VAWG and HIV&AIDS. They also illustrate the importance of investing in girls. Most girls who have gone through the programme remain in school and continue on to the university level. Many have themselves become counsellors, eager to give back to the community what they have gained. In this way, GPI programmes ensure that youth and inexperience need not be risk factors for HIV.

Building an integrated approach in the health sector and beyond

Gender plays an important role in determining a woman's vulnerability to HIV infection and violence and her ability to access treatment, care and support and to cope when infected or affected.

—Sexual and Reproductive Health of Women Living with HIV&AIDS

As demonstrated by the practices profiled in the last chapter, marginalization and violence against key population groups hinder access to prevention, treatment, care and support for women and girls dealing with HIV&AIDS. The threat of violence is a barrier to accessing HIV testing and counselling services, as well as to HIV disclosure. Without the knowledge of their HIV-positive status, or ability to access treatment and care services, women may fall ill or die unnecessarily. An effective response to the twin pandemics thus requires an integrated and holistic approach in the health sector to address the interconnections between violence and HIV&AIDS, and to acknowledge both the immediate and long-term physical, psychological, legal and economic needs of survivors.

The creation of an integrated approach to the two pandemics must be understood in the context of attaining universal access to prevention and treatment. International consensus is growing on the need to increase provider-initiated testing and counselling, in addition to voluntary counselling and testing (VCT) initiated by the client. With this additional responsibility on health providers comes an increased need to train them on the connections between the dual pandemics, as well as to create protocols for addressing them. In many settings, health care providers, particularly those who are managing HIV testing and counselling services – and HIV counsellors themselves – are not aware of the associations between HIV and violence against women and girls. Nor do all providers conform to international standards ensuring consent and confidentiality. In the context of HIV and VAWG, such violations can produce devastating results.

The examples detailed here provide two promising models for an integrated approach to addressing the dual pandemics. The first, a 'one-stop shop' for survivors of sexual violence, illustrates a rights-based approach to health care whereby women receive free treatment, care and support in the face of violence and HIV, as well as assistance in doc-

Sven Torfinn/Panos Pictures/ActionAid/UK branded image
Date original created: 29 September 08 Country: Kenya

Judith Atieno Basil, Usigu, near Kisumu, Kenya, October 2008. Judith, 25, is the secretary of the Ulusi Youth Group, a group supported by ActionAid. Ulusi is active within the community, trying to raise awareness concerning HIV&AIDS, early pregnancies, school drop-outs, sexually transmitted diseases, domestic violence, human rights, child abuse and other social problems. Most people in the community earn a living either by fishing on Lake Victoria or by farming.

umenting their case, reporting the details to law enforcement and accessing longer-term care. The second example demonstrates a means for improving hospital procedures by integrating protocols around VAWG and HIV into standard medical practice. Both approaches use health care as an entry point to comprehensively address the two pandemics as they affect poor women and girls.

Offering holistic support: Nairobi Women's Hospital, Kenya

Given that sexual assault is certainly not in the budget of the victim, she definitely doesn't have the money set aside to finance care and treatment. There should be a one-stop shop where women can receive comprehensive care.

—Dr. Samuel Thenya, Founder, Nairobi Women's Hospital

In Kenya, multiple factors collectively keep survivors of sexual violence from obtaining medical treatment, care and support. Many cannot afford the minimum charge for hospital services. Feelings of shame, embarrassment and humiliation deter others from reporting the crime. Social stigmas associated with HIV may deter women and girls from choosing to learn their status, even in situations of gang rape or when there is a high likelihood that they have been exposed to the virus.

Such discrimination is embedded in the very legislation that should serve to protect women, since legal provisions in Kenya deter women from seeking justice. While the Kenyan Sexual Offences Act of 2006 provides for increased protection for survivors of sexual violence, it also criminalizes the offence of making false allegations. According to Alberta Wambua, Deputy Director of the Gender Violence Recovery Centre (GVRC) at Nairobi Women's Hospital, "If someone comes and rapes me and—after all the rulings—is found innocent, I'll be taken to prison for the number of years that this person would have served if he had been found guilty."

Further stipulations in the law hinder redress for survivors. The police can only keep the accused in custody for 48 hours if they don't have complete documentation of the crime. Yet time and money are needed to build a case and collect evidence, and to address the consequences of sexual abuse. Women are often unable to press charges because they cannot afford the cost of medically documenting the assault, which can cost as much as US $200. If the survivor can't submit the necessary documents within the prescribed 48 hours, the perpetrator will be released.

