

Issue Brief: Stopping violence against women and girls for effective HIV responses



**The Global Coalition
on Women and AIDS**

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“I am one of the thousands of women who are a testimony of the vulnerability when the intersection of gender based violence and HIV happen in the lives of women. Any failure in preventing violence against women and girls will result in more HIV positive cases and more deaths among women and girls.”

Gracia Violeta Ross -
The Bolivian Network of People Living with HIV/AIDS (REDBOL)

“Violence against women cannot be tolerated, in any form, in any context, in any circumstance, by any political leader or by any government. The time to change is now.”

Secretary-General Ban Ki-moon¹

Introduction



UNAIDS / G. Pirozzi

This issue brief is part of a series published by the Global Coalition on Women and AIDS (GCWA), designed to provide information on women's rights and gender equality issues in the context of HIV. This brief describes the links between violence against women and HIV, with a focus on what is needed to better address these linkages, meet women's prevention, treatment and care needs, and uphold the rights of women and girls.

The inter-connections between violence against women and HIV, as both a root cause and consequence of HIV, are now widely acknowledged. Violence against women may increase the risk of transmission of HIV both directly and indirectly. Forced sex may directly lead to HIV transmission, and women and girls may be unable to negotiate safer sex out of the fear of violence. Women living with HIV may also face increased levels of violence, due to stigma and

discrimination. The UNAIDS Agenda for Women and Girls² and the UNAIDS Strategy 2011-2015³ recognize the importance of addressing gender equality and violence against women and girls as an integral part of the HIV response. Moreover, addressing violence against women is not only key to the achievement of Millennium Development Goal (MDG) 3 on women's empowerment and gender equality and MDG 6 on halting and reversing the HIV epidemic, but also to MDG 4 (child health) and MDG 5 (maternal health). However, most countries fail to invest in the prevention of violence and provide the much needed services to survivors of physical and sexual violence, including in conflict situations. This brief will therefore provide an overview of the latest research and recommended approaches to better manage violence against women and girls.

What are the facts violence against women and girls

WHAT ARE THE FACTS ON VIOLENCE AGAINST WOMEN AND GIRLS?

Violence against women and girls is one of the most pervasive and harmful manifestations of gender inequality and constitutes a human rights violation. Women and girls are at increased risk of violence due to factors such as, race, ethnicity, caste, class, age, disability, sexual orientation, gender identity, HIV and health status, migrant or refugee or other status. These factors also make some men and boys vulnerable.

- Based on available country data, between 15 and 71% of women experience physical or sexual violence or both from their intimate partners in their lifetime.⁴
- The prevalence of forced first sexual encounter among adolescent girls younger than 15 years ranges between 11% and 45% globally.⁵
- Recent research cites “alcohol abuse, cohabitation, young age, attitudes supportive of wife beating, having outside sexual partners, experiencing childhood abuse, growing up with domestic violence, and experiencing or perpetrating other forms of violence in adulthood”, as variables which increase the risk of a male partner committing intimate partner violence. Furthermore, the “strength of the association is greatest when both the woman and her partner have the risk factor.”⁶
- Women who have experienced intimate partner violence are more likely to have poorer health than women who have never been abused. In addition to injuries, physical health consequences from violence include HIV and sexually transmitted infections; sexual and reproductive ill-health, including infertility; and maternal ill-health, including increased risk for high blood pressure, risk of

antepartum haemorrhage and of miscarriage.⁷

- Recent research suggests that intimate partner violence during a pregnancy is a common experience, ranging between approximately 2.0% in Cambodia and the Philippines to 13.5% in Uganda among ever-pregnant women; with half of the surveys estimated prevalence being between 3.9 and 8.7%.⁸
- It is estimated that in the last decade, over 58 million girls were married before the age of 18 years; of those, 15 million were 10-14 years old. Many were married against their will, often experiencing violence.⁹
- Studies in Central and South Asia, Europe, and North America estimate that 40% to 70% of sex workers experience violence each year.¹⁰ Where sex work is criminalized, sex workers are denied access to justice, health care and other services when they face violence.¹¹

The persons most frequently responsible for these forms of violence against women are men who are close to them — their partners, family members, teachers and community leaders.¹² Despite some progress in introducing laws to protect women and girls from violence, consistent brutality from both State and non-State actors has been demonstrated by the increasing rates of femicide^a.

