Addressing violence against women and HIV/AIDS

What works?

World Health Organization

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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

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WHO Library Cataloguing-in-Publication Data

Addressing violence against women and HIV/AIDS: What works?

1.Domestic violence. 2.Battered women. 3.HIV infections - prevention and control. 4.Acquired immunodeficiency syndrome. 5.Risk reduction behavior. I.World Health Organization. II.UNAIDS.

ISBN 978 92 4 159986 3 (NLM classification: WC 503.6)

Printed by the WHO Document Production Services, Geneva, Switzerland.

Contents

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
aOR	adjusted odds ratio
aRR	adjusted risk ratio
CI	confidence interval
HIV	human immunodeficiency virus
HSV-2	herpes simplex virus type 2
IMAGE	Intervention with Microfinance for AIDS and Gender Equity (study)
IPV	intimate partner violence
NGO	nongovernmental organization
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission (of HIV)
PRC	post-rape care
RHR	Department of Reproductive Health and Research
RR	risk ratio
SAHAPS	South Africa HIV/AIDS Post-test Support Study
STI	sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VAW	violence against women
VCT	voluntary counselling and testing
WHO	World Health Organization

Acknowledgements

This report is based on a consultation organized by the Department of Reproductive Health and Research (RHR) of the World Health Organization (WHO), on behalf of the UNAIDS family in Geneva from October 27 to 29, 2009. The meeting was supported with funds from UNAIDS.

The WHO and UNAIDS would like to thank each of the meeting participants for sharing their expertise, experience and valuable work in creating interventions and programmes at the intersection of violence against women and HIV. This report was prepared by Kristin Dunkle of Emory University, Atlanta, Georgia, United States of America and Claudia García Moreno from WHO/RHR. Substantive contributions were made by Rachel Jewkes of the Medical Research Council, Pretoria, South Africa and Julia Kim of the United Nations Development Programme (UNDP). Valuable comments and input on the first draft of the report were provided by Aziza Ahmed, Nazneen Damji, Susana Fried, Camilla Gendola, Sofia Gruskin, Theresa Hwang, Suzanne Maman, Lori Michau, Judy Polsky, Anita Raj, Susan Settegren, Jay Silverman, Charlotte Watts and Alice Welbourn.

The report summarizes discussions held at the meeting and the resulting conclusions. It does not represent official WHO or UNAIDS policy.

Executive summary

From 27 to 29 October 2009, a working group of expert researchers, policy-makers, and practitioners met to review the current state of evidence and practice in developing and implementing interventions and strategies to address the intersections of violence against women (VAW) and human immunodeficiency virus (HIV). The meeting aimed to make policy and programmatic recommendations for national and international HIV/acquired immunodeficiency syndrome (AIDS) programmes and develop an agenda for future programme development, evaluation and research efforts. This report summarizes the presentations, discussions and recommendations from the meeting.

Over a decade of research from countries in different regions of the world documents an undeniable link between VAW and HIV infection. The relationship between VAW and HIV risk is complex, and involves multiple pathways, in which violence serves both as a driver of the epidemic, and at times a consequence of being HIV positive. Rape is one potential cause of direct infection with HIV through violence for some women. However, the primary burden of HIV risk from VAW and gender inequality arises through longer-acting indirect risk pathways. These involve both chronically abusive relationships where women are repeatedly exposed to the same perpetrator, as well as the long-term consequences of violence for women who have experienced prior, but not necessarily ongoing, exposure to violence (in childhood or as adults).

Addressing both VAW and gender inequality jointly in programmes will contribute to effective HIV prevention. Such synergistic linking forms an important element of effective combination prevention for HIV. Numerous studies have shown that individual choices and behaviours are embedded in many layers of social and community context, from marriages and extended families, to communities and countries. Effective HIV-prevention programmes must address key elements of the context that gives rise to HIV risk, in order to have lasting impact. Any long-term solution to VAW and/or HIV prevention therefore requires addressing the social context and the gender inequalities that form a core element of this context. Gender inequality can be addressed at different levels and through different approaches – the strongest synergy is often achieved by intervening on multiple levels simultaneously, using coordinated strategies that are mutually reinforcing.