The Gender Violence Recovery Centre (GVRC), established in March 2001 at the Nairobi Women's Hospital, specifically addresses these thorny issues. Operating as a one-stop shop, the GVRC offers free and timely treatment for survivors of sexual assault, including voluntary counselling, testing and provision of post-exposure prophylaxis (PEP). Their treatment offers hope to survivors of violence who need to know whether they have contracted HIV. According to Ms. Wambua, "very few people know that there is something you can do within 72 hours to prevent HIV transmission after sexual assault." Recognizing that HIV infection might not be immediately detected, patients receive repeat testing after three and six weeks. Additionally, women receive trauma and adherence counselling to help them through the four-week period necessary for PEP to work effectively. Those women who test positive are given HIV and trauma counselling and are referred to appropriate facilities to access longer-term care such as free anti-retroviral (ARV) therapy.

> "The provision of free services is made possible because of the centre's administrative structure: as a non-profit charitable trust of the hospital, the GVRC is managed more like an NGO than a health care facility."

Founded in part to respond to the stigma faced by survivors of sexual violence and HIV, and to the lack of established standards for their care, the GVRC has created guidelines for treatment and support. Health providers receive continuous training, monitoring and evaluation to

ensure they are effectively and sensitively responding to the needs of their clients. The centre's integrated approach treats the emotional implications of violence and HIV as seriously as the health-related repercussions. As Ms. Wambua explains, "By the time she comes for medical attention, the woman has been beaten and is in bad shape. Women don't consider psychological trauma as abuse, only physical trauma. They don't want to take any action and believe that they are the ones doing something wrong. [Despite the abuse] they often go back to the same family." Psychosocial support includes a variety of counselling options: one-on-one, family therapy and monthly group sessions where participants share experiences and help each other. Issues around disclosure of violence and HIV status are explored to help women safely transition back to their daily lives. When necessary, the social work department makes referrals for services such as legal action and temporary shelter.

This open-door policy allows women and girls from marginalized and economically disadvantaged groups to access services and support. Providing such access was the intention of founder Dr. Samuel Thenya, who identified cost as a major barrier to care for survivors of sexual assault. The provision of free services is made possible because of the centre's administrative structure: as a non-profit charitable trust of the hospital, the GVRC is managed more like an NGO than a health care facility. Funding is provided through multilateral and bilateral donors as well as large international corporations, rather than by the women themselves.

The GVRC also works to strengthen the linkages between sexual assault and HIV at the policy level. Through the use of an elaborate data management system, it collects and collates data on all treated patients, and analyses trends in the experience of violence survivors, including statistics on those contracting HIV. As the main resource in Kenya for statistics on gender-based violence and HIV, the GVRC serves a vital purpose for multiple stakeholders. Survivors have the documentation to press legal charges and further their case. Advocates use the data as a tool to support policy change, including lobbying for implementation of stronger sexual violence legislation. And government officials can better understand the intersection between the two pandemics. Through these documentation efforts, the monitoring unit helps civil society groups hold policy makers accountable.

As the only institution of its kind in East Africa, the services of the GVRC are in high demand. Since its establishment in 2001, the GVRC has treated over 10,000 survivors of violence. Many of the women served would never have received an initial assessment, let alone comprehensive care, without the centre's assistance. GVRC's framework for provision of care serves as a model for integrated services that truly meet women's physical, emotional and social needs in the face of the twin pandemics.

Creating protocols to address the intersection: Argentina's FEIM

Our research examined information on the recognition and respect of the sexual and reproductive rights of Women Living With HIV&AIDS (WLWH). We found that these rights were part of the discourse by HIV/AIDS programme officials with 'politically correct' language, but in general this did not correlate with the reality of services offered daily. These rights, as with human rights in general, are recognized 'in theory' by the health system but in the majority of cases not incorporated into practice.[47]

—Mabel Bianco, FEIM Executive Director

Legislation in Argentina has guaranteed sexual and reproductive health care for all women since 2002. Yet implementation of the law falls far short in reality. Women and girls

"It's a schizophrenic thing: We treat the pregnant woman until the day before childbirth. Then she goes to the maternity hospital for delivery, we lose her and she reappears four or five months later and we don't know what happened in connection with her HIV.

These hospitals are only 50 blocks apart."

living with HIV often face discrimination at service points and have been forced to conceal their condition in order to access health care. Stories abound of HIV-positive women forced to wait for the one lab technician allocated to draw their blood, or the only obstetrician willing to attend to their births. It is common for women to be tested without their consent, then offered HIV services and treatment only for as long as they are pregnant, but not once they give birth. According to one Argentine physician, "It's a schizophrenic thing: We treat the pregnant woman until the day before childbirth. Then she goes to the maternity hospital for delivery, we lose her and she reappears four or five months later and we don't know what happened in connection with her HIV. These hospitals are only 50 blocks apart."[48]

Denial of health care for HIV-positive women in Argentina itself is driven by stigma and pervasive discrimination. Mabel Bianco, Executive Director of Fundación para Estudio e Investigación de la Mujer (FEIM), has researched the quality of health care experienced by women living positively. She affirms that "during the interviews, prejudices among doctors came to the fore. For example, the idea that it is unadvisable for positive women to have sexual intercourse. If they do, it is unacceptable that they become pregnant. These prejudices lead to advising, even promoting and facilitating women's sterilization, a practice illegal in Argentina until mid-2006 when the law was amended." [49]

Founded in 1989, FEIM addresses the intersection of the two pandemics in the public hospitals of Buenos Aires. Since no such standards existed in Argentine hospitals, FEIM advocated for the creation of a protocol to specifically address linkages between violence and HIV&AIDS. FEIM worked with the city's Ministry of Health and the Chief of the Ministry's HIV Unit to put pressure on hospitals to implement these new gender-friendly policies as well as to dispel the stigma and discrimination surrounding HIV status.

