



Violence Against Women Living with HIV/AIDS: A Background Paper

Fiona Hale *and*
Marijo Vazquez



DEVELOPMENT CONNECTIONS AND THE INTERNATIONAL COMMUNITY OF WOMEN
LIVING WITH HIV/AIDS (ICW GLOBAL) WITH THE SUPPORT OF UN WOMEN

*'If you have come to help me, you are wasting your time.
But if you have come because your liberation is bound up
with mine, then let us work together.'*

ABORIGINAL ELDER, EDUCATOR,
AND ACTIVIST LILLA WATSON
(BORN 1940)

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With thanks to Alice Welbourn for inputs and comments on earlier drafts of this paper.



ICW Global



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FOREWORD

The subject of violence against women living with HIV has been gaining currency within the international agenda on HIV, gender and development; however, to date it has received only limited attention in research, the policymaking process and specific interventions. In November 2010, Development Connections, the International Community of Women Living with HIV/AIDS (ICW Global) and UN Women convened the Virtual Forum on Violence against Women Living with HIV. The present background paper collects and analyzes definitions, data and practices on the subject, while exploring their strategic implications for research, advocacy and programming. The rationale for the paper was to frame the online dialogue within an informed, global perspective.

The history of violence, before and after the HIV positive diagnosis of women, is important for understanding the interrelationships among the underlying determinants and consequences of HIV and VAW. It implies an examination of specific theoretical and ethical issues such as how to define violence, the kinds of questions we should ask to explore the links between HIV and VAW, and the methods we use to answer them. The authors of this paper propose a definition of violence against women living with HIV which includes acts, structures and processes which cause harm to women living with HIV. In this sense, violence may be direct, structural, and/or cultural, across multiple levels.

While violence against HIV positive women may reflect the dimensions of VAW in general, it is also a unique venue to examine the ways in which gender and other social markers such as ethnicity, class, age, and disability, are interconnected along with structural processes. The domain of violence against positive women is an arena for developing explanatory paradigms on VAW and HIV in sets of social relations that produce and reproduce inequalities from difference. It is the analysis of the social context of inequality that tells us why and how living with HIV is an important predictor of women experiencing violence by partners, family members, community members and service providers, among others.

Obtaining information on violence against HIV positive women has proven cumbersome due in part to a lack of systematic research on this issue and a failure to categorize violence as a consequence of HIV positive diagnosis. As pointed out by the authors, the problem is sometimes framed under the headings 'stigma and discrimination' and/or 'violation of sexual and reproductive rights'. To date, there have been few initiatives worldwide designed to respond to violence against positive women; consequently, evidence regarding promising practices in different settings and with diverse groups of positive women is limited. Although scarce, the available data provides important insights into the dimensions of the problem.

In order to achieve and fulfill the international commitments on human rights, gender equality, HIV, and violence against women, all types of violence against positive women should be eliminated. We hope this paper supports the efforts of governments, civil society organizations, international agencies and other stakeholders toward this goal.

Dinys Luciano—Director, Development Connections

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THE AUTHORS

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Fiona is a freelance consultant and Salamander Trust Associate focusing on HIV/AIDS, sexual and reproductive health, gender and development. Her background encompasses research, NGO and programme management, writing, editing, facilitation and training. She is also a qualified translator, and speaks English, Spanish and French. Fiona has worked in community development since 1995. She spent six years at ActionAid with the Latin America and the Caribbean regional programme, and from 2003-2008 was the International Network Manager of the International Community of Women living with HIV/AIDS (ICW). Her recent work includes Salamander Trust consultancies for IPPF and International Civil Society Support, an analysis of gender in health research, and a factsheet on cervical cancer, HPV and HIV for the Athena Network. She is a former Chair of the UK-based Haiti Support Group, and a current member of the Management Committee of Streetwise, an organisation providing free, confidential advice, counselling, sexual health and support services to young people aged 13-25 in the North East of England.

MariJo Vázquez

MariJo Vazquez is Spanish and has worked as a translator, proof-reader and editor. She speaks Spanish, English, French and Arabic. After her HIV diagnosis in 1996, she trained and worked in counselling and group facilitation. She began by working in support group settings, later focusing on local and international training in gender and sexual and reproductive health and rights. She is a founding member of the Athena Network, and has represented the International Community of Women living with HIV/AIDS (ICW) and HIV positive women at international level, including being a delegate to the UNAIDS Programme Coordinating Board. During her time as Chair of ICW (2005-2008), her focus was very much on increasing consultation, communications and accountability within ICW and its governing body. MariJo's recent work includes Salamander Trust consultancies for IPPF, International Civil Society Support, and WHO. She co-edited the 2009 publication, *Sanar a través de nuestras historias: Las mujeres construyen la memoria histórica del VIH* (Healing through our stories: Women construct a historical memory of HIV), a collection of the personal stories of 20 women living with HIV across Spain (http://www.redpositiva.red2002.org.es/documentos/libro_SATNH_web.pdf). Currently, MariJo is a Board member of The Constellation (an international organisation aiming to connect Local Responses around the world), and teaches a Masters module on participatory and community-led research at the Universidad Autònoma in Barcelona.

Alice Welbourn

Alice Welbourn is an international activist and campaigner on women's rights and HIV/AIDS. She has worked on international gender and health issues for over 25 years. Her PhD involved research in rural Kenya, and she lived and worked in rural areas of East, Southern and West Africa for several years. Diagnosed HIV positive in 1992, she wrote a training package on gender, HIV and relationship skills called Stepping Stones, now widely used across Africa, Asia and Latin America (www.steppingstonesfeedback.org). Alice is a former international chair of ICW, a former member of the Leadership Council of the Global Coalition on Women and AIDS (GCWA), and of the UK Sexual and

Reproductive Health and Rights Network steering committee. Alice currently sits on the UNESCO Global Advisory Group for sex, relationships and HIV education and is a member of the Steering Committee of the GCWA. She is also a co-founder and current chair of trustees of the Sophia Forum (the UK Chapter of the Global Coalition on Women and AIDS); and is on the Steering Committee of the Athena Network. Alice has written extensively, and her articles have been published in the press, international newsletters, on the internet and in peer-reviewed journals. In December 2008, she launched a web-based audio project, entitled “Women, HIV and Motherhood”, featuring interviews with prominent HIV positive women activists from around the world (<http://www.stratshope.org/d-audio.htm>). In late 2008, she founded the Salamander Trust (www.salamandertrust.net), which she currently directs. She is also an Honorary Fellow of the Peninsula College of Medicine and Dentistry, in the South West of England. Dr Welbourn speaks German fluently and is conversant in French, Spanish, ki-Swahili and basic Somali. In 2007 Dr Welbourn was honoured by an award from the World YWCA for innovative leadership in the response to HIV. She is married and a mother of young adults.

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This publication was made possible by the generous support of UN Women. We express our profound gratitude to Nazneen Damji (UN Women) for her active commitment and support to the Virtual Forum on Violence against Women Living with HIV and the production of this background paper. Special thanks to the three facilitators of the Virtual Forum: Olive Edwards (Jamaican Network of Seropositives, JN+, representing ICW), Anda Samson (DVCN consultant/The Netherlands) and Deborah Billings for enabling the creation of collective knowledge and promoting a dialogue and interchange among participants using this background paper.

PART ONE

Current definitions, data on types of violence, social determinants and consequences of violence against women living with HIV

1. DEFINING VIOLENCE

We start this paper by thinking about violence in the broadest sense—as one of the elements that sustains and perpetuates an unequal society in which some people have control over others in a hierarchical scale of power which is based on exploiting differences between people. Given this understanding, the violence which keeps this system in place becomes part of the system, and condoned by society. Violence is used to achieve and assert power and control over others, and becomes accepted (to greater or lesser degrees) as part of normal social structures. Peace studies distinguishes between ‘structural’, ‘personal’ (also referred to as ‘direct’) and ‘cultural’ violence (Galtung, 1969; 1990; Farmer, 1996; Farmer et al., 2006). In this schema, personal violence ‘shows’ (Galtung, 1969, p. 173), unlike structural violence, which is based on exploitation, repression, marginalisation and fragmentation (Galtung, 1990) and manifests itself as ‘disparate access to resources, political power, education, health care, and legal standing’ (Farmer et al., 2006, p. 3). ‘Cultural’ violence refers to ‘aspects of culture... — exemplified by religion and ideology, language and art, empirical science and formal science... — that can be used to justify or legitimize direct or structural violence’ (Galtung, 1990, p. 291). As Paul Farmer points out, ‘The idea of structural violence is linked very closely to social injustice and the social machinery of oppression’ (Farmer et al, 2006, p. 3).

This paper will start from the premise that violence against women living with HIV can be structural, cultural and personal. It also is based on an understanding that difference based on factors including gender, sexuality, socio-economic status, ethnicity/‘race’, and HIV status, are key to maintaining the power hierarchies that support and underpin violence of all three types.

Social Determinants of Health and Social Determinants of Violence

WHO defines health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (World Health Organization, 1948). There is a growing acceptance that health is something which is socially determined. In other words, health is shaped by ‘the conditions in which people are born, grow, live, work and age, including the health system... [and] by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices’ (World Health Organization, http://www.who.int/social_determinants/en/).