While key principles and strategies for intervening to jointly address VAW and HIV are becoming clear, the evidence for what constitutes best practice is still emerging. One key purpose of the consultative meeting was to bring programme and policy experts and researchers together to review the current state of knowledge, develop recommendations grounded in evidence, and define a research agenda for improving future intervention efforts.

Current research on interventions to address VAW and HIV

The currently available intervention research at the intersection of VAW and HIV, reviewed at the meeting, covers the following areas:

- Community randomized controlled trials of interventions that address violence against women, gender norms, and HIV prevention through participatory approaches, and which treat incident HIV infection as a clearly stated a priori outcome of interest.
- Programmes that aim to reduce HIV risk among rape survivors as part of post-rape care (PRC), including provision of post-exposure prophylaxis (PEP).
- Programmes where reducing VAW and reducing HIV risk are regarded as joint outcomes of interest.

- Studies addressing the risk of VAW in the context of HIV counselling, testing and care, and projects evaluating incident VAW as a potential adverse or beneficial outcome of an HIV-prevention intervention.
- Programmes that aim to reduce HIV risk among survivors of VAW, through providing support with behaviour change and HIV risk reduction.
- Reports describing assessments of differential impact of HIV-prevention interventions by the gender-based violence status of participants, including both analyses that were planned a priori and post hoc analyses.
- Programmes that aim to reduce violence against female sex workers. It must be noted that adolescents constitute a large subpopulation among sex workers that is underrepresented within sex-worker networks and HIV-prevention efforts, and they deserve targeted prevention efforts.

Examples of many of these types of interventions were reviewed at the meeting and are summarized as case studies in this report. Key issues and lessons learned from them informed the conclusions and recommendations summarized below.

Conclusions and policy and practice recommendations

- Studies from around the globe confirm the links between VAW and HIV. These studies show that women living with HIV are more likely to have experienced violence and that woman who have experienced violence are more likely to have HIV.
- The relationship between VAW and HIV risk is complex, and involves multiple pathways. Violence against women places women at increased risk of HIV both through direct risk of infection and through creating an environment in which women are unable to adequately protect themselves from HIV.
- There is a growing body of well-evaluated, promising programmes that should inform our work on VAW and HIV prevention. These interventions, summarized in the report, fall into various categories, but generally address: gender-equality interventions, including those that seek to empower women economically and through gender-equality awareness, and those working with communities and/or men and boys to challenge gender norms; comprehensive post-rape care; those that address VAW in the context of HIV testing; and those focused on violence against sex workers. Lessons learned from these interventions, in the form of broad principles of action, should be shared broadly and scaled-up. Simultaneously, increased support is required for research into strategies for adaptation and implementation of proven programmes in new environments and differing conditions.
- Policies and programmes addressing gender inequality and gender-based violence will help achieve universal targets for HIV prevention, treatment and care. Investment in responses in these areas is an essential part of HIV programming.
- Long-term interventions that address structural factors, gender inequalities and harmful gender norms are essential if one is to reduce VAW and HIV; locally relevant ways of achieving gender and structural transformation need to be developed and evaluated. Some of the strategies reviewed here demonstrate that changes can be made within a project time frame. At the same time, there is also a need to move forward urgently to achieve shorter-term gains such as enhanced voluntary counselling and testing services and the provision of comprehensive post-rape care that addresses the psychological and physical health needs of sexual-violence survivors.
- A menu of actions addressing both long-term and short-term needs related to violence and

HIV has the potential to have an impact upon not only MDG 6 (HIV), but all the health-related MDGs, including the reduction of maternal mortality and achievement of universal access to reproductive health and rights. In addition, this approach is at the heart of MDG 3 (gender equality and empowerment of women) and MDG1 (reducing poverty).

- There is an urgent need for funding to support more programme evaluation and research on interventions, and for developing new methodologies for evaluating complex interventions in order to continue to develop the evidence on effective interventions to address both VAW and HIV prevention.