DEFINITIONS OF VIOLENCE AGAINST WOMEN

The understanding of violence against women within international human rights norms and standards has been evolving for several decades. Violence against women, as defined in this brief, includes sexual, physical, or emotional abuse by

a “Femicide refers to violent killing/murder of women because they are women and occurs in many contexts, cutting across the four spheres.⁶⁹ It includes murder in the context of intimate partner violence, sexual murder, killings in the name of honour” (A/66/215. Report of the Special Rapporteur on violence against women, its causes and consequences. 2011)

Links between violence against women and girls, gender inequality and HIV

an intimate partner (known as intimate partner violence), family members (family violence or incest) or others; sexual harassment and abuse (including by authority figures such as teachers, police officers or employers), trafficking for forced labour or sex, child marriages, dowry related violence and so-called “honour” crimes; and sexual violence in conflict situations.

Inter-governmental mechanisms have helped to develop international consensus on the definition. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the main international instrument relating to the human rights of women, defines violence against women as a “form of discrimination that seriously inhibits women’s ability to enjoy rights and freedoms” and as such is prohibited under the Convention.¹³ The 1993 UN Declaration on the Elimination of Violence against Women, states that “violence against women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (Article 1). Intimate partner violence, one form of violence against women, is defined by the World Health Organization as “behaviour in an intimate relationship that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviours”.¹⁴

One recent definition of gender-based violence, created by communities of women living with HIV from several continents, defines violence against women as “any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV.”¹⁵ This definition highlights the abuses of power which can also take place in relation to

women and girls in the health, financial and legal sectors and can exacerbate the negative experiences of women living with HIV.

WHAT ARE THE RELEVANT INTERNATIONAL LEGAL AND HUMAN RIGHTS INSTRUMENTS?

CEDAW provides the normative legal framework and the tools to ensure the implementation of HIV-related rights in the face of gender-based violence and discrimination”. The right to be free from violence is derived from several interconnected human rights which have been recognized in both international and regional conventions, such as the right to life; to security; the right to not be subjected to torture or to cruel, inhuman or degrading punishment or treatment; and to health. Under the UN Declaration on the Elimination of Violence against Women, Member States have an obligation to “exercise due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons” (Article 4-c). However despite global level commitments, national legislation often fails to protect women from violence; for example, marital rape is not a prosecutable offence in at least 53 States.¹⁶

LINKS BETWEEN VIOLENCE AGAINST WOMEN AND GIRLS, GENDER INEQUALITY AND HIV

In recent years, much research has been undertaken on violence against women and girls and HIV. It is clear that there is a complex interplay between the different factors determining the association between violence and HIV. While some research^{17 18} shows that women who have experienced violence are more likely to be living with HIV than those who have not, a recent cross-sectional study of demographic and health

Data on HIV and violence against women and girls

surveys (DHS) data failed to prove such an association, possibly due to methodological limitations.¹⁹ Research points towards sociocultural views on gender roles and power imbalances as underlying factors of the link between HIV, gender inequality, and violence against women and girls. In societies where ideals of masculinity involves control of women and demonstration of male strength and toughness, men are more likely to control sexual encounters, engage in risky sexual behaviours, and have multiple partners.²⁰ Research shows that men who perpetrate intimate partner violence show other risk behaviours that put their female partners at higher risk of sexually transmitted infection, including HIV.²¹ Furthermore, evidence from India affirms that men who commit acts of violence against women are more likely to be living with HIV.²²

Violence limits women's power over their own bodies and reproductive and sexual lives. Violence against women reduces the likelihood that they will be able to influence the timing and circumstances of sexual intercourse, resulting in more unwanted sexual intercourse, and less condom use.²³ When sexual violence occurs within the family, women and girls, face greater difficulties in seeking help and accessing medical services, including for HIV due to the intimidation, control and fear provoked by the abuser.²⁴ Marginalised women, such as female sex workers and women drug users, are disproportionately likely to experience sexual and physical violence and are at increased risk of HIV.²⁵ This can include exploitation by police.²⁶