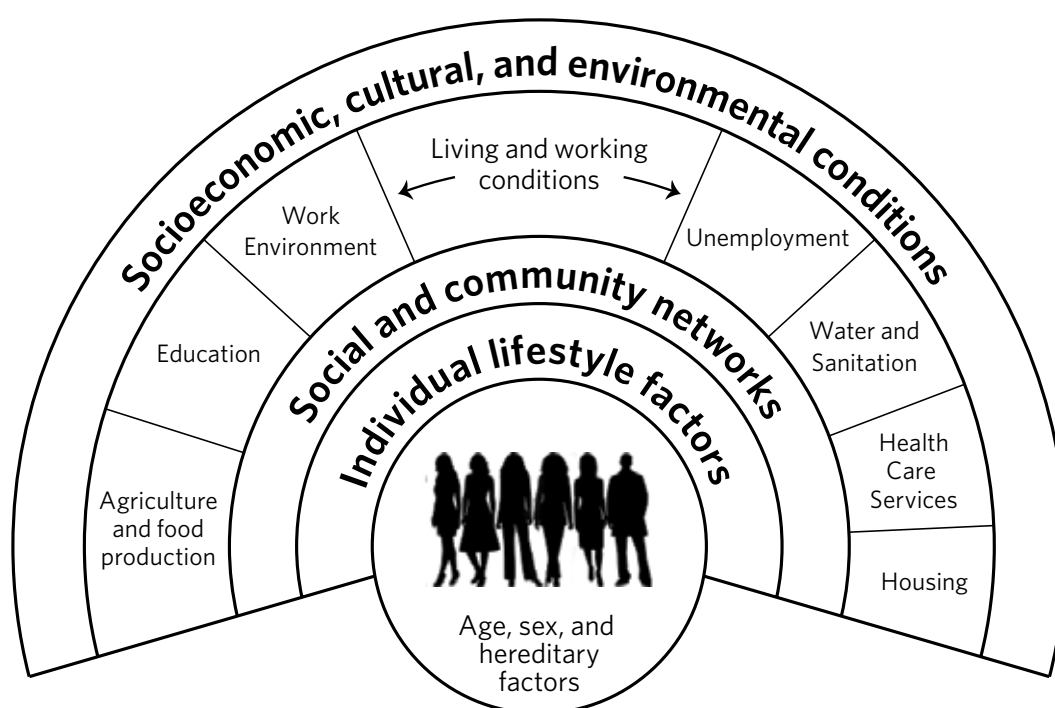
Yet discussions about women’s vulnerability to HIV often focus on individual factors which increase ‘risk’. There is generally less focus on the underlying causes of poverty, violence and gender inequality (Watts, 2009, pp. 3-4).

Violence needs to be dealt with as an integral part of multisectoral HIV responses.

(UNAIDS, 2010) p. 10

So, like structural, cultural and direct violence, the social determinants of health are based on inequalities, and also cause further inequalities – and not only in health. The concepts are closely linked. Human rights are increasingly seen as an important tool for addressing these inequalities, reducing violence, increasing development, and improving health (Gruskin & Tarantola, 2008; Tarantola et al., 2008; Gruskin, Bogecho & Ferguson, 2010).

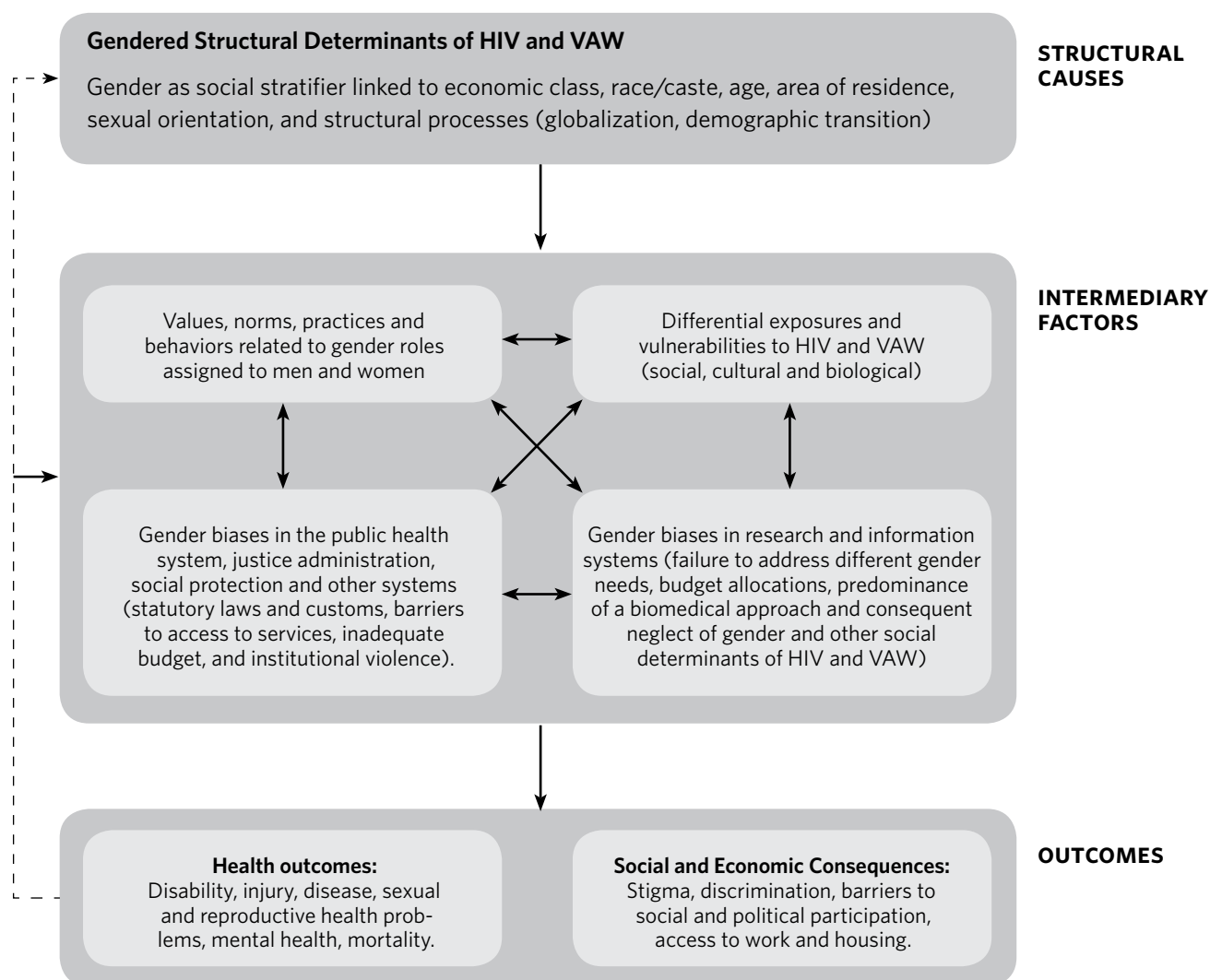
Social determinants of health



(World Health Organization, 2008)

A 2007 framework for analysing gender inequality in health highlights three spheres: a) structural causes, b) intermediary factors and c) health outcomes, social and economic consequences (Sen, Ostlin & George, 2007). This framework is useful in bringing together the lived experiences of women with the broader structural context of gendered social determinants, which sets the scene for those experiences, and the cultural (intermediary) factors including gender bias which foment them.

Gender inequality in health



(Adapted from Sen, Ostlin and George, 2007)

We will return to this framework below as we develop a suggestion definition of violence against women living with HIV.

Defining Violence Against Women

‘Violence against women’ is now generally recognised to be a serious public health and human rights issue globally. For many women around the world partner violence is a daily occurrence. Global population surveys indicate that between 15% and 71% of women have been physically or sexually assaulted by an intimate partner at some time in their lives, yet this is a silent epidemic. One fifth to two-thirds of women interviewed for the WHO multi-country study on domestic violence and women’s health had never told anyone about their partner’s violence prior to the WHO interview (Garcia Moreno, 2006). A number of key

international instruments on violence against women have pushed the issue up the agenda, and sought to progressively expand definitions of violence against women as understanding and acknowledgement of the issue has grown.

The definition which is commonly used is the Declaration on the Elimination of Violence against Women.

DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN

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

- a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
- b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
- c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.'

(United Nations General Assembly, 1993)

The Beijing Platform for Action expanded on this definition.

THE 1995 BEIJING PLATFORM FOR ACTION

Violence against women includes: violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery and forced pregnancy; forced sterilization, forced abortion, coerced or forced use of contraceptives; prenatal sex selection and female infanticide.

The Beijing Platform for Action recognizes the particular vulnerabilities of women belonging to minorities: the elderly and the displaced; indigenous, refugee and migrant communities; disabled; women living in impoverished rural or remote areas, or in detention.'

(UNFPA, 2005, p. 6)

More recently, the Women Won't Wait campaign defined violence against women as explicitly linked to social, economic and legal inequity, and as one aspect of gender-based violence, as follows.

WOMEN WON'T WAIT

This NGO interagency campaign defines violence against women as 'any physical, sexual, or psychological violence perpetuated against a woman or girl.'

'We know that women and girls can be exposed to violence as the result of conflict, war, and social unrest and in the work place or other public spheres. However, we also know that violence against women and girls is most often perpetrated by partners, family members, and acquaintances.

Additionally, we understand VAW/G to be inextricably linked to social, economic, and legal inequity as a consequence of gender. Therefore, we recognize that most Violence Against Women and Girls is a form of gender-based violence.'