Recommendations for the United Nations

The following policy and practice recommendations emerged as a consensus from meeting participants:

- The United Nations (UN) should support and advocate with young women and men for active HIV prevention that specifically incorporates gender-based violence prevention and gender-equality perspectives.
- UN agencies should continue to support policy-makers to address gender inequality as a key driver of the HIV epidemic, as well as an important issue in its own right. Gender-equality initiatives should be integrated into national HIV strategies, policies and implementation mechanisms.
- The UN, in collaboration with other partners, should support the development of regional networks of organizations and practitioners, with a focus on supporting inclusion of gender equality and eliminating VAW as an integral part of HIV programming.

National strategic planning

- Implementing measures at all levels to promote gender equality and preventing as well as redressing VAW should be incorporated as important targets in national HIV strategies and plans.
- HIV prevention, treatment and care efforts should include an assessment of impact on VAW and gender inequality. Links between reducing poverty, increasing gender equality, reducing violence against women and girls and reducing HIV should be explicitly acknowledged and addressed in strategic plans for all relevant sectors.
- National strategic plans should explicitly recognize the community level as a key focal point of change.
- Existing approaches that have been shown to be effective or promising should be adapted, replicated and scaled up. A solid evaluation component must be included and is key to building up the evidence base in this field. Building on existing examples, other locally relevant interventions to address structural drivers must be encouraged and evaluated.
- Sustainable funding must be allocated for such programmes.

Programme design

- Programmes designed to reduce violence in the context of HIV prevention should consider the full range of diversity of persons experiencing and perpetrating gender-based violence.
- Integrating VAW into HIV programming should be informed by a human rights approach.

Post-rape care

- Access to quality, comprehensive post-rape care services including PEP should be ensured, according to WHO guidelines.
- Post-rape care should be implemented, based on the various existing evidence-based models appropriate to the setting, and with multisectoral linkages.

Sex work

- Programming must recognize that sex workers experience violence from a range of perpetrators, including clients, individuals such as brothel owners or other go-betweens who

control clients' access to sex workers or sex workers' access to clients (controllers) and law enforcement. Perpetrators also include long-term partners, relatives, neighbours and other members of the community.

- Programmes must be developed to address the high levels of violence and related HIV risk experienced by adolescents who sell sex.
- The programmatic response should not be limited to sex workers, but should include the full scope of those involved in sex work, VAW and HIV prevention, including the law enforcement, clients, partners, controllers and family. Interventions also need to address stigma and discrimination against sex workers in the broader community, in the media and in law and policy.

Monitoring and evaluation

- It is essential to ensure that programmes include a strong monitoring and evaluation component that can contribute to strengthening the evidence base for addressing the intersections of VAW and HIV/AIDS.
- It is important to monitor gender equality and reducing VAW incidence as positive process and outcome indicators related to reducing HIV risk.
- It is also important to monitor increased VAW incidence as a potential adverse outcome of HIV-related interventions.
- Reporting should be improved so that there is a systematic way of assessing the extent and progress or deterioration in type and level of VAW, specifically including violence against sex workers and other key populations.

Research agenda

Expanding the evidence base

- Development and evaluation of innovative new strategies that integrate VAW and HIV should be prioritized, with the goal of dual impact.
- Efficacy trials should be complemented by effectiveness trials.
- Evaluations of successful or promising interventions (e.g. IMAGE and Stepping Stones) should be replicated in other settings.
- New programmes should explore the effectiveness and added value of combining VAW/HIV prevention with microfinance or other poverty-reduction initiatives.
- Strategies and guidelines for effectively adapting proven interventions to new and different settings need to be better developed.
- Support should be given to methodological innovations for new evaluation strategies and new ways of demonstrating programme impact, especially for community-based and structural interventions.