This protocol includes a standard set of questions for patients, the provision of emergency contraception for preventing pregnancy, and post-exposure prophylaxis (PEP) for HIV. There is now a focus on comprehensive care, including psychological and legal services. Psychologists and social workers are taught to pay attention to the plight of survivors of violence, especially those who have contracted HIV. The protocol encourages hospital workers to follow up with patients for several months to help provide emotional support and track the patient's progress. According to Ms. Bianco, without this follow-up, survivors of violence were often "lost in the system," since health services did not track their progress or provide continuous care. At the suggestion of FEIM, the Sexual and Reproductive Health Unit and the HIV/AIDS Unit created a simplified methodology to facilitate the implementation of this protocol in all services.

"Protocols and procedures around the dual pandemics are only effective if health care professionals, from doctors to technicians, understand and appreciate the linkages between violence and HIV&AIDS."

FEIM's advocacy with the Buenos Aires Ministry of Health also promoted the incorporation of gender-based violence analysis into services provided to women living with HIV/AIDS. Likewise, the study of HIV status was incorporated into the care for all victims of violence in public health care services in the city of Buenos Aires.

Protocols and procedures around the dual pandemics are only effective if health care professionals, from doctors to technicians, understand and appreciate the linkages between violence and HIV&AIDS. FEIM trains doctors on the sexual and reproductive rights of women living with HIV&AIDS. In so doing, they not only challenge prejudices in the emergency room, but they also develop a cadre of champions within the health care system who are equipped to carry out the mandated protocols.

While more research must be conducted to ascertain the impact of this work, early signs are promising. FEIM is beginning to assess the experience of violence survivors before and after the implementation of the protocols to demonstrate the importance of integrated and long-term service provision. By analysing patients' clinical histories through a human rights framework, they offer hospital staff a new perspective on the ways in which social issues such as gender-power relations influence women and girls' vulnerability to violence and HIV&AIDS.

Holding policy makers accountable

Accountability requires every president and prime minister, every parliamentarian and politician, to decide and declare that "AIDS stops with me."

—**Kofi Annan**, Former UN Secretary General

Brian Sokol/ActionAid Nepal

Participants engage in activities to commemorate World AIDS Day in Birganj, Nepal, on Monday the 1st December 2008.

The integrated strategies explored in the last chapter were only made possible through the will of key stakeholders and decision makers. From international donors to public health advocates, from doctors to social workers, policy makers and service providers must be held accountable for stemming the tide of violence against women and girls and the spread of HIV&AIDS. Yet despite growing consciousness of the magnitude of the dual pandemics and the linkages between them, even experts in their respective fields may lack conceptual clarity about the intersection. Indeed, too many policy makers remain unaware or unconvinced of their responsibility to address these problems, and without a clear understanding of the connection between VAWG and HIV&AIDS, stakeholders feel little sense of accountability.

Accountability—particularly from policy makers such as governments, international donors and UN agencies—is necessary in order to address the pandemics and their intersections. On the state level, this includes investigation of violations, punishment of perpetrators and comprehensive redress for violence survivors, as well as access to treatment, care and support for women and girls living with HIV&AIDS, in line with government commitments to the universal access process and international human rights standards. For international donors, this includes ensuring that VAWG is also addressed through HIV&AIDS funding streams.

Research and documentation are important tools for instilling a sense of responsibility in policy makers who are balancing a host of competing demands. Research can establish the causal relationship between the two pandemics, analyse the degree to which policy makers themselves are investing to address the twin pandemics, and generate strategies for monitoring and reporting to ensure that commitments are upheld. Effective research and documentation can underpin a variety of advocacy efforts to create more gender-sensitive policies and to target funding towards responding to the intersection.

A corresponding practice for holding policy makers accountable involves training the women and girls most affected by or at risk for violence and HIV&AIDS to know their rights. A cadre of empowered women at the grass-roots level can offer a powerful testament to the magnitude of the issues because their experiences and direct testimonies are hard for those in power to ignore.