It further defines gender-based violence as 'violence (physical, sexual, or psychological) that is perpetuated against a person because of that person's gender, gender identity, or gender performance or the perpetrator's understanding of gender roles and or expectations.

Gender-based violence is often, but not always, violence against women and girls.

Transgendered or transsexual people, homosexual or bisexual people, and boys or men who do not conform with society's gender expectations are often also the targets of gender-based violence.'

(Women Won't Wait, 2010)

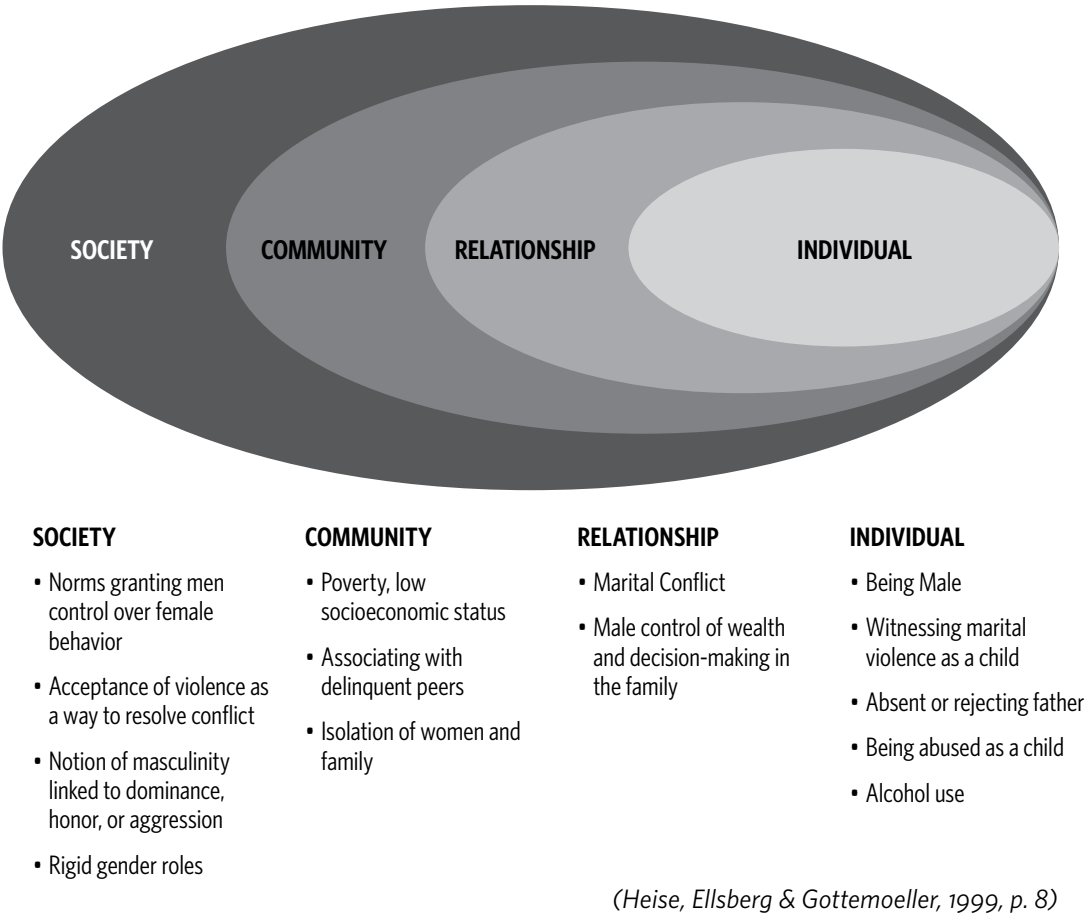
As interest in violence against women and gender-based violence¹ has grown, a number of different, but overlapping, approaches to understanding, describing and systematising knowledge about violence against women have been developed. These include:

- The gender perspective
- The human rights approach
- The criminal justice approach
- The public health approach (*World Health Organization & London School of Hygiene and Tropical Medicine, p. 6*)

¹ The terms 'violence against women' (or VAW) and 'gender-based violence' (or GBV) are often used interchangeably. For the purposes of this paper, we focus on violence against women, understanding this to be an expression of gender-based violence in which women and girls are the targets.

For more information on these approaches, see World Health Organization & London School of Hygiene and Tropical Medicine, 2010.

A highly influential model has been the ecological model (Heise, 1998; Dahlberg & Krug, 2002; World Health Organization & London School of Hygiene and Tropical Medicine, 2010), which provides a framework for organising existing research on violence against women into ‘an intelligible whole’ and a more integrated approach to theory building regarding gender-based abuse (Heise, 1998, pp. 265-266). Many projects, programmes and analyses addressing partner violence take the ecological model as their starting point.



As we have shown, definitions of violence against women have become progressively broader. Yet we suggest that they do not fully encapsulate HIV positive women’s specific experiences of violence.

Defining Violence Against Women Living With HIV²

It is now well established that partner violence is linked to HIV. While there is still much that is not understood about the link, the evidence base is growing. The younger women are when they first have sex, the more likely it is to have been forced sex. Forced sex is correlated to HIV risk (WHO, 2005), and the extremely high HIV prevalence among young women in some parts of the world would bear this out. At the recent Vienna 2010 International AIDS Conference, Charlotte Watts presented the results of a study³ which draws on data from 96 countries, which shows conclusively that intimate partner violence doubles women's risk of contracting HIV (Welbourn, 2010b; a).

It stands to reason that if partner violence was part of the backdrop to HIV acquisition, it is likely to remain part of the story after testing. Needless to say, an HIV positive diagnosis for a woman does not suddenly end partner violence. Yet this and the range of other types of violence which HIV positive women experience remain a hidden phenomenon. Even when the will to understand and the funding is there—which it often is not—it is obvious that asking women about their experiences of violence poses some challenges. The data that does exist is partial. However, it gives shocking indications of the extent to which violence—structural, cultural and direct—is part of the experience of being an HIV positive woman. Intersectionality—the overlap of social determinants of HIV and social determinants of violence—means that often the violence experienced by HIV positive women mirrors that experienced by women generally. HIV, however, exposes women to violence in new situations. HIV also acts as one more 'determinant', pushing women further down the hierarchy of power. However, as far as we are aware, there is no existing definition of violence against women living with HIV. We propose a definition of violence against women living with HIV which acknowledges the importance of power with regard to structural, cultural and direct violence:

Defining Violence Against Women Living With HIV

We propose the following definition: *'Violence against positive women is 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.'*

With thanks to the following women who contributed to refining this definition:

- **Alice Welbourn**, Director, Salamander Trust
- **Mony Pen**, Project Manager, Cambodian Community of Women living with HIV/AIDS
- **Olive Edwards**, Jamaican Network of Seropositives, JN+
- **Patricia Wayon**, Program Manager, Liberia Women Empowerment Network (LIWEN)

² We have chosen not to abbreviate 'violence against women living with HIV'. This is based on our understanding of cultural violence, and the potentially dehumanising and depoliticising effects of referring to people by acronyms.

³ The study has not yet been published: this is based on the presentation at AIDS2010.

In considering violence against women living with HIV, the evidence suggests that in addition to the types of violence described in the Declaration on the Elimination of Violence Against Women, the Beijing Platform for Action and the Women Won't Wait campaign, HIV positive women are also exposed to a whole series of other types of violence. Often, these are framed as 'stigma and discrimination', or lack of respect for human rights, and only rarely are they referred to as violence against women. (In fact, this is true even when they are clearly within the definitions of violence against women given above, as is the case with forced sterilisation of HIV positive women, for example.)

Shunning; eviction; barring women from seeing their children; maltreatment by service providers; police violence, abuse and extortion; loss of livelihoods ... these are all avoidable, unnecessary, and result in direct and tangible harm to HIV positive women. But violence against women living with HIV also takes a more indirect form. The use of discriminatory language; legislation and policy which is developed without using the lenses of gender and HIV status; clinical trials which do not adequately respect women's autonomy, humanity and rights; the dominance of Western scientific understandings of 'evidence'; institutional failure to understand the realities of HIV positive women's experiences and to create supportive environments—these are equally damaging, and create a structural and cultural climate in which violence against women living with HIV is accepted, to the extent that it is not even recognised for what it is.

Fortunately, there have been key advances in understanding violence against women as it relates to HIV. Until recently, work linking HIV/AIDS and violence against women has focused heavily on how violence against women increases women's vulnerability to HIV, and negatively impacts on HIV prevention. Thanks to the work of HIV positive women, their organisations and their allies around the world, there is now a growing recognition that violence remains (and/or becomes) a major issue for women after an HIV positive diagnosis. Yet there is still much to be done to address the linkages between violence against women and HIV, and to ensure that 'VAW and HIV' is not seen only in terms of prevention of HIV transmission, important as this is. A consultation meeting in Toronto in 2006 found that 'GBV and HIV remain seen ... as largely separate and distinct areas of work. To bring these together and, at the same time, to add in human rights, feminism, sexuality or any of the other frameworks has been found to be challenging' (Center for Women's Global Leadership & Health, 2006, p. 5).