Post-rape care

- Research to deepen understanding of and improve PEP adherence among survivors of sexual violence should be supported.
- Research to evaluate different models of psychological support for adult and child rape survivors should also be supported.
- New strategies for delivering post-rape care for children should be developed and evaluated.
- While maintaining a strong perspective that access to comprehensive post-rape care is an important human rights issue, the cost–effectiveness of various service-delivery models should be assessed, to inform advocacy for expanded roll-out and scale-up of programmes.

Research in clinical settings

Priorities include:

- research on the best strategies for integration of supported disclosure in different testing settings;

- research on ways of incorporating discussions of gender equality and violence into voluntary counselling and testing (VCT) and post-HIV test support for those who test HIV positive;
- research on ways of incorporating interventions to promote gender equitable norms of masculinity at the time of male circumcision;
- research on the implications of male circumcision for women, in accordance with the WHO recommendations on the impact of male circumcision on women.

Introduction

The links between violence against women (VAW) and human immunodeficiency virus (HIV) are undeniable, as is the promise and potential of joint prevention programming. Growing evidence now exists to affirm that directly addressing VAW and gender inequality as key programmatic components of HIV prevention has significant potential to make programmes more effective.

From 27 to 29 October 2009, a working group of expert researchers, policy-makers and practitioners met to review the current state of evidence and practice in developing and implementing interventions and strategies to address the intersections of VAW and HIV. (The agenda and list of participants are supplied in Annex 1.)

The meeting objectives were to:

- review the current level of evidence supporting different strategies that link VAW and HIV, and assess their relevance for programme development;
- make policy and programmatic recommendations for national and international HIV/acquired immunodeficiency syndrome (AIDS) programmes;
- develop an agenda for future programme development, evaluation and research efforts, including identifying effective methodological and logistical strategies for developing, testing and scaling-up "evidence-based" interventions.

This report summarizes some of the work shared, the discussions, and the conclusions and recommendations from the meeting.

Violence against women arises from and perpetuates gender inequality within societies. It increases women's risk of HIV and can also be a result of being HIV positive *(2)*. Research over the last decade from diverse cultural settings has conclusively established that women who experience VAW or high levels of gender inequality in their sexual relationships are at increased risk of HIV infection through a range of direct and indirect pathways *(3–7)*. Similarly, evidence shows that men who perpetrate or use violence are more likely to engage in sexual risk-taking behaviour, and thus are at increased risk of HIV – social norms for men surrounding multiple and concurrent partnerships, as well as sexual risk-taking and substance use, encourage behaviours that endanger men as well as their sexual partners *(8–13)*.

Gender is used to refer to ideas about characteristics of women and men that are socially constructed, while sex refers to anatomical and biological characteristics of people's bodies: male, female or intersex (possessing both male and female traits). Babies are generally labelled female or male at birth, but learn from social cues how to be girls and boys, and later women and men. Gender includes social ideas about sexuality, including sexual behaviour and sexual partners.

Gender analysis identifies, analyses and informs action to address inequalities that arise from the different social roles assigned to women and men, the unequal power relationships between them, and the consequences of these inequalities on their lives, their health and well-being. Gender analysis in HIV programming highlights how inequalities constrain women's ability to protect themselves from HIV, and to seek safe testing, care and support services. Gender analysis in HIV also highlights how the social construction of men's roles increases their own HIV risk, as well as the HIV risk for women.

(Adapted from *Integrating gender perspectives in the work of WHO: WHO gender policy* (*1*).)

HIV-prevention programmes must therefore address the interrelated problems of gender inequality and VAW in order to be effective – not only at preventing heterosexual transmission of HIV, but also at interrupting all interpersonal HIV transmission routes, including injection drug use, that are impacted by unequal and inequitable gender relations and VAW. In recognition of this, the Joint United Nations Programme on HIV/AIDS (UNAIDS) Outcome Framework for 2009–2011 includes "Stopping violence against women and girls" as one of nine priority areas in its action agenda.