The organizations profiled in this chapter have successfully incorporated research, documentation or rights training into their advocacy efforts as a means of holding stakeholders accountable. Through international campaigns and national tribunals, these initiatives have several strategies in common. They add to the evidence base by actively soliciting and delivering data in ways most likely to influence policy makers. They find key advocacy opportunities and use them strategically to advance their cause. And they strive to bridge the gap between stakeholders who are otherwise disinclined to collaborate. Together they illustrate key practices being used to hold those in power accountable.

Building bridges between movements: Women Won't Wait campaign

Separate funding and programming streams – to combat HIV&AIDS on one hand and, on the other, to eradicate violence against women and girls – mean not only that there are far fewer resources allocated to efforts to address violence as a cause and consequence of HIV infection, but also that the strategic imperative for integrating these efforts continues to suffer from a dangerous, dysfunctional and ineffective split.

—Women Won't Wait, 'Show Us the Money: Is Violence against Women on the HIV/AIDS Funding Agenda?'

It's difficult to hold stakeholders accountable without the necessary information to justify your cause. For Women Won't Wait—End HIV and Violence against Women Now (WWW), an international campaign launched in March 2007 focused on the intersection of violence against women and girls and HIV&AIDS, the first step in international advocacy efforts was to collect data where none existed. While influential donors in the HIV&AIDS field profess a commitment to women's rights, actual funding and programme implementation do not always correspond to that pledge. Public donors are obligated to be accountable for their policies and programmes and transparent in their operations. As such, Women Won't Wait set out to analyse the policies, programmes and funding streams of prominent multilateral and bilateral agencies to determine whether their rhetoric about addressing violence against women matched the reality.[50] By focusing on the five largest international public HIV&AIDS donors, the campaign was able to paint a comprehensive picture of the international AIDS response to violence against women and girls.

The findings of the WWW analysis, profiled in a publication titled 'Show Us the Money', demonstrated what activists already knew: that combatting violence against women and girls is not an integral aspect of HIV&AIDS work among major public donors. Violence against women and girls is rarely highlighted as a major driver or consequence of the disease, nor is it measured statistically with regard to HIV&AIDS prevention, treatment and care. And because donors don't specifically track funding to combat violence against women within their HIV&AIDS portfolio, it is difficult to determine exact amounts allocated to address the intersection.

By investing in research to determine donor priorities around the intersection, measured by where and how monies are being allocated, the WWW campaign created a set of tools which help civil society to hold policy makers accountable. Using their analysis as a baseline from which to assess donor progress, the WWW campaign developed specific indicators, targets and recommendations that they brought to the attention of key stakeholders, notably the governments of the G8 countries. Having gathered data about the level of investment of key donors in confronting the intersection of the two pandemics, the WWW campaign made stronger demands and was able to clearly articulate policy recommendations. One year after the launch of the initial report, the campaign released a follow-up titled 'What Gets Measured Matters', which documented updates to the donor's HIV&AIDS policy, programming and funding streams in relation to VAWG. In this way, they were able to track changes and trends in donor priorities.

Equipped with this evidence, Women Won't Wait began to mobilize public support. The campaign's first challenge was to bring together two powerful civil society movements which themselves had rarely worked together. Despite the links between the two pandemics, and the robust history of activism around each one, there had been relatively little collaboration between them. According to Cynthia Rothschild of the Center for Women's Global Leadership, a member of the Women Won't Wait campaign, "there are a number of women human rights activists, HIV activists, sexual rights activists, women's health activists, who have felt over the years that there is increasing attention to women and HIV. However, in totally different camps there have not been focused, effective and strategic projects that link the two. For many of us we saw the campaign as a place where we could really heighten the profile of the points of intersection. We felt that that was a critical interdisciplinary contribution to make."

While it was clear from the very beginning that a feminist agenda would be guiding the campaign, there were issues to overcome in building bridges between the two move-

> “Building the capacity of health care and justice providers to understand their obligations towards people who are living positively will increase access to health and legal services.”

ments. Chief among these was the fact that HIV and women’s rights activists often face the intersection from different points of engagement. “In many instances, people begin in one area (either HIV or women’s rights/anti-violence work) and seek to integrate the other topic into their pre-existing work or focus area. Consequently not all work at the points of intersection is undertaken from the same vantage points, or addressed with the same vocabulary, or with the same outcomes in mind.”[51]

Indeed, one promising aspect of the WWW campaign is its effort to bring activists from different backgrounds together who share common goals. These include organizations based in and focused on both the Global North and South. According to Ms. Rothschild, the Women Won’t Wait campaign has a core task: “This is about building foundations that help people to make the conceptual and practical links between violence against women and HIV&AIDS, and creating a different awareness among activists and policy makers. Awareness is not just for awareness’ sake, but for policy-making.” A strategic choice was made to involve civil society organizations already well known for their work in one or both of these areas and who already had access to key actors within the HIV&AIDS donor community and familiarity with lobbying strategies. In this way, campaign members were well placed both to engage in national level advocacy as well as international efforts to influence the Global Fund’s gender policy and the UNAIDS/UNDP gender guidance.