A key gap is the 'lack of systematic mechanisms for mutual learning between women's organizations and HIV organizations' (Center for Women's Leadership & Global Health, 2006, p. 6). There is a need to develop appropriate ways of talking about, understanding and analysing violence against women living with HIV, and to directly address it through policies, programmes and projects. It is also vital that the issue be brought to the realm of the 'community'—HIV positive women must be at the heart of work on violence against

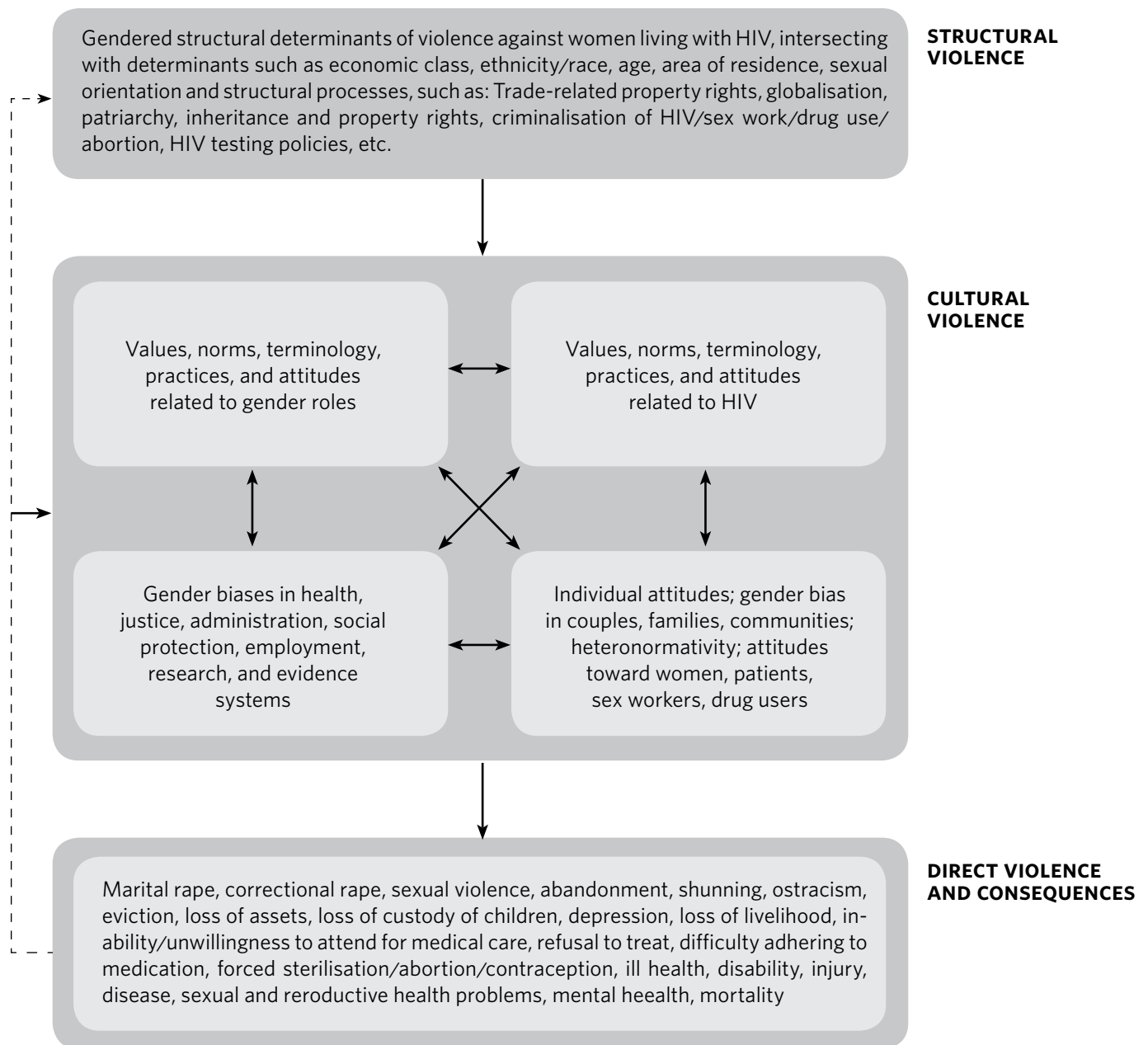
women living with HIV, and local ownership of responses to violence against women living with HIV is of prime importance.

Information and evidence on violence against women living with HIV is somewhat difficult to obtain. This is partly because it is often contained in reports and studies on stigma and discrimination, or access to services, or HIV testing, or sexual and reproductive health, or adherence to treatment. Even in the AIDS community, the word 'violence' is seldom used except in connection with HIV prevention.

It is concerning that while the visibility gained for women's experiences through work on 'stigma and discrimination' has been a big step forward, and has placed them firmly on the agenda of the HIV community, the identification of women's experiences as 'stigma and discrimination' has meant that HIV positive women's experiences have not been taken up by the women's movement as examples of violence against women.

Similarly, much of the work done to date on HIV positive women's sexual and reproductive health and rights has not been framed as 'violence against women', even when it falls squarely into the definitions proposed by the UN Declaration on VAW, or the Beijing Platform for Action. Instead, many experiences are framed as being a 'lack'; of capacity, of access, or of informed consent. By using this type of language with its suggestion of technical deficits, there is a neutralisation of experiences which are clear manifestations of structural, cultural and/or direct violence against women living with HIV.

The table below is our reinterpretation of Sen, Ostlin and George (2007), in which we attempt to depict the causes and consequences of violence against women living with HIV, using the concepts of structural, cultural and direct violence.



The reinterpretation of violence from the perspective of women living with HIV proposed by Nizarindandi Picasso (Picasso, 2008b; a) of ICW Latina includes experiences of structural, cultural and direct violence, as follows:

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

(Picasso, 2008b)

Of course this list is not exhaustive. However, it provides a very useful entry into an analysis of the specific ways in which violence is experienced by HIV positive women.

2. VIOLENCE AGAINST WOMEN LIVING WITH HIV: THE DATA

Documentation of violence against women living with HIV is increasing. There is a small but growing body of research which is specifically concerned with violence against HIV positive women. There is a much larger body of work on stigma and discrimination against people—including women—living with HIV. In this section, we draw on documentation of HIV positive women's experiences of violence, and academic research findings, to present key data which may be useful in advocacy on the issue.

The data highlights are presented by the site or setting of violence.

Partner

For HIV positive women, sexual, physical and psychological partner violence is common. Cultural and structural violence means that women are often held responsible for violence in the relationship, and are encouraged by parents, in-laws and society to stay with the violent partner. In many circumstances, the law and gendered financial constraints makes leaving extremely difficult. A South African study found that women with violent partners are more than 50% more likely to be HIV positive than other women (Dunkle et al., 2004). In Tanzania, young HIV positive women were 10 times more likely to report partner violence than young HIV negative women (Maman et al., 2002).

Also in Tanzania, HIV positive women identified domestic violence as 'one of the most prevalent problems linked to HIV'. It is usually triggered when a man comes home drunk; when a woman comes home and tells him she has HIV; and when a woman will not have sex with her husband (Murray et al., 2006). In the USA, a WHO study found that 20.5% of women living with HIV reported physical abuse because of their status, and in Kenya, 19% of women reported partner violence because of their HIV status (Nilo, 2008, p. 29). In Zambia, HIV positive women with violent partners had serious difficulties accessing and adhering to HIV treatment because of violence. Many women miss doses because of violence from their partners, and then face judgemental treatment from health workers who blame them for poor adherence (Human Rights Watch, 2007).

Consequences of partner violence include poor access to health care and women's ability to take HIV medication consistently (Human Rights Watch, 2007). Domestic violence may prevent HIV positive women 'from accessing treatment, thus potentially leading to infection of her children, death herself, and/or orphan status for her offspring' (Murray et al, 2006).

Family/in-laws

HIV positive women may experience direct violence at the hands of family and in-laws, who may also be channels of structural and cultural violence, and thereby expose HIV

'I was taken to A&E [Accident and Emergency] for head injuries after he punched me and I passed out. I could not tell anyone because he kept threatening to tell friends and family about my HIV status so I remained with him and the abuse' (Patience).

(PozFem UK, 2008, p. 5)

'I started taking medication in 2006. My husband does not know. I take the medicine out of a bottle and put it in a plastic bag or in a paracetamol box ... Sometimes I would miss a dose; he comes back at 18.00 hrs, drunk, closes the door and says, "Today you are going to freak out." He locks me in, he beats me up and locks me out of the house. .. I go to the neighbours, if they have mercy they will let me in, if not, I sleep under a tree until tomorrow. As a result of that I miss doses sometimes. I feel very bad. I don't even feel like taking the medicine.'

Berta K., Lusaka

(Human Rights Watch, 2007).

positive women to further violence. In many settings, women have very little autonomy, and routinely experience violence within the family setting. In India, HIV positive women are usually blamed for their husband's death and are often evicted from their houses, with one study putting the numbers of women experiencing this as high as 91% (NACO, cited by Development Connections, 2010).

In Vietnam, HIV positive women have been ejected from their homes or had their children removed from them by their in-laws (Thi et al., 2008). The family setting is also the site of violence when it comes to exclusive breastfeeding or avoidance of breastfeeding (Fletcher, Ndebele & Kelley, 2008), with mothers facing pressure and questioning from family and others about their feeding choices (Doherty et al., 2006; Rogers et al., 2006; Sibeko et al., 2009).