The agenda for the expert meeting, "Addressing violence against women and HIV/AIDS: what works?" covered different types of VAW, different populations and different intervention settings and strategies. Topics covered included intimate partner violence (IPV), rape, sexual assault and gender inequalities, as well as the unique risks of violence and discrimination faced by sex workers and women who use substances. Settings and strategies discussed ranged from post-rape care (PRC) of individual survivors, to clinic-based programmes linked to disclosure, and from community mobilization efforts challenging gender inequality to national and international campaigns, work with boys and men and programmes addressing economic and other forms of empowerment of women. Strategies targeting adolescents, sexuality education and other school-based interventions, and those focused on reducing alcohol use, were briefly touched upon but not addressed in any depth in the meeting and are therefore not included in this report.

While the agenda covered an array of types of VAW and programme strategies, it was not intended to be all-inclusive. For example, other forms of gender-based and sexual violence are undoubtedly contributors to HIV risk, including violence in conflict settings or prisons, and against disabled women. The same is true for sexual violence directed against boys, and homophobic and transphobic violence directed against people perceived as violating social norms about sexual and gender self-expression. The evidence base surrounding effective strategies for intervening on the interface of these types of violence and HIV is still emerging, and should be evaluated and integrated into programmatic recommendations as it develops. The focus of the meeting and this report, however, is on the evidence for intervention strategies at the intersection of IPV, non-partner sexual violence against women/girls, and HIV.

The meeting moved beyond asking "Should we jointly address VAW and HIV?" to rather discuss "How best can we do so?". It opened by summarizing two commissioned reviews: a literature review of the evidence linking VAW and HIV *(14)* and a systematic review of intervention strategies at the intersection of violence and HIV *(15)*. This was followed by presentation of intervention case-studies and descriptions of work in progress. Presentations were grouped by focus of the intervention, and each session was followed by discussion. The final sessions focused on; (a) developing recommendations for policy and programmes; and (b) identifying areas for further research.

The UN defines *violence against women* as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

There are many forms of VAW. Some of these include sexual, physical, or emotional abuse by an intimate partner; physical or sexual abuse by family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers) and trafficking for forced labour or sex. Systematic sexual abuse in conflict situations is another form of VAW (*16*).

This report reviews the evidence on linkages and describes why addressing gender inequality and VAW through programming and interventions is essential for effective HIV prevention. It then summarizes findings from the review of published research into VAW and HIV intervention. The next section of the report covers interventions and work in progress presented at the meeting. The report concludes with collaboratively developed recommendations for implementation, adaptation, and roll-out of programmes. Finally, it identifies areas on which to build from existing knowledge.

Evidence for the links between violence against women and HIV

The published literature on VAW and HIV and a decade of research from countries in different global regions clearly document the undeniable link between VAW and HIV, with violence being both a risk factor for HIV and a consequence of being identified as having HIV. Cross-sectional research from Africa and India has consistently found that women who have experienced partner violence are more likely to be infected with HIV *(3–5, 17, 18)*. In Rwanda, women who had been sexually coerced by male partners were 89% more likely to be HIV positive (adjusted odds ratio [aOR][1]=1.89; 95% confidence interval [CI][2] 1.20–2.96) *(17, 18)*. In the United Republic of Tanzania, women seeking voluntary counselling and testing who had experienced violence were also more likely to be HIV positive (aOR=2.39; 95% CI 1.21–4.73); among women under 30 years, those who had experienced violence were about 10 times more likely to be HIV positive *(3)*. In South Africa, women seeking routine antenatal care who had experienced physical or sexual violence were 53% more likely to test HIV positive (aOR=1.53; 95% CI 1.10–2.04), and those experiencing high levels of gender power inequality in relationships were 56% more likely to test HIV positive (aOR=1.56; 95% CI 1.15–2.11) *(4)*. Similarly, in a study of over 28 000 married women in India, 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 (aOR=3.92; 95% CI 1.41–10.84) *(6)*. Additional research from India, analysing data from over 20 000 husband–wife dyads, confirmed that abused wives face increased HIV risk, based both on the greater likelihood of HIV infection among abusive husbands and elevated HIV transmission within abusive relationships *(7)*.