The campaign also sought to build on members’ work as individual organizations and give it sharper cohesion and a higher profile under the coalition banner. In fact, the strong cooperation between groups working together as a coalition was key to many of the campaign’s achievements. One year before the creation of Women Won’t Wait, members had started working together at the United Nations General Assembly meetings on HIV and at the 2006 International AIDS conference. The trust and collaboration developed through their pre-campaign work was a critical component of success for an international network whose planning and strategizing occurs primarily through an email list and monthly conference calls. Equally significant was the flexibility of the campaign structure which allowed for the development of tailored responses to important advocacy opportunities such as the G8 summit or meetings of the Global Fund. Ms. Rothschild recalls, “We adopted a dual track—we developed and advocated women’s rights-focused demands and integrated our demands in wider HIV and CSO agendas.”

This proactive and carefully crafted strategy has already contributed to notable results. In June 2007, the G8 countries—the largest contributors to the UN system—issued a communiqué which, for the first time, included language about the feminization of the HIV&AIDS pandemic, with reference to violence against women and girls, sexual and reproductive health rights, and ‘sexual minorities’. Specifically the communiqué directed the Global Fund to institute a gender-sensitive response to HIV. The Global Fund has also taken significant steps to employ more gender-sensitive responses to the pandemics, by hiring new staff (so-called ‘Gender Champions’), increasing internal gender expertise, and offering gender guidelines for country proposals. In September 2007, UNAIDS followed suit by including costing to address VAWG in their global estimates of resource needs in 132 countries related to HIV&AIDS–the recommended investments countries need to make to achieve universal access to prevention, treatment, care and support by 2010. While such progress cannot be solely attributed to the campaign’s efforts, the advocacy of a larger network of stakeholders alongside this success is testament to the power of coalition-building in holding policy makers accountable.

Bringing a rights-based framework to rural communities: CIRDDOC, Nigeria

Stigmatization of women living with HIV by health service providers, legal aid providers, police and others results in lack of sympathy and understanding on the part of the very people from whom women are seeking comfort and support. The prevailing attitude is that because HIV is sexually transmitted, therefore, everyone who has HIV must have been promiscuous.

—Oby Nwankwo, CIRDDOC Executive Director

Using the law to exercise one’s rights may seem like a foreign concept in rural Nigeria, where survivors of sexual violence

are often punished by the very legal system set up to protect them. Judgement, censure and blame are common attitudes of law enforcement officials handling situations of rape. Similarly, women and girls living with HIV&AIDS face great social stigmatization. It is common for them to be expelled from the family, dismissed from the work place, stripped of their property or driven from their matrimonial homes.

The Civil Resource, Development and Documentation Centre (CIRDDOC), established in 1996, addresses these issues through a two-pronged strategy aimed at helping rural women exercise their rights. One aspect of the strategy involves bringing legal services directly to communities with little knowledge of the legal system. The other involves training health and law enforcement workers about the intersection of the pandemics and the kinds of challenges confronting women who face them.

CIRRDOC's efforts not only open up political spaces for rural women, but encourage service providers to become allies of the clients they serve. According to Oby Nwankwo, Executive Director of CIRDDOC, "Building the capacity of health care and justice providers to understand their obligations towards people who are living positively will increase access to health and legal services. Building capacity of women who are living positively enables them to overcome stigma and access services freely."

In line with their commitment to encourage political participation among marginalized groups, CIRDDOC has established fifteen Community Information Centres throughout rural Nigeria. Equipped with generators, televisions and video players—all scarce in regions without electricity—the centres facilitate access to news and legal information, legal services and support. A team of paralegals, development information officers and civic educators works with women to demystify and simplify the law, including step-by-step guidelines to access legal services. Civic educators further explore issues around gender, violence and HIV&AIDS through workshops and community forums.

Once a year the Centre holds public tribunals, providing dramatic backdrop for women to speak out against the abuses they have suffered, and to raise awareness around violence, HIV and larger issues of sexual and reproductive rights. Civic educators recruit women from the larger community to testify. While some tell their stories veiled to protect their safety and privacy, others use the public forum to gain widespread exposure for their cause.

Strategically planned to coincide with larger national and international conferences such as the Nigeria Social Forum, the tribunal attracts an audience of several hundred members, including government officials and legislators. A panel of judges analyses the evidence and delivers a verdict on each case. The personal, often harrowing nature of the stories allows women themselves to access justice and support: In several instances, audience members have stepped forward to offer direct assistance in response to the stories they have heard. By putting a human face on the dual pandemics, CIRDDOC-sponsored tribunals encourage implementation of critical pieces of legislation, such as a national law against violence against women. They also add to the evidence base linking violence to HIV&AIDS in a very public and compelling manner.