Community

There is little research on the nature of community-level stigma against women living with HIV (Shamos, Hartwig & Zindela, 2009). Factors such as age, race, socio-economic status, sexuality, marital status, sex work and drug use (Bennett, 1998; Sandelowski, Lambe & Barroso, 2004; Emlet, 2005; Emlet, 2006; Lekas, Siegel & Schrimshaw, 2006; Korner, 2007; Sandelowski, Barroso & Voils, 2009), as well as community location and size intersect to determine the types of violence HIV positive women experience within the community.

Schools can be a site of violence for HIV positive young women and girls.

Health services

Medical care is one of the many settings where HIV positive women experience violence, abuse and lack of respect for their rights. A recent UK study carried out by Positively Women (now Positively UK) found that while 96% of HIV positive survey participants were registered with a general medical practitioner (a 'GP'), 60% would not tell their GP about their HIV status because of the fear of judgemental treatment or breaches of confidentiality. 33% felt their HIV status prevented them from accessing good GP care (Petretti, 2009, p. 4). HIV positive sex workers, drug users and young women may face particular forms of violent treatment in the healthcare setting.

Reproductive rights violations are identified by UNFPA as a form of gender based violence. These include:

- unavailability or disruption of contraceptive supplies;
- judgmental or biased treatment based on reproductive status or choices;
- coercive family planning counseling;
- denial of contraceptives;
- forced sterilization;
- verbal or physical abuse by providers and health-centre staff that poses a barrier to reproductive health care access.

'When I told the vice principal that I was HIV positive I was told to leave, unless everyone was informed. I was shocked and horrified to see my nightmare come true. Even though it is illegal, the school continued to discriminate against me — and told all the staff of my HIV status. I bailed out, knowing I could not win.'
Stephanie, Australia.

(International Community of Women living with HIV/AIDS (ICW), 2008).

These are violations which HIV positive women around the world have reported and documented, and there is a growing body of evidence that such reproductive rights violations are commonplace in the case of HIV. HIV positive women's organisations and others have been working to raise awareness of these issues and challenge them by whatever means is most appropriate. In some places, there has been official recognition of these as violence against women, as in the case of Venezuela's 2006 law on violence against women which recognises 'obstetric violence' and 'gynaecological violence' as forms of violence against women (UNFPA, 2008, p. 16).

Routine antenatal testing can be an extremely violent experience for many women testing positive.

A US study (Lester et al., 1995) found that 35% of their sample of women testing positive in pregnancy experienced discriminatory health care, compared to none of the women sampled who tested negative in pregnancy. Pregnant women who are not willing to be tested for HIV, or who test positive for HIV, may be denied antenatal services, treated judgementally by health staff, and can experience violence and ostracism from partners and other community members (Welbourn, 2008, p. 15).

Studies by the International Community of Women living with HIV/AIDS (ICW) in India and Nepal found that HIV positive women attending reproductive health services were pinched, punched and scolded by health workers during procedures because of their HIV status (ICW, 2009a; b). Health service violence against HIV positive women also occurs in the labour ward. ICW found that HIV positive women were being told to wait until all other women had been delivered: 'If I touch you and then I deliver other women's children, the virus will be transmitted to them. I just do not care what you go through' (ICW, 2009b).

Abortion and sterilisation services (where these exist) frequently deny access to HIV positive women. An ICW study in India found that 5 out of 7 HIV-positive women interviewed in Delhi were denied abortion or sterilisation services in government hospitals because of their HIV status. 'Because you have HIV we cannot perform sterilisation—the operation will affect your brain' (ICW, 2009).

On the other hand, there is mounting evidence of HIV positive women undergoing forced or coerced sterilisation and/or termination of pregnancy, including evidence from Namibia, Thailand and Chile (Paxton et al., 2005; Gatsi, 2009; Cole, 2010). In other places too, HIV positive women's organisations have documented numerous examples of sterilisation and abortion being made a condition of care or service access for HIV positive women.

There is also evidence of injectable contraception being offered as a condition for receiving HIV treatment (De Bruyn & Paxton, 2005; de Bruyn, 2006; Stevens, 2008).

'I was diagnosed during pregnancy but I was just too scared to tell my partner. It was too much... I was scared he would leave me and being pregnant I couldn't deal with it.'

PozFem UK, 2008, p. 4).

'I really wanted a child. The third time when I became pregnant, the doctor told me, "You have to terminate the pregnancy." They forced me to terminate, and they sterilised me.'

(Mea, 2009).

In Namibia, in 2007, ICW began documenting cases of violations of the sexual and reproductive rights of HIV positive women, including women subjected to forced or coerced sterilisation or abortion. Now, HIV positive women who had been sterilised without consent are fighting their case in court (Cole, 2010).

A key recommendation for addressing violence against HIV positive women in health care settings is for more reflective practice among health care providers to 'conscientiously uncover their true feelings about HIV positive women' as a way of acknowledging their personal biases and also, hopefully, to minimise the negative impact on women in their care (Blake et al., 2008). Ongoing, culturally-sensitive training for health workers is also seen as critical (Bharat & Mahendra, 2007; Andrewin & Chien, 2008). This includes training for maternity service workers on aspects of particular relevance to women such as consent, confidentiality and disclosure (Turan et al., 2008). Training in gender, human rights, and sexual and reproductive rights of women living with HIV is also highlighted (Bell et al., 2007).

Employment and livelihood settings

ICW has documented any number of examples of violence against HIV positive women in relation to work—in formal and informal settings. These include unauthorised disclosure of HIV status, testing without informed consent, and dismissal or retraction of job offers. A number of recent studies confirm that HIV positive women are affected by workplace violence, removal from jobs, refusal of employment, and unfair treatment, in countries as diverse as Swaziland (Shamos, Hartwig & Zindela, 2009), Vietnam (Thi et al., 2008), Ghana (Ulasi et al., 2009), China (Yan, 2008), and five African countries (Kohi et al., 2006). In a South African study among HIV positive men and women, one in five had lost a place to stay or a job because of their HIV status (Simbayi et al., 2007), and Caribbean women now living in London raised the issue of employment discrimination and job loss in Jamaica after an HIV positive diagnosis (Anderson et al., 2008). UNESCO and the World Bank have also documented HIV positive women teachers' experiences of violence in their workplaces (UNESCO, 2007; World Bank, 2009).

Police, detention and border authorities

Police violence against sex workers, including rape, sexual, physical and psychological violence, extortion, illegal arrest, forced testing, and outings and media shamings, have been documented in Eastern European countries by the Sex Workers' Rights Advocacy Network (Crago, 2009).

Prison is for many women where they learn they are HIV positive. Confidentiality is minimal, and access to appropriate care and treatment is poor, with women often experiencing violence from other inmates, health workers and prison staff (Strachan, 2010; PozFem UK, 2008, p. 6; UNODC, 2008). In some places, isolation and segregation of HIV positive

That's the bad thing about it, everybody know as soon as you go in that dorm that you're HIV-positive. I don't think it's fair they've got us singled out like that, when folks have come in and not told their families yet. I think we should have freedom of choice about whether to be tested or not.'

MARY W., ALABAMA

(ACLU and HRW, 2010, p. 25)

'A friend had only two weeks medication supply and was due to be deported. She saw the doctor at the detention centre who said it was not the UK's responsibility to provide more than three days worth of medication should she be deported! One of the drugs she takes is not available in her home country and she is already resistant to many ARVs.'

(PozFem UK, 2008, p. 7)

inmates is still the norm (American Civil Liberties Union (ACLU) and Human Rights Watch (HRW), 2010).

In the UK, HIV positive women asylum seekers awaiting deportation face violence (Asylum Aid, Positively Women and ICW, 2009) including being denied access to medication.

The law

Gender bias in the legal system is of serious concern vis a vis violence against HIV positive women, who face a lack of legal protection vis a vis marital rape, employment protection, property rights, inheritance rights and others.

Criminalisation of sex work, drug use, abortion, same sex relationships, exposure and transmission of HIV, is also a major issue (Aids Legal Quarterly, 2009; Athena Network, 2009; American Civil Liberties Union (ACLU) and Human Rights Watch (HRW), 2010).

The structural and cultural violence which is endemic in society is clearly highlighted by a recent legal case in Quebec, Canada. In this case, a Canadian woman made a charge of domestic violence against her male partner. He retaliated by bringing a charge of HIV exposure. Despite her insistence that she had disclosed her status to her partner several years earlier, she was sentenced to a year in prison, while the court dropped her domestic violence charges (ALQ, 2010, pp. 3-5).

'I feel now that through this experience I am left feeling like a criminal for being HIV positive and my fear is that now people won't be tested through fear of prosecution about being positive ... to be where I am today, in prison. I am learning how to live a criminal life. I am unable to talk to my son. I wake up every day on edge, waiting for someone to discriminate against me for being who I am.'

(PozFem UK, 2008, pp. 12-13)

PART TWO

Existing initiatives addressing violence against women living with HIV

3. PROJECTS/PROGRAMMES SPECIFICALLY ADDRESSING VIOLENCE AGAINST WOMEN LIVING WITH HIV

One very important development in addressing violence against women living with HIV is recent work to promote and increase integration of services addressing HIV and violence against women (Luciano Ferdinand, 2009).