Young women, aged 15 to 24, are particularly vulnerable to HIV infection. Globally, 26% of all new infections take place among young women whilst in some Sub-Saharan African countries, young women are up to 8 times more likely to be HIV positive than their male peers.²⁷ While broader gender norms and issues such - inter-generational sexual coupling between young

women and older men, power imbalances between men and women, access to sexual and reproductive health services, may contribute to higher infection rates among young women, experiencing violence further increases young women's risk of HIV.^{28 29}

DATA ON HIV AND WOMEN AND GIRLS

- 50% of people acquiring HIV globally are women and girls.³⁰
- Young women, aged 15-24, are most vulnerable, with 26% of all new people with HIV being in this group.³¹
- HIV is the leading cause of death of women of reproductive age.³²

DATA ON HIV AND VIOLENCE AGAINST WOMEN AND GIRLS

- A landmark study from South Africa calculated that if gender inequalities were improved so that no women were in relationships with low power, 13.9% of new HIV infections could be prevented. Additionally, 11.9% of new HIV infections could be avoided if women were not subjected to more than episode of physical or sexual abuse by their partner.³³
- A study of over 28,000 married women in India found that those who had experienced both physical and sexual violence from intimate partners were over three times more likely to be HIV-positive than those who had experienced no violence.³⁴
- Evidence from India shows that men who perpetrate violence are more likely to have HIV.³⁵
- A survey of women living with HIV in Argentina, Brazil, Chile and Uruguay in 2008 showed that many had a history of violence, with 78.1% reporting experiencing some type of violence; 69.9% psychological violence from a partner, 55.6% physical violence, 36.3% sexual violence, and 32.8% sexual abuse in childhood.³⁶
- In addition to human and social costs, the economic cost of violence – including the direct costs to health, legal, police and other services – is substantial. The cost of intimate partner violence in the United States alone is estimated to exceed \$5.8 billion per year.³⁷

What kinds of interventions are working?

Women may also experience violence as a consequence of their HIV diagnosis, undermining access to HIV services.^{38 39 40} While women are regularly the first to know their status because of testing through ante-natal services, disclosure of their HIV status, unless skilfully handled by health staff and community workers, can result in rejection and violence from partners, their families and their communities.⁴¹ Women living with HIV have also further been subjected to institutional violence, including violations of their sexual and reproductive rights. These violations include forced sterilizations and abortions, denial of voluntary sterilization and safe legal abortions, clinical trials that do not respect their women's bodily integrity or autonomy, and discriminatory practices in health-care settings, constituting further barriers to services.⁴² The stigma and discrimination faced by female sex workers and women drug users creates even greater barriers to accessing HIV and sexual and reproductive health services, as well as services to manage violence, including accessing justice. For example, in Russia, domestic violence and police harassment feature among barriers preventing women who use drugs from seeking HIV related services.⁴³

A survey conducted by the International Community of Women Living with HIV found that women who are living with HIV, and especially girls, find it difficult to reveal having experienced violence to others for fear of shame, rejection and abandonment.⁴⁴ The survey found that women and girls may blame themselves for having acquired HIV, and this false sense of guilt may expand to the experience of violence. This means that women with HIV may feel that they 'deserve' a violent and punitive relationship, and that escaping would be impossible because nobody else would accept having a relationship with them and because they fear that their HIV status could be divulged to their communities.⁴⁵

WHAT KINDS OF INTERVENTIONS ARE WORKING?

"To be a partner for women and girls against violence and injustice, you do not have to be an expert on human rights and gender. You do have to be committed to always asking in your daily work: "How can I better engage women and girls to understand what they need? How can I better support human rights, gender equality and end sexual and other forms of violence?"