The other promising aspect of CIRDDOC's work involves sensitizing legal and health service providers. CIRDDOC's trainings employ the Mutapola Framework, a rights-based approach putting women squarely at the centre of the HIV&AIDS response. CIRDDOC is collaborating with ActionAid Nigeria to provide resources for the Mutapola training. 'Mutapola' represents every woman and girl affected by HIV, personalizing the disease for individuals who may not know or understand the nature of the gender issues surrounding it. The multi-pronged nature of the strategy, which includes the right to treatment and care, secure livelihood and the creation of an enabling legislative environment where women and girls can claim and exercise their rights, allows service providers to put themselves in the place of the women with whom they work. Internalized stigmas disappear as judges, lawyers, doctors and others begin to understand the ways in which gender inequalities make women and girls vulnerable to one or both of the pandemics.

By empowering rural Nigerian women and sensitizing their legal and health providers, CIRDDOC equips women to exercise their rights and demand accountability. Women trained through CIRDDOC assert that they are more confident to live positively; are more knowledgeable about managing HIV, including learning about treatment options; and are more likely to access services. They are also more likely to understand how to use the law to access redress in situations of violence or after disclosure of their HIV status. For women in remote and rural Nigerian villages, this knowledge is invaluable.

Conclusion

"This is about building foundations that help people to make the conceptual and practical links between violence against women and HIV&AIDS, and creating a different awareness among activists and policy makers. Awareness is not just for awareness' sake, but for policy-making."

While VAWG and HIV&AIDS are mutually reinforcing threats, promising strategies such as those profiled in this report can provide important insights for confronting the intersection between the twin pandemics. From working with men to encourage respectful and sexually responsible behaviour in the face of HIV&AIDS, to creating integrated protocols on violence and HIV in health care settings, this report illustrates a range of strategies being implemented to address the linkages between the two pandemics. Complementing the existing evidence base on initiatives addressing the intersections, *Together We Must!* highlights selected organizations that illustrate the range of interventions making a difference within communities. The profiled strategies should inform ongoing efforts to achieve the universal access to prevention and treatment of HIV&AIDS that governments have agreed to implement by 2010, and to meet the 2015 targets identified in the United Nations' Secretary-General's campaign Unite to End Violence against Women.[52]

This report categorizes the profiled strategies into four groups, reflecting different approaches necessary to confront the intersection. The first category focuses on the role of community mobilization in changing harmful gender norms. Because gender inequalities sustain and perpetuate both pandemics, creating a community culture in which violence is unacceptable and women living with HIV&AIDS are supported to live productive, violence-free lives is essential to breaking the links between them. The second category highlights methods of empowering traditionally marginalized populations, including young women, and women from racial and sexual minorities. Targeting groups that are disproportionately affected by both pandemics is an important means of encouraging women and girls themselves to become agents of change.

The third group of strategies illustrates the creation of integrated approaches, acknowledging the need to connect health responses with comprehensive social services and transform the knowledge and attitudes of health practitioners and service providers to be more supportive of survivors of violence and women and girls living with HIV&AIDS. The last category examines strategies for holding policy makers accountable for their efforts to address the linkages between the pandemics. Whether through research, documentation or rights-based training for HIV-positive women and girls, advocates are increasingly making their voices heard, bringing forth a broad new emphasis on gender-sensitive policies at the highest levels of decision-making.

While no single strategy can or should be implemented in isolation, collectively these approaches represent the beginnings of a road map for addressing the links between VAWG and HIV&AIDS. The report aims to encourage governments, donors, international NGOs and others to consider these efforts and assess the potential for scaling them up as part of compliance with the universal access process and towards improved response to and prevention of VAWG. The experiences profiled here suggest at least five recommendations for the design, implementation and monitoring of effective programmes to confront both VAWG and HIV&AIDS:

1) More research is necessary to identify and evaluate effective strategies for addressing the intersection between HIV&AIDS and VAWG, and to document the lessons learned.

Although the research and data linking VAWG as cause and consequence of HIV&AIDS is getting stronger, information on effective strategies for addressing the intersection is not

always easy to obtain. While many promising initiatives are taking place around the world, the organizational strategies profiled here represent only a small sample of the kinds of practices that are being undertaken globally. Much more research is necessary to monitor, evaluate and catalogue the most effective practices and to document lessons learned in order to upscale these efforts. *Together We Must!* is intended as a starting point for more extensive research and data-sharing about efforts to confront the intersection of the two pandemics.

2) National and global data on violence against women and girls and HIV&AIDS should be collected and disseminated as a means of holding policy makers accountable.

A common theme throughout the profiled strategies has been the importance of research and documentation. Profiling the specific nature of violence, how the incident interrelates with HIV, as well as the rates and levels of prosecution and conviction serve both the goals of individual redress and of larger advocacy efforts. Similarly, analysis of national and international responses to the dual pandemics from donors and policy makers, such as the degree to which HIV funding streams address violence against women and girls, are an important advocacy tool. As a critical means of influencing policy change, data should be solicited and analysed, then strategically packaged to most effectively influence policy makers.