Emerging evidence from analysis of longitudinal data from young women in South Africa shows that women who have experienced IPV or high levels of gender inequality in their sexual relationships with men are at elevated risk of later acquiring HIV, with increasingly severe violence associated with increasing risk of new HIV infection *(19)*.

Gender inequality and VAW are integrally linked. Violence against women is an important consequence of gender inequality; VAW also serves to reinforce and reproduce gender inequality at both societal and relationship levels *(20)*. Qualitative research shows that the intersections of HIV, gender inequality and gender-based violence lie in the patriarchal nature of most societies, especially in ideals of masculinity that are predicated on control of women and valorize male strength and toughness *(20)*. These ideals readily translate into risky sexual behaviours, sexual predation and other acts of VAW *(20)*. They also help create expectations that men have an unquestionable right to have multiple partners and to control both their sexual encounters and women whom they partner. Emerging evidence from South Africa, India and the United States of America shows that men who perpetrate violence against women engage in higher levels of sexual risk behaviour *(8–12)*, and evidence from India and South Africa affirms that men who commit acts of violence against women are more likely to be HIV

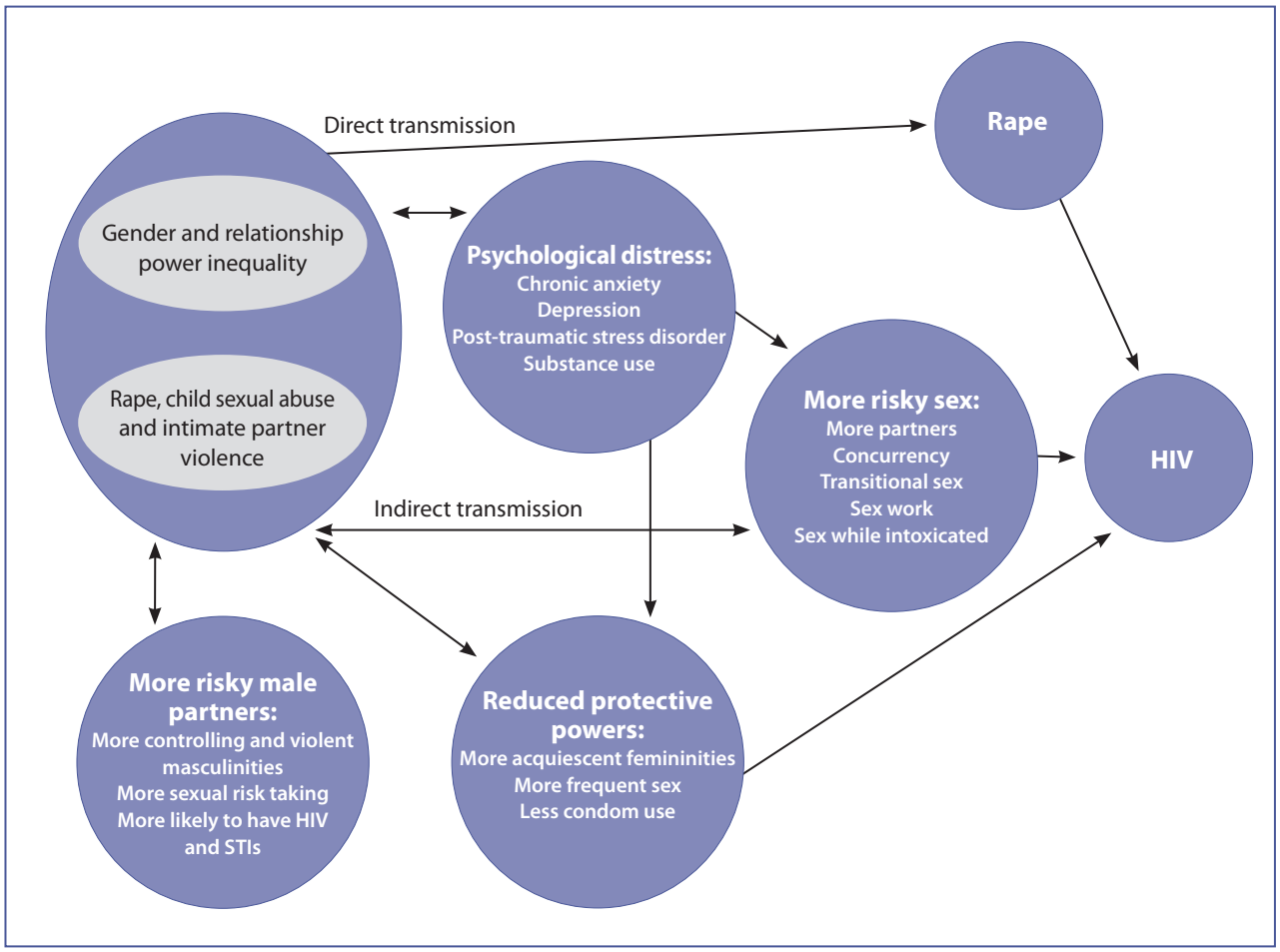
[1] The odds ratio is a statistical measure of the effect of a given factor, such as violence, on an outcome, such as HIV infection. For example, the "odds" of an event, like getting HIV infection, is the ratio of the chance of it occurring to the chance of it not occurring. The "odds ratio" then measures the *relative* chance that two different groups, for example women who have and have not experienced violence, will experience an outcome, such as becoming HIV positive. If the odds ratio is 1, the chance is 1:1, or the same. If the odds ratio is higher than 1, the chance is increased; for an odds ratio of 2.0, the chance is double. If the odds ratio is less than 1, the chance is decreased; so for an odds ratio of 0.5, the chance is half. An "*adjusted* odds ratio" is an odds ratio calculated in a way that takes the effect of other variables such as age, education, marital status, etc., into account.