Michel Sidibé, Under-Secretary-General and Executive Director UNAIDS⁴⁶

A broad array of interventions, mostly at community level, has been initiated in communities across the world on HIV and violence against women and girls. The section below highlights a selection of interventions with well documented achievements.

Stepping Stones, a training programme on gender, communication and relationship skills - creating greater community dialogue and engagement. By challenging and changing behaviour and/or attitudes related to violence against women, and reducing stigma and discrimination in the community, Stepping Stones has worked to lower HIV vulnerability for women and to mitigate the effects of HIV where already present.⁴⁷ By fostering greater community dialogue, Stepping Stones workshops engages with older and younger groups of men and women, separately and together. They have taken place among communities in 100 countries - in Africa, South and South East Asia, the Pacific, Central America, and Eastern Europe and Central Asia. A randomised controlled trial to measure the impact of Stepping Stones in rural South Africa found that although no reduction in incidence of HIV was reported, the program



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did have an impact on several risk factors for HIV. The assessment found reduced levels of violence perpetration reported by men in the programme, along with associated reduced incidence of herpes simplex type 2 (HSV-2).⁴⁸ The programme has been adapted by many organizations for use in diverse contexts, including for use with sex workers (India), with men in prisons (India), with men who have sex with men (Caribbean), with people with disabilities (India), with people who inject drugs (Myanmar, Russia, Tanzania) and with people living with HIV (Malawi, Zimbabwe, Central America). The curriculum is available in 20 languages.⁴⁹

The **Intervention with Microfinance for AIDS and Gender Equity (the IMAGE intervention)** in South Africa integrated participatory gender and HIV training into an ongoing microfinance programme, and supported women in loan groups to conduct mobilization activities in their communities. A trial showed that past year levels of intimate partner violence among participants was more than halved over two years, and that younger participants had increased uptake of voluntary counselling and testing services, and reduced levels of casual sex. There was no evidence however of a broader diffused impact on the sexual behaviour or HIV incidence among adolescents in the study communities. Comparisons with women who received micro-finance alone suggest that it was the combination of

micro-finance and training that led to this impact on violence. The model has subsequently been scaled up to a further 20,000 households at low incremental cost, although a further evaluation concluded that the impact of community mobilization was hindered by factors such as cultural norms, social marginalization and women having a variety of other responsibilities. The model has already been replicated in other settings. Other models that seek to combine gender and HIV training with livelihood interventions for women and men require further investigation.⁵⁰

The **One-Stop Crisis Centre** model was initially developed in Malaysia for women who experienced physical violence and later extended to rape and sexual assault. This model of integrated services was introduced in all hospitals in Malaysia in 1996, offering not only client-sensitive services, but also access to legal, social, welfare and counselling services in one location—usually the accident and emergency departments of urban public hospitals. In addition, some centres offer shelter facilities. This integrated service model allows the public system and civil society to join forces in providing services to clients. For example, in some urban centres, NGOs (non-governmental organizations) provide active support to the One-Stop Crisis Centre service by being “on-call” - to provide counselling, emotional support and assistance where needed. Several other countries have

adopted a similar model, including Bangladesh, Malaysia, Namibia and Thailand.⁵¹

The One Man Can Campaign encourages men to take action to end violence against women. The campaign was launched by Sonke Gender Justice Network in 2006 in South Africa and is operationalized in seven countries in the Southern African region. The campaign promotes the idea that everyone has a role to play in creating a better, more equitable and more just world. It encourages men and boys to take action – “to build a movement, demand justice, claim our rights and change the world”, with a particular focus on ending domestic and sexual violence and promoting healthy, equitable relationships that protect against HIV. The campaign is a very broad partnership engaging the UN, the South African Government, NGOs and faith-based organizations. An impact evaluation found that participants reported positive behavioural changes in terms of HIV testing, awareness and reporting of violence, and condom use.⁵²