3) Standardized protocols and training for health care personnel are necessary to guide them on the connections between VAWG and HIV&AIDS.

If a woman or girl has the financial and social means, a health provider may be her first resource after an incident of sexual violence. Similarly, HIV-positive women and girls are often reliant on health providers for information, care and support. But protocols must be in place to provide guidance on linking services that address VAWG on the one hand and HIV&AIDS on the other. As demonstrated in this report, those who respond first to sexual assault must be knowledgeable about administering PEP, voluntary counselling and testing (VCT) and/or provider-initiated support, as well as about advising women and girls on treatment options. The interrelated nature of the dual pandemics makes it critical for health care personnel, including those conducting HIV testing, to understand and address the implications of disclosure and treatment, including potential violent outcomes. Training modules should include case studies focusing on violence scenarios, and health care personnel should actively initiate discussions exploring women and girls' experiences and fears of violence. Furthermore, health care personnel should have a well-defined referral system in place to facilitate access to post-test support and care, including accessing treatment, negotiating risk reduction and disclosing positive test results. Partnerships should be forged with other facilities that provide legal, socio-economic and psychological support.

4) Efforts must be made to engage excluded communities in the places where they live, work and play.

Criola did it in Brazil by dodging bullets on the streets of the *favela*. Their efforts brought awareness, knowledge and HIV&AIDS services to marginalized Afro-Brazilian women and girls disproportionately affected by the dual pandemics. In Nepal, Equal Access used radio to reach out to migrant workers and their families, as well as to women living with HIV&AIDS. In Nigeria, Girls Power Initiative partnered with the formal education sector to reach adolescent girls in the classrooms of their schools. In each of these instances, the organizations engaged excluded groups by accessing the spaces where they live, work and play. While the environment might not always be safe or supportive, these approaches succeeded in reaching excluded communities to provide information, education and skill-building to help protect them from both VAWG and HIV&AIDS.

5) Community buy-in from a range of stakeholders is needed to address stigma and discrimination associated with VAWG and HIV&AIDS.

Whereas violence against women and girls was once kept in the shadows because of cultural taboos, the women's rights movement is now actively advocating against it. Similarly, living openly with HIV has become an important expression of AIDS activism. Yet despite progress in the public perception of violence and HIV among social movements, and increasing awareness of the links between the two, many communities around the world have yet to acknowledge the scale and breadth of the pandemics, or to understand the gendered issues that are driving them. As demonstrated throughout the report, successful strategies for confronting the intersection of VAWG and HIV&AIDS include a range of stakeholders, converting even the most sceptical to support the cause. Only when parents in a traditional Nigerian village attest to the virtues of safe sexuality education in schools, or when religious leaders in one of the poorest South African provinces lead a march of men and boys to protest violence against women and girls, will the links between the pandemics truly be broken. Community acceptance and promotion of gender equality is the only way to erase the pervasive scourge of stigma, discrimination and violence worldwide.

Notes

[1] See for example, R. Royce, 'Sexual Transmission of HIV/AIDS', *The New England Journal of Medicine* 336/15 (1997), 1072-1078, cited in UNFPA, *State of the World's Population: Making 1 Billion Count: Investing in Adolescents' Health and Rights* (New York, 2003), 23. Available at http://www.unfpa.org/publications/detail.cfm?ID=154; UNAIDS, 'AIDS - 5 years since ICPD: Emerging issues and challenges for women, young people & infants', (Geneva, 1999) 11. Available at http://data.unaids.org/Publications/IRC-pub01/jc150-icpd_en.pdf.

[2] Suzanne Maman, 'HIV-positive women report more lifetime partner violence: Findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania', American Public Health Association (Washington, DC, 2002). Available at http://www.ajph.org/cgi/reprint/92/8/1331.pdf.

[3] Recent debates have focused on differential risk within concentrated epidemics, affecting specific sub-populations versus generalized epidemics, affecting entire populations. While women may be more vulnerable to HIV in generalized epidemics, a gender-sensitive approach addressing violence against women is critical in both scenarios.

[4] See Royce, op. cit. 23.

[5] See for example, UNFPA, 'State of World Population: The Promise of Equality: Gender Equity, Reproductive Health and the MDGs', United Nations Population Fund (2005). Available at http://www.unfpa.org/swp/2005/english/ch1/index.htm; Shelley Clark, 'Protecting Young Women from HIV/AIDS: The Case Against Child and Adolescent Marriage', *International Family Planning Perspectives* (2006). Available at http://www.guttmacher.org/pubs/journals/3207906.html; G.M. Wingood, 'Child sexual abuse, HIV sexual risk, and gender relations of African-American women', *American Journal of Preventive Medicine*, 13/5 (1997), 380–84. Abstract available at http://www.ncbi.nlm.nih.gov/pubmed/9315271?log$=activity.