[2] A confidence interval describes the likely range of the true value for any statistically estimated number.

infected *(7, 13)*. While individual women may resist male power, women are largely expected by society to accept men's behaviour. In many settings and situations, women are expected to be acquiescent, sexually ignorant and tolerant of men' sexual risk taking. Violence against women also 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 *(21–23)*.

The relationship between VAW and HIV risk is complex, and involves multiple pathways. Violence against women places women at increased risk of HIV both through direct risk of infection and through creating an environment in which women are unable to adequately protect themselves from HIV. As shown in Figure 1, rape is one important potential cause of direct infection with HIV through violence for some women. Yet even in settings with a high prevalence of HIV, the low risk of HIV transmission from a single sexual act *(24)*, even with accompanying injury, makes it unlikely that rape outside the context of an intimate partnership results in a substantial population-level proportion of HIV cases. While providing HIV post-exposure prophylaxis (PEP) for rape survivors is, without question, an important human rights issue, from a population perspective, the primary burden of HIV risk from VAW and gender inequality arises through longer-acting indirect risk pathways. The first of these involves chronically abusive relationships where women are repeatedly exposed to the same perpetrator. In most cultures, much rape and sexual

Figure 1. Links between violence against women and HIV. (STI: sexually transmitted infection)



assault occurs in the context of ongoing sexual relationships. Women's HIV risk is also increased in physically abusive or controlling relationships that may lack overt sexual violence. Indirect pathways for HIV risk include the long-term consequences of violence for women who have experienced prior, but not necessarily ongoing, exposure to violence (in childhood or as adults) and controlling practices.

In both developed and developing countries, past exposure to sexual and other forms of violence and controlling behaviour from a sexual partner is consistently associated with subsequent high-risk sexual behaviour in women who have survived violence, including multiple and concurrent sexual partnerships, increased numbers of overall partners, lower levels of condom use, increased substance use and sexual intercourse while intoxicated, and increased participation in transactional sexual intercourse as well as commercial sex work *(25–33)*. This increased risk is partly due to the psychological impact of violence, which can last many years after the violent acts, and can include post-traumatic stress disorder, other forms of anxiety, depression, dissociative symptoms and substance use – often as a form of self-medication *(29, 30, 34)*. Thus, the abuse feeds a vicious cycle, enhancing future risk of HIV infection as well as the risk of further abuse.