The SASA! Activist Kit for Preventing Violence against Women and HIV, developed by Raising Voices was designed to inspire, enable and structure effective community mobilization to prevent violence against women and HIV. The approach is grounded in the ecological model and scales up the stages of the change model to phases of community mobilization: Start, Awareness, Support, Action. Male and female community activists spearhead a wide range of activities in their own neighborhoods designed to influence knowledge, attitudes, skills and behaviors on gender, power, violence and activism ultimately to reduce women’s experience of violence by decreasing social acceptability of violence. SASA! is currently being implemented by over 25 organizations in sub-Saharan Africa in diverse settings such as religious, rural, refugee, urban and pastoralist communities. SASA! is also being adapted for use in Haiti and Mongolia. SASA! is being evaluated by a community randomized controlled trial in Uganda with results expected mid-2012.⁵³

Another innovative undertaking is **Program H**, developed by the Brazil’s Instituto Promundo. Recognizing that ideas about gender norms are formed early in life, this programme encourages young men in slum areas of Rio de Janeiro to analyze traditional gender roles and norms associated with masculinity, reflect on what it means to be a man, challenging them to consider the advantages of gender equitable behaviors and calling for transformation of their behavior and attitudes. The program supported young men to question traditional gender norms in the areas of sexuality and reproductive health, fatherhood and caregiving, violence, emotions and preventing and living with HIV. Evaluation showed that Program H resulted in significantly greater percentages of young men supporting equitable gender norms over time, and in two of the three intervention sites, these changes were significantly associated with decreased reports of symptoms of sexually transmitted infections.⁵⁴

Avahan - Karnataka Health Promotion Trust, is a multilevel intervention which aims to prevent violence, harassment and stigma against sex workers, men who have sex with men and transgenders in Karnataka, India. According to a WHO report between “11% and 26% of female sex workers had been beaten or raped during 2010, by perpetrators including clients, police and regular partners. Sex workers experiencing violence visited clinics less often, had lower condom use, experienced more condom breakage, and had a higher prevalence of gonorrhoea.”⁵⁵ The Karnataka Health Promotion Trust, was developed to address these issues at the following three levels - firstly with sex workers as the main stakeholders; police, lawyers and media at the secondary level; and lastly through advocacy aimed at policy transformation. As part of the initiative a crisis management team, to help with medical, counseling and legal support, was set-up. An initial evaluation of the initiative found that sex workers were more positively portrayed in the media; there was an increase in the reporting of non-police violence and a decrease in the reporting of police violence.⁵⁶

What is needed



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WHAT IS NEEDED?

“Stopping violations of women’s human rights is a moral imperative... Joining in the efforts to stop violence is everybody’s responsibility. Governments, private enterprises, civil society groups, communities and individual citizens can all make essential contributions. Men and boys must be active in encouraging respect for women and zero tolerance for violence. Cultural and religious leaders can send clear messages about the value of a world free of violence against women.”

(Michelle Bachelet, Under-Secretary-General and Executive Director, UN Women.)⁵⁷

At the 2011 High Level Meeting on AIDS, countries pledged to “eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV” and to “ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality in order to increase their ability to protect themselves from HIV infection, including their sexual and reproductive health, free of coercion,

discrimination and violence, and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence.”⁵⁸ The proposed actions, although not exhaustive, would contribute to delivering on this commitment.

Actions for National Governments

1. **Multi-sectoral response.** National governments need to adopt a multi-sectoral response to prevent and reduce the occurrence of violence against women.⁵⁹ Given the link between HIV and violence against women, such a strategy needs to be part of the overall national HIV strategic plan.⁶⁰ Considering the many –inter-linked - factors that influence intimate partner violence, there is a clear need to combine efforts to transform gender norms and attitudes, address prior histories of abuse, and reduce harmful drinking with development interventions such as increased access to secondary education for girls and boys.

- a. Such a context-specific prevention strategy would include primary prevention activities in schools to address issues of relationships, gender roles, power and coercion within existing youth violence and bullying

Actions for National Governments



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programmes. This requires commitment and the engagement of local governments, civil society and the international community.