Outside of the services setting, the End Forced Sterilisation campaign in Namibia is a good example of HIV positive women and their allies organising to address a concrete form of violence against HIV positive women (<http://endforcedsterilisation.wordpress.com/>). There are many other examples—though few of them use the terminology of violence against women. Indeed, the aims are often expressed in positive language geared towards creating enabling or supportive environments, and increasing solidarity with and awareness of HIV positive women and their issues. Relevant projects include:

- ICW's **Silent Voices** project, by women living with HIV who use, or have used, drugs and/or alcohol, started with women sharing their experiences, and led to the development of an action plan which included advocacy to local health and harm reduction decision makers (ICW, 2007).
- ICW's **Positive Women Monitoring Change** project involved women developing a framework to monitor their experiences of access to care, treatment and support; sexual and reproductive rights; and violence against women, against the commitments of their countries to instruments such as the UNGASS and Abuja Declarations and the GIPA principle (ICW, 2008a)
- The **People Living with HIV Stigma Index** addresses many aspects of violence related to HIV. In the Dominican Republic, the Index questionnaire also included supplementary questions which included a special focus on women, gender violence and young girls (Stigma Index, 2010).
- Projects developed by HIV positive women to provide information, practical and emotional peer support for women living with HIV who are pregnant or new mothers, including:
 - **From Pregnancy to Baby and Beyond** Project (www.positivelyuk.org), run by a positive woman with joint advisory groups of positive women and physicians, provides support throughout antenatal and postnatal care.

- **Mothers to Mothers** (www.m2m.org), which has trained and employed 1700 HIV positive mothers across 686 sites in Southern and East Africa to provide mentoring and support to HIV positive pregnant women and new mothers.
- **Mamas' Club in Uganda** for young HIV positive pregnant women and new mothers (www.mamasclub.org).

4. KEY REPORTS HIGHLIGHTING VIOLENCE AGAINST WOMEN LIVING WITH HIV

Some key reports which also worthy of mention are listed below.

Reports documenting violence against HIV positive women:

- The powerful Human Rights Watch report, *Hidden in the Mealie Meal*, analyses how partner violence against HIV positive women in Zambia impacts on their ability to access and adhere to HIV treatment (2007).
- ICW has produced two reports documenting violence against HIV positive women in reproductive health care services in Nepal and in India, and has carried out follow-up advocacy work (ICW, 2009a and 2009b).
- The Athena Network produced *10 reasons why criminalisation of exposure and transmission will harm women* (Athena Network, 2009), analysing the impact of HIV criminalisation on women.
- Sex Workers' Rights Advocacy Network (SWAN) (2009) *Arrest the Violence: Human Rights Violations Against Sex Workers in 11 Countries in Central and Eastern Europe and Central Asia*.
- ACLU and Human Rights Watch (2010) *Sentenced to Stigma: Segregation of HIV-Positive Prisoners in Alabama and South Carolina*.
- *Courage and Hope: African Teachers Living Positively With HIV*. This film by the Partnership for Child Development gives voice to teachers living with HIV, who detail the challenges they face once their positive status becomes public. These range from stigmatization to shunning and discrimination against them and their families (World Bank, 2009).

5. GAPS AND CHALLENGES

We reviewed programmes and projects which specifically aim to address the links between violence against women and HIV. It is clear that many such interventions are designed to change 'risk behaviour', or to achieve public health goals of reducing HIV transmission, rather than to address violence against HIV positive women specifically or, more generally, to build healthy communities and a better society for all.

Rights based approaches are clearly important in addressing violence against women living with HIV. However, the importance of understanding the issue as something which is systemic, and tackling it as a product of our social system, requires work at a community and societal level to address the root causes of violence against women living with HIV. Many programmes start from the basis of needs. There are fewer projects or programmes which are based on the right to a healthy community, which must involve everyone.

While many projects or programmes on violence against women make reference to HIV, there appears to be little exchange and learning between programmes about what works. Similarly, there seem to be many more interventions which provide training for activists and staff on how to work on violence against women and HIV, and far fewer which promote social change with community members, or which work towards communities which are free of violence and which provide supportive and enabling environments for women living with HIV.

6. SUCCESSES

However, despite the fact that relatively little project and programme work focuses specifically on violence against HIV positive women, there are some interesting examples of work which takes a holistic approach to violence against women and HIV, and which in doing so, aims to address the root causes of gender based violence against women, including HIV positive women. Given our broad definition of violence against women living with HIV, and our focus on structural, cultural and direct violence, we suggest that these approaches are of particular interest, even though they do not only focus on HIV positive women.

One reason for this is that they seek to incorporate primary prevention (preventing violence before it occurs), as well as secondary prevention ('approaches that focus on the more immediate responses to violence, such as pre-hospital care, emergency services or treatment for sexually transmitted infections following a rape') and tertiary prevention ('approaches that focus on long-term care in the wake of violence, such as rehabilitation and reintegration, and attempt to lessen trauma or reduce long-term disability associated with violence') (Dahlberg & Krug, 2002). This makes them innovative: until recently, most responses focused on secondary or tertiary prevention (World Health Organization & London School of Hygiene and Tropical Medicine, 2010, p. 7).

The projects/programmes outlined below offer approaches which can be adapted to different contexts, on the basis of specific community needs and priorities in each case. In each case, we believe the best approaches are based on multi- or inter-sectoral understandings, and on community involvement from the outset. But there is not a one-size-fits-all approach. Any project must start with community dialogue if it is to successfully address the issues and be owned by those involved.

Addressing violence against women living with HIV without taking into account the wider context in which this violence takes place will only limit the extent to which our solutions will address the issue. Favouring expediency over complexity can only give short-term gains. It is vital that work to address violence against women living with HIV is linked to work to build and strengthen communities. One can not work without the other. We take as our starting point the understanding that violence against women living with HIV is part of a system which has violence at its core. This requires broad responses.

Fundamental to success or failure is that in each context, the work should be developed on the basis of the conditions and priorities identified by those involved. This approach, which requires certain personal and organisational attitudes and values, provides the group or community with a way of addressing issues from their own perspective, applying their own capacity, and finding their own way to appropriately address the situation. The role of professionals in this is to facilitate the community process, not to lead it or to impose their 'expertise'.

The approaches we propose share common traits:

- They promote community dialogue and foster common reflection and deeper understandings of the root causes of violence, based on people's own experiences. They allow communities to find the best response to address the specific situation in each context.
- They value the development of links with other organisations and projects which are working for social change, to share approaches and learn from each other.
- They are adaptable to different realities, because they are led by community-defined priorities and needs.
- They have confidence in the capacity of communities.
- They focus on highlighting strengths before addressing problems or needs.
- They involve the whole community, or as much of it as possible.
- The methodology is participatory in the broadest possible way, not just at specific points in the project.

Our intention is not to endorse the initiatives listed over others, but to illustrate the kind of existing projects which we believe have interesting lessons to share with regards to addressing violence against women living with HIV.

Stepping Stones

www.steppingstonesfeedback.org

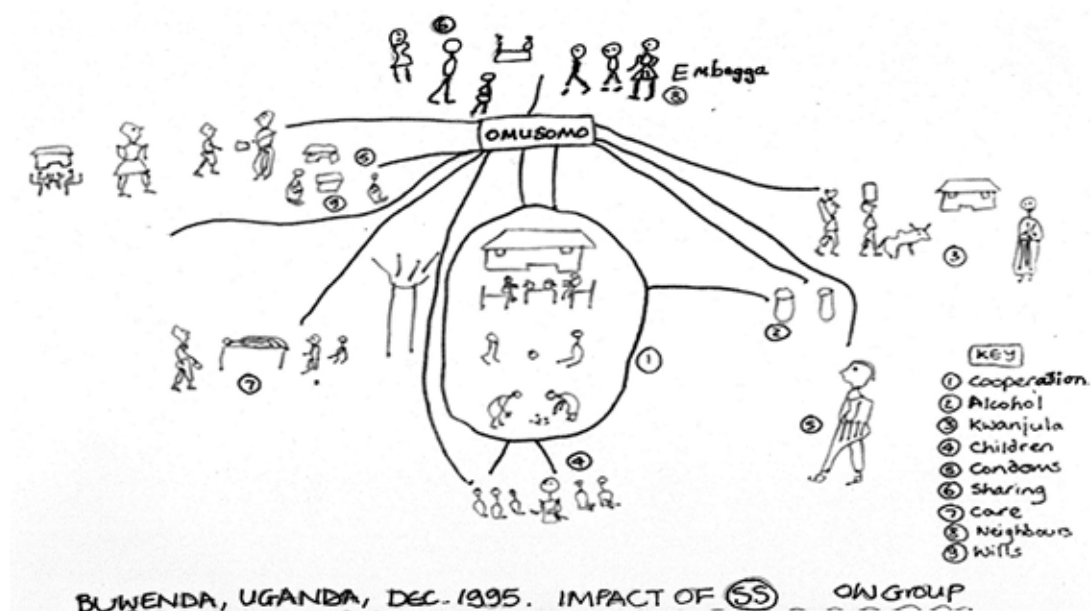
The Stepping Stones programme addresses issues of gender inequality and unequal power relations by creating dialogue among community members. All the exercises are based on participants' own experiences. Role play and drawing exercises enable everyone to take part: no literacy is needed, so everyone relies on their own experiences equally.

By fostering greater community dialogue, Stepping Stones workshops in communities in over 100 countries across all the continents have helped to reduce the acceptability and prevalence of violence and to promote discussion and awareness about HIV. People feel safe because most sessions take place in groups of their own gender and age, with facilitators of the same gender and similar age.