[6] Risa Denenberg, 'Childhood Sexual Abuse as an HIV Risk Factor in Women', in T*he Body: Complete HIV/AIDS Resource*, (New York: Gay Men's Health Crisis, 1997). Available at http://www.thebody.com/content/art13469.html. See also UNIFEM, 'Act Now! A Resource Guide for Young Women on HIV/AIDS', Association for Women's Rights in Development (AWID, 2002). Available at http://www.unifem.org/attachments/products/ActNow_eng.pdf.

[7] Population Council, 'Can Livelihoods Training Alter Girls' Lives?' in 'Transitions to Adulthood', *Population Brief* 11 (2005). Available at http://www.popcouncil.org/publications/popbriefs/pb11(3)_4.html.

[8] See for example, Suzanne Maman, op. cit.; UNFPA, op. cit., 23.

[9] Amy Medley, 'Rates, barriers and outcomes of HIV sero-disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes', *Bulletin of the World Health Organization* 82/4 (2004), 299–307. Available at http://www.who.int/bulletin/volumes/82/4/299.pdf.

[10] Yakin Ertürk, 'Intersections of Violence against Women and HIV/AIDS: Report of the Special Rapporteur on violence against women, its causes and consequences', United Nations Economic and Social Council Commission on Human Rights (2005). Available at http://daccessdds.un.org/doc/UNDOC/GEN/G05/102/11/PDF/G0510211.pdf?OpenElement.

[11] Ibid.

[12] UNAIDS, 'Policy Brief, Criminalization of HIV Transmission' (Geneva: UNAIDS, 2008), 6. Available at http://data.unaids.org/pub/BaseDocument/2008/20080731_jc1513_policy_criminalization_en.pdf

[13] In 2005, world leaders committed to dramatically scaling up HIV/AIDS prevention, treatment, care and support with the goal of coming "as close as possible" to universal treatment access by 2010. Pillars of this strategy include increased resources to fight AIDS, greater access to medications, and reduction of stigma, discrimination and vulnerability of persons affected by HIV/AIDS and other health-related issues.

[14] For further reading see UNIFEM reports on HIV and VAW. Available at http://www.unifem.org/gender_issues/hiv_aids/; Global AIDS Alliance 'Violence against Women and Children & HIV/ AIDS, Factsheet, 2009' (Washington, DC: Global AIDS Alliance, 2009). Available at http://www.globalaidsalliance.org/page/-/PDFs/Factsheet_VAWG_March_2009.pdf.

[15] See for example,

- Center for Women's Global Leadership, 'The Intersection of Violence Against Women and HIV/AIDS', A Strategic Conversation, New York, N.Y., 1 April 2004. Available at http://www.cwgl.rutgers.edu/globalcenter/events/VAW%20HIV%20NY%20Mtg.doc;

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- The Athena Network, http://www.athenanetwork.org
- With Women Worldwide, an initiative of the International Women's Health Coalition, http://www.iwhc.org/index.php?option=comcontent&task=view&id=3321&Itemid=581

[16] Women Won't Wait Campaign, 'Act Now to End HIV and Violence against Women Toolkit', 2. Available at http://www.womenwontwait.org/index.php?option=com_docman&Itemid=98.

[17] Susan T. Fried, Women Won't Wait Campaign, 'Show Us the Money: Is Violence against Women on the HIV&AIDS Donor Agenda?' (Washington, D.C.: ActionAid, 2007). Available at http://www.womenwontwait.org/index.php?option=com_content&task=view&id=27&Itemid=1.

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[19] UNAIDS, '2008 Report on the Global Aids Epidemic' (Geneva: UNAIDS, 2008) 67. Available at http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp.

[20] Cheywa Spindel, Elisa Levy, Melissa Connor, eds., 'With an End in Sight', (New York: UNIFEM, 2000) 22. Available at http://www.unifem.org/resources/item_detail.php?ProductID=14.

[21] Quote from Sonke's digital storytelling program, 2007. Available at http://www.genderjustice.org.za/digital-stories/tapiwa.html.

[22] Shanaaz Mathews, 'Every six hours a woman is killed by her intimate partner': A national study of female homicide in South Africa', MRC Policy Brief, Gender and Health Research Group (Tygerberg, South Africa: Medical Research Council, 2004). Available at http://www.mrc.ac.za/policybriefs/woman.pdf.

[23] Audrey E. Pettifor, 'Sexual Power and HIV Risk, South Africa', International Conference on Women and Infectious Diseases, *Emerging Infectious Diseases*, 10/11 (2004) 3. Available at http://www.cdc.gov/ncidod/EID/vol10no11/pdfs/04-0252.pdf.

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