- b. Ensure evidence-based comprehensive sexuality education for all children from the age of 5 years, which challenge and change norms regarding violence against women and girls, in line with UNESCO guidelines.⁶¹
- c. Establish an enabling legal environment, together with supportive policies that protect women and girls against violence and promote gender equality, as further described below.
- d. Support primary prevention strategies, such as combining microfinance with gender equality training; promotion of communication and relationship skills within communities; reduction of access to, and the harmful use of alcohol; transformation of cultural gender norms to move the culture away from violence.⁶²
- e. Ensure the meaningful engagement of organizations, particularly those with experience addressing violence against

women, including sex worker and women's organizations and networks of women living with HIV, as well as their representation on national AIDS councils, Global Fund Country Coordinating Mechanisms and other relevant fora to help ensure that the links between violence against women and HIV are effectively addressed within the design, implementation and monitoring and evaluation of national AIDS programmes. There is good evidence that working with young men to analyse and challenge inequitable gender norms can reduce both risk behaviours for HIV acquisition and violence against women. This calls for community-based education campaigns to change harmful norms, practices and behaviours that perpetuate violence against women and girls and reinforce its social acceptability.⁶³ This would include supporting and engaging with women's organizations, working with men and communities to address violence, HIV and AIDS organizations, faith-based groups as well as community leaders in preventing and coping with violence and its links to HIV.

2. **Integrated health services.** Health facilities are often the first contact point for women who have experienced violence. As such, the health sector needs to play a key role in identifying violence and delivering the necessary health services, as well as ensuring referral to non-health services, including legal services, thereby engaging civil society.^{64,65} Countries may review existing service delivery models to integrate responses to violence against women into their public health system, for example, utilizing emergency or women's health services, including reproductive health and family planning services. Equally important is the existence of well-functioning referral mechanisms within the health sector - in case of multiple-site integration - as well as to external, non-health services, thereby engaging civil society.⁶⁶ Countries are also encouraged to develop policies on violence or address it through their health sector policy. Specific attention needs to be given to capacity building of health workers to ensure state-of-the-art knowledge, and appropriate attitude and sensitivity.
- a. While utilizing the different entry-points, such as family planning, HIV testing and counselling, and care services, as well as child health care, special attention must be given to women potentially more at risk of violence, such as young women and pregnant women, as well as those with history of risk factors.
 - Ensure that women drug users have access to services, including support groups, harm reduction, care and support that are woman-friendly, and include trained women staff members and volunteers that are sensitive to their needs, particularly for women who are not comfortable receiving care or treatment from men.
 - Provide psychosocial support to children affected by violence to address the link between childhood exposures to violence and subsequent involvement in violence and/or risky behaviours.
 - b. Maximize coordination between HIV and violence prevention and mitigation services, particularly in countries highly affected by these intertwined epidemics, and remove barriers to integrating these essential services on the ground. Ensure that services are available to women and girls in all key affected populations. The particular needs of women who use drugs, women in prison and lesbian, bisexual and transgender women and girls who are often not able to access services due to multiple layers of stigma need also to be considered. Services should also be available to all women and girls vulnerable to and living with HIV, whether in these key affected populations or not.
3. It is recommended that **health service delivery** in different settings include access to quality, comprehensive post-rape care services including Post Exposure Prophylaxis (PEP), sexually-transmitted infection screening, emergency contraception, safe abortion, where legal, and post-abortion care, treatment of injuries in accordance with WHO guidelines, including in conflict and humanitarian emergency situations. According to WHO, it is of equal importance to provide PEP, in a context that offers comprehensive support to rape survivors, through integrated efforts that address the full range of health, psychosocial support, and policing/justice needs of rape survivors.⁶⁷ It is further recommended that "psychosocial support needs to include trauma counselling, PEP adherence counselling, long-term counselling and rehabilitation, safe housing or relocation services, and referral to and support with navigating the criminal justice system should the survivor choose to pursue criminal charges."⁶⁸
 4. **Evidence.** Expand national, regional and global indicators to track violence against women and girls, services available, services utilized, and gaps, disaggregating this data by age and geographical location. Undertake quantitative and qualitative studies on the different forms of violence against women; on the multiple intersections between HIV and violence against women; and what forms of

Actions for development partners



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interventions are feasible and effective in different settings, in order to better understand the problem and adopt effective public policies to address both pandemics.