Stepping Stones addresses issues at several levels simultaneously: individual, family and peer networks, community, society. In line with psychologist Lev Vygotsky's "social constructivism", it recognises that behaviour change for all of us is more sustainable if individual change is supported by social change (Vygotsky, 1978; Kim, 2001). There is now a community of practice of over 900 organisations which are using Stepping Stones around the world. WHO and USAID have both recently identified Stepping Stones as a key tool in reducing gender violence in communities. (<http://www.steppingstonesfeedback.org/index.php/page/Resources/gb?resourceid=20>)

'Here we can see in this diagram: prevention education; condom distribution; property and inheritance rights; a reduction in gender violence and greater harmony in the household; reduction in alcohol consumption (i.e. less expenditure also); and, critically, greater care and support for people with HIV and their carers.'

(Welbourn, 2010c)



A number of evaluations of Stepping Stones have taken place. See www.stepsstonesfeedback.org/index.php/page/Resources/en?resourceid=7

Community Life Competence Process (CLCP) (The Constellation)

www.communitylifecompetence.org

Like Stepping Stones, the Constellation uses a participatory approach, and focuses on community ownership of both problems and solutions. The aim is to facilitate ways for communities to become competent to deal with any threat to 'community health'.

The Constellation starts from the principle that every community has the capacity to respond to life challenges, to build a common vision, to act and to adapt. The Constellation reveals and nurtures that capacity. Once we discover our strengths and take ownership, we start to act. Communities think and act for themselves. Facilitators stimulate them to take action through an approach that appreciates strengths and fosters local ownership, based on what the Constellation refers to as SALT:

- S: Stimulate, Support
- A: Appreciate
- L: Listen, Learn and Link
- T: Transfer, Team

For evaluations of the Constellation and the Community Life Competence process, see <http://www.communitylifecompetence.org/en/94-resources>

SASA!

www.raisingvoices.org/sasa/index.php

The SASA! approach addresses the link between violence against women and HIV/AIDS. It is designed to inspire, enable and structure effective community mobilization for prevention of violence against women and HIV/AIDS, by challenging patriarchal norms.

SASA! is the Kiswahili word for "now!" and also serves as an acronym for Stages of Change which shape the programme:

Start: Start thinking about violence against women and HIV/AIDS as interconnected issues and foster power within yourself to address these issues.

Awareness: Raise awareness about how our communities accept men's use of power over women, fueling the dual pandemics of violence against women and HIV/AIDS.

'Earlier I was totally discriminated by my own family and neighbors due to my HIV status and my profession. But after ACP [AIDS Competence Process] came, I'm totally accepted and I now earn my income by selling vegetables... Many nurses would now like to resign from the hospital and work on HIV/AIDS in the communities. We are very much impressed with ACP, because it has helped us realize our potential. Our community is now stronger. We have plans, a five year plan with ACP.'

(WHO/UNICEF, 2009, p. 1)

Support: Support the women, men and activists directly affected by or involved in these interconnected issues, by joining your power with others’.

Action: Take action. Use your power to prevent violence against women and HIV/AIDS.

SASA! uses four strategies: local activism, media and advocacy, communication materials and training to reach a variety of people in a variety of ways.

A formal three-year evaluation of SASA is currently being carried out. The baseline study is available at <http://www.raisingvoices.org/files/SASA!studyInfoSheet.FINAL.lowres.09.pdf>

Puntos de Encuentro (Nicaragua)

www.puntos.org.ni

Puntos de Encuentro (meeting places) is focused on young people, and provides community education through experience. “Somos Diferentes Somos Iguales” (‘we are different, we are the same’, or SDSI in its Spanish acronym) is a Puntos de Encuentro project which promotes the rights of adolescent girls and boys in daily life. With the TV series “Sexto Sentido” [Sixth Sense], the radio programme “Sexto Sentido Radio” [Sixth Sense Radio], as well as materials and training for youth leaders and communicators, and through coordination with service providers, organisations, local and national media, the project aims to foster a more favorable environment in which young men and women can take more control of their own lives and live a life free of domestic violence and discrimination.

SDSI is based on the idea that people, organisations and communities are protagonists in their own change processes. The project promotes critical reflection on the rights of young people and adolescents, with an analysis of traditional social norms and how they often reinforce the subordination of women and young people. It also seeks to open up spaces in which young people can dialogue and debate, and then act as they see fit.

The project covers a multitude of issues which are relevant to young men and women. It promotes an analysis of how societal norms around gender, generation and sexuality influence how people act in different situations and how we take decisions, as well as their impact on participation and leadership. This analysis is based on the principles of diversity, equity and non-discrimination on the basis of social conditions such as gender, age, ethnicity/race, class, sexual orientation, disability and HIV status. Issues addressed include: health, sexual and reproductive rights, sexuality, negotiation within sexual relationships, sexual identity/orientation, safe sex, condom use, emergency contraception, HIV/AIDS and other sexually transmitted infections, family and domestic violence, gender violence and sexual abuse, human rights, poverty, migration, social exclusion and drug use.

Josephine lives in Kampala, Uganda. She was married when she was only 18-years-old, because her parents could no longer afford to send her to school or to support her. Her husband was very violent and was not monogamous. Fearing possible exposure to HIV from her husband, Josephine attempted several times to leave him, only to be forced back to him each time he demanded the return of the dowry he had paid to her parents. When Josephine discovered that her husband had infected her with HIV, she kept her diagnosis a secret from him, fearing more violence. After he died, his family took custody of Josephine’s children.

(Raising Voices, 2010)

The summary of results of the programme shows that it successfully created solidarity and enabling environments for people living with HIV, and changed attitudes towards gender norms and violence against women.

(Solórzano et al, 2008, p. 32)

Mahila Samakhya (India)

Mahila Samakhya evolved out of the National Policy on Education in 1986 in India. This programme aimed to build collectives at the village level of rural poor and landless women which would become forums for reflection, learning and collective action. What emerged were collectives of women who met together, analysed their life situations, discussed what they could do about it and took action to create the change. In Uttar Pradesh, for instance, the collectives first organised around issues like water, health and sanitation which concerned the entire village. Progress in these issues enhanced the social status of the collectives. Domestic violence emerged as a significant issue with the collectives but the members found it difficult to address this issue. Training, mobilisation and critical reflection increased their sensitivity to the complexities of domestic violence and they ultimately created separate forums specifically to deal with violence against women. This resulted in Nari Adalats or Women's Courts being set up which handle cases of domestic violence. These function as alternative systems of justice; they do not have legal sanction but work solely on community approval. Decisions made at these courts are difficult for men to dismiss because they have community backing.

A number of evaluations have been carried out of the MS programme in different states of India and are available online.

Men as Partners

www.engenderhealth.org/our-work/gender/men-as-partners.php

Since its inception in 1996, Men as Partners (MAP) has been developed in 15 countries. It uses community-based workshops to challenge the attitudes and behaviors that perpetuate violence against women and increase their vulnerability to HIV. Through frank discussions of gender stereotypes and power dynamics, the programme engages men and boys as positive forces for change in reducing violence, particularly as it contributes to the spread of HIV. A preliminary evaluation showed that workshop participants were more likely to believe that men and women should have equal rights and that wife-beating was wrong.

MAP evaluations can be found at <http://www.engenderhealth.org/our-work/gender/men-as-partners.php>

A sangha woman in Tehri, Uttar Pradesh recalls, "my husband told me to stay at home and look after the housework, instead of going and gossiping. If I was late in cooking his dinner after a meeting, I was beaten." Another woman in Andhra Pradesh recalls the taunts she and her friends faced in the village, "today you could not cook because of the meeting, tomorrow you will ask men to wash clothes. What do you think you are going to do, rule the country?"

Jandhyala, no date, p. 4.

'Some pioneering women jurists in remote Indian villages are barely literate, but they know the law often ignores women. Sitting in a circle on the floor, they dispense justice in cases of divorce, abandonment, violence, rape and dowry demands.'

(Sharma, 2000)

IMAGE

<http://genderviolence.lshtm.ac.uk/research-portfolio/intervention-with-micro-finance-for-aids-and-gender-equity-image-south-africa/>

The Intervention with Microfinance for AIDS & Gender Equity (IMAGE) program in Limpopo Province, South Africa integrates HIV prevention and violence training into its microfinance programs for rural women. The aim is to provide women with small loans to start a business and gain greater economic independence. When combined with training on HIV prevention, the programme empowers women to stand up to violence, stay safe from HIV, and changes the way they are perceived by their families and communities.

The IMAGE Foundation has 31,000 clients in Limpopo, and 12 years of experience. The twelve month training is structured in two phases. In phase 1, ten sessions cover gender and HIV, and phase 2 addresses community mobilisation (Watts, 2009, p. 24)

The programme has been evaluated, and both quantitative and qualitative findings indicate that economic empowerment of women can contribute to reductions in intimate partner violence (Kim et al, 2007).

I used to be one of those guys who were abusive. It was really difficult for me to come to terms with that. Actually, I asked to be excused from facilitating that because I feel really conflicted with that. I couldn't talk about it for two or three workshops. But I spoke about it with my other colleagues and I went through a healing process. A month later I could talk about it. I felt great because I could talk about my experiences openly, then help other people to talk about theirs.

(Peacock and Levack, 2004, p. 185)

PART THREE

Strategic issues regarding violence against women living with HIV

When we face problems or disagreement today, we have to arrive at solutions through dialogue. Dialogue is the only appropriate method. One-sided victory is no longer relevant. We must work to resolve conflicts in a spirit of reconciliation and always keep in mind the interests of others. We cannot destroy our neighbors! We cannot ignore their interests! Doing so would ultimately cause us to suffer. I therefore think that the concept of violence is now unsuitable. Non-violence is the suitable method.

— 1989 NOBEL PEACE LAUREATE THE DALAI LAMA

Violence against women and HIV/AIDS are often still seen as separate issues. Narrow understandings of what constitutes ‘evidence’ mean that the issue of violence against women living with HIV is not taken seriously or considered within the WHO Global Burden of Disease framework. The efforts of HIV positive women have increased awareness of their experiences of violence, but much remains to be done.

This section makes selected recommendations relating to advocacy, research, programming and policy on violence against women living with HIV.

7. ADVOCACY

Recommendations:

- Implementation of the recommendation of UNAIDS’s Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV, 2010 – 2014, for actions to ensure that ‘all forms of violence against women and girls are recognized as violations of human rights and are addressed in the context of HIV’ (UNAIDS, 2010, p. 12), and that HIV be included in the Secretary-General’s UniTE to End Violence Against Women campaign.
- Linking of efforts across sectors, governments, agencies, organizations and communities.
- Linking of prevention of violence against HIV positive women to care. This requires that primary, secondary and tertiary prevention should be integrated.
- Healthcare providers have an important role to play in addressing violence against women living with HIV, both through their behaviour and attitudes towards HIV positive women, and by increasing integration of HIV and VAW services. They should be encouraged to increase their understanding of the links between HIV and VAW through involvement in community discussions and by taking part in specific training on HIV and VAW linkages.

- Use of bottom up initiatives can contribute to creating a critical mass of change that will support policy and legal change. Community-based participatory learning approaches involving men and women creating more gender-equitable relationships, thereby decreasing violence.
- Strengthening communities is vital to ensuring that governments are held accountable.
- Stigma and discrimination experienced by women living with HIV should be recognised as violence against women.
- Mandatory testing of women in prisons and other detention centres and of migrants, sex workers and drug users is a form of violence against women. Testing in pregnancy can be experienced as an extreme act of violence by women found to be HIV positive. Other times and ways to promote testing must be found.
- Creation of institutional cultures of care, respect and support for HIV positive women, and in which institutions cross-reference each other (i.e. where an institution will cross-check with another before finalising decisions, in case their decisions will have unforeseen impacts of on HIV positive women).

8. RESEARCH

- Different approaches to building the evidence base must be considered. The lack of reliable data on violence against women living with HIV is not because the phenomenon is not well known to those working in the field, but due to the dominance of hierarchies of knowledge which privilege some kinds of 'evidence' over others.
- In order to deepen our understanding of what works for HIV positive women, more research is needed into multilayered causes of violence (HIV, gender, sex work, drug use...) and how these are being addressed at different levels.
- Research must be done in such a way as to strengthen communities. Extractive research should have no place in the response to violence against women living with HIV.
- Unsupported statements such as 'more women than men have access to ARVs' (WHO, 2010) are no longer acceptable. WHO and other bodies must acknowledge that treatment to prevent mother to child transmission should not be seen as equivalent to women having access to ARVs for their own health. There should also be acknowledgement of and further research on women being forced to share medication with violent and abusive partners.
- Research into violence against women living with HIV should take into account the following issues which have so far been sidelined in mainstream perspectives: violence, HIV and loss of child custody; the impact of seasonality and the hungry season on violence against women with HIV; the impact of HIV-related care responsibilities on violence against women; links between violence, HIV and mental health/depression.

- Research into the impact of development interventions on violence against women and HIV is vital. The recent focus on cash transfers has not sufficiently acknowledged the potential for such programmes to ‘reinforce convention divisions of labour and gender stereotypes’ if they are not carefully managed (Commission on the Status of Women, 2010, p. 4).

9. PROGRAMMING AND POLICY DEVELOPMENT

- The intersections between VAW and HIV need to be framed as based on unequal power relationships. Long term and short term measures are required, and both need to be specific to the context.
- Policies should be analysed in a holistic way. Policies such as criminalisation of HIV transmission, routine antenatal HIV testing, provider-initiated opt-out testing, treatment access, partner notification, and other policies, must be analysed using the lens of violence against women living with HIV. HIV programming must take into account violence against women living with HIV.
- Policies must be based on MIWA (meaningful involvement of women living with HIV/AIDS) in order to ensure that they promote well-being and supportive, enabling environments for HIV positive women. This should include support for HIV positive women’s networks, organisations and support groups.
- Strategic partnerships need to be in place, combining governmental and non-governmental initiatives to strengthen impact at different levels.
- In some countries, there are specific agencies for HIV, gender, drug use, but they are not working together. Multi-sectoral approaches to violence against women, HIV and other co-existing factors (drug use, sex work) are important to ensure a holistic approach to health. Integration of gender equality into HIV strategies and implementation and ensure that violence against women is part of HIV planning
- It is important that violence against women be addressed by working with men and women in sensitive ways. In situations where women experience violence, the consequences of not working sensitively, slowly, with a long-term view rather than focusing on short-term objectives, can be extremely serious.

‘The role of GBV as an impediment to SRH, however, has as yet received limited recognition in practice, in particular, at the programme implementation level . Violence against women fuels SRH problems — including unwanted pregnancies, unsafe abortions, fistulas, sexually transmitted infections and HIV — and causes their recurrence. Women in abusive relationships are prevented from negotiating condom use or using other contraceptives there is growing alarm concerning the links between sexual violence and HIV, especially among young women in high prevalence countries . And violence during pregnancy — an especially neglected form of abuse — has serious repercussions for both infant and maternal health outcomes.’

(UNFPA 2008, p. 13)

CONCLUSION

Violence is pervasive in society. Non-violence must be the response, not only within projects or programmes but in every sphere of life. As a general conclusion, we highlight the importance of promoting peace, gender equality, and non-violence as a way of relating and as a response to violence against women living with HIV.

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Especially the following articles:

- Alice Welbourn 'Into the firing line: placing young women and girls at greater risk'
- Marlow Valentine, 'Still forced to live on the margins of society: Western Cape End Hate Campaign'
- Marlise Richter, 'Criminalisation of sex work... Sex work, HIV and AIDS and the socio-legal context in South Africa'
- Jennifer Gatsi, 'Denying us the right to reproduce: Forced and coerced sterilisation of HIV positive women'
- American Civil Liberties Union (ACLU) and Human Rights Watch (HRW) (2010) *Sentenced to Stigma: Segregation of HIV-Positive Prisoners in Alabama and South Carolina*. [Online]. Available at: <http://www.hrw.org/en/reports/2010/04/14/sentenced-stigma-o> (Accessed: September 12, 2010).

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LIST OF ADDITIONAL RESOURCES ON VIOLENCE AGAINST HIV POSITIVE WOMEN

Series of recorded sessions

Recorded sessions produced as learning resources of the "Virtual Forum on Violence against Women Living with HIV" convened by Development Connections, the International Community of Women Living with HIV (ICW Global) and UN Women in November 2010:

- a. Fiona Hale (Salamander Trust) - Current definitions and data on types of violence, dimensions, social determinants and consequences of violence against women living with HIV. <https://sas.illuminate.com/p.jnlp?psid=2010-10-27.0746.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>
- b. MariJo Vazquez (Salamander Trust) - Projects and programmes addressing violence against women living with HIV. <https://sas.illuminate.com/p.jnlp?psid=2010-10-26.1123.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>
- c. Alice Welbourn (Salamander Trust) - Strategic issues regarding violence against women living with HIV for advocacy, research, programming and policy development. <https://sas.illuminate.com/p.jnlp?psid=2010-11-01.0617.M.2DD2F5468818ACF401D20DDBBA6353.vcr&sid=voffice>

Blog on violence against women living with HIV (DVCN)

Join this dialogue and share your perspectives on evidence, existing projects and programs, and the strategic issues for advocacy, research, programming and policy development on violence against women living with HIV. English: http://www.dvcn.org/blog_posts/view/5. Spanish: http://spanish.dvcn.org/blog_posts/view/7

Interviews

- a. Mazuba Haanyama—OSISA, South Africa. International Campaign "Non-negotiable: My body, my womb, my rights" on Forced Sterilisation of Women Living with HIV. <http://www.youtube.com/watch?v=o4DLxAaihdE&feature=related>

- b. Interview with Nizarandi Picasso (ICW Latina). Development Connections. November, 2007. http://www.dvcn.org/uploads/client_70/files/EntrevistaNizaPicassoVol1No31.pdf

Links

- a. UN Women. Web Portal on Gender and HIV/AIDS. <http://www.genderandaids.org>
- b. ICW resources. <http://www.icwglobal.org/en/resources.php>
- b. Sexual Violence Research Initiative: www.svri.org

Videos and TV spots

- a. Women with life - Produced by Intercambios <http://www.alianzaintercambios.org/videos.php?idioma=english>
- b. Public service announcements on HIV and VAW - UNIFEM, Art Center College of Design in Pasadena, California, and the Pan American Health Organization (PAHO). http://www.unifem.org/materials/item_detail.php?ProductID=31

References included in the recorded session by Alice Welbourn

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