5. **Economic and legal empowerment.**

Promoting economic and legal empowerment of women and girls as well as comprehensive interventions and measures to address legal, inheritance and property rights, access to resources in order to equip women with the tools, legal and economic independence needed to avoid or escape violence, and reduce their risk for HIV as well as to increase the health and quality of life of those living with HIV. This includes developing and increasing comprehensive programmes and initiatives aimed at ensuring that women living with HIV have independent income-generation through providing access to grants, incentives and subsidies and credit to women and women's groups.

6. Strengthen the **legal and policy environment,**

so that laws prohibiting violence against women and girls are enacted and enforced, that systems to report on the prevalence of violence against women are established and maintained, and that these monitoring mechanisms effectively feed into the design of national HIV programmes.

- a. Provide training to law enforcement officials and others who may encounter victims of sexual violence about the risk of HIV and proper referrals to prevention information, medical treatment, and post-exposure prophylaxis, where appropriate, to reduce the immediate risk of contracting HIV.
- b. Training for law enforcement officers to sensitize their attitudes and increase their responsiveness to the violence against women and girls and violence experienced by women living with HIV.
- c. Strengthen the capacity of civil society organisations, especially organisations led by women living with HIV, to engage in advocacy and activism intended to compel governments to fulfil their legal and policy commitments.
- d. Ensure that all institutional service providers, including health staff, police, social workers, magistrates, judges and prison staff, receive pre- and in-service training to ensure that the safety and security of women in their care is paramount at all times as a minimum standard of service delivery. Training opportunities should critically analyse cultural “justifications” of violence against women and girls and address personal beliefs, as

well as professional obligations, for health-care professionals, law enforcement officials, and other service providers, in order to spur implementation of existing legislation and support monitoring and evaluation.

- e. Develop and implement protocols for the care of victims of intimate partner violence and victims of rape, and train justice and law enforcement personnel on both protocols.

Actions for development partners

The UN and other development partners, such as U.S. President's Emergency Plan for AIDS Relief (PEPFAR), should

1. Increase support for **comprehensive and inclusive programmes** that address the linkages between violence against women and HIV through coordinated multi-sectoral interventions and funding mechanisms, engaging bilateral and multilateral organizations as well as foundations and private sector donors.
 - a. Support programming that recognizes and address the full scope of needs and rights those involved in sex work, violence against women and HIV prevention, including women living with HIV, law enforcement, health staff, media, clients, partners, controllers and family. Interventions to promote safer sex among sex workers must be part of an overall effort to ensure their safety, promote their health and well-being more broadly, provide a safe working environment and protect their human rights.
 - b. Facilitate access for women drug users, including support groups, harm reduction, care and support, to services that are woman-friendly, and include trained women staff members and volunteers that are sensitive to their needs.

- c. Ensure that violence against women is fully integrated into global health initiatives such as *The Global Plan Towards the Elimination of New HIV Infections Among Children By 2015 and the Every Mother, Every Child* initiative on maternal and child health.
 - d. Ensure that new guidelines and approaches to HIV, including earlier initiated treatment, and treatment as prevention fully address violence against women and girls as a key challenge to improving health outcomes.
2. Support **civil society engagement** in all aspects of integrated HIV and violence policy and programming.
 - a. Support women living with HIV, sex workers, women's organizations and others with experience in working on violence to continue developing skills and confidence, so that those directly affected are able to participate actively and widely at both policy and community level.
 - b. Support youth leadership and engagement in HIV prevention that specifically incorporates gender-based violence prevention and supports human rights.
 - c. Support civil society partners and host governments to develop and implement initiatives aimed at engaging men and boys, including through primary prevention and secondary interventions aimed at addressing trauma related to exposure to violence.
 - d. Provide funding for advocacy and activism aimed at advancing women's rights and addressing violence against women in the context of HIV.
 3. Allocate **funding for research and evaluation** of programme strategies to reduce violence against women and girls and its links to HIV and support national surveys tracking the attitudes towards and incidence of violence against women to inform the design of HIV programmes.

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