Early sexual activity, forced and/or in the marriages of minor-aged girls, heightens female risk for HIV. Physiologically, younger age increases biological susceptibility for HIV among females; disproportionate representation of adolescents among cases of sexually transmitted infection (STI) and victimization from sexual violence heighten this vulnerability *(35)*. In the context of conflict settings, sexual assault of women and girls is more common; as noted earlier in this review, such sexual violence can heighten female risk for HIV, although recent data indicate that conflict-related rapes may not be increasing HIV prevalence overall in regions affected by conflict *(36)*. In the context of economic inequities across neighbouring nations, regions or areas, sex trafficking is more likely and it disproportionately affects minor-aged girls *(37, 38)*. Further, those trafficked at younger ages are at substantially greater risk for HIV relative to those trafficked as adults, although all sex-trafficked females are at heightened risk for HIV relative to non-trafficked female sex workers, regardless of age *(39)*. Early age at marriage for girls, an issue that has been linked with intimate partner and other forms of gender-based violence *(40)*, also appears to be an HIV risk, at least in high-epidemic nations such as Kenya and Zambia *(40, 42)*.

Evidence for interventions to address violence against women and HIV

While key principles and strategies for intervening to jointly address VAW and HIV are becoming clear, the evidence for what constitutes best practice is still emerging. One key purpose of the consultative meeting was to bring programme and policy experts and researchers together to review the current state of knowledge, develop recommendations grounded in evidence, and define a research agenda for improving future intervention efforts.

A wide range of research on interventions and programmes that address the interface between VAW and HIV is emerging. A growing number of HIV research and programme evaluations are also beginning to examine the positive and negative impacts of their programmes on participants' experience of violence as an important outcome. These evaluation efforts have addressed multiple intervention levels including the individual, couples, groups, communities, health systems, prisons and national media. Preliminary findings from a systematic review of peer-reviewed publications that was commissioned for the meeting found that the existing literature covers six major types of research:

1. Community randomized controlled trials of interventions that address violence against women, gender norms, and HIV prevention through participatory approaches, and that treat incident HIV infection as a clearly stated a priori outcome of interest

Only two such trials have been completed, Stepping Stones *(43)* and IMAGE (Intervention with Microfinance for AIDS and Gender Equity) *(44)*. Neither demonstrated an impact on new HIV infections, but both showed impact on at least one measure of VAW. Stepping Stones also showed a reduction in new herpes simplex virus type 2 (HSV-2) infections among participants – it is to date the only behavioural intervention in Africa that has been shown in a randomized controlled trial to impact on a biological outcome.

Both Stepping Stones and IMAGE were reviewed in detail at the meeting and are presented in the next section as case-studies.

2. Programmes that aim to reduce HIV risk among rape survivors as part of post-rape care, including provision of post-exposure prophylaxis

Providing PEP to rape survivors is an unquestionably important human rights issue, but equally important is providing PEP in a context that offers comprehensive support to rape survivors. Evidence shows that PEP delivered outside comprehensive post-rape care is often ineffective due to lack of adherence *(45–52)*. Comprehensive post-rape care requires integrated efforts that address the full range of health, psychosocial support, and policing/justice needs of rape survivors. In addition to PEP for HIV and other STIs, health needs of survivors include emergency contraception and assessment and treatment of injuries. There is also the opportunity to collect and document forensic evidence to support criminal prosecution of the perpetrator. Psychosocial support needs 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. Policing and justice needs include ensuring the safety of the rape survivor, statement-taking, proper handling of forensic and other evidence, thorough investigation of crime scenes and prosecution of perpetrators. Providing comprehensive services to rape survivors not only serves their health needs and their human rights, but also creates a supportive context for adherence to PEP and effective post-rape HIV prevention.

Establishing systems to provide appropriate post-rape care, including PEP, is an excellent case-study in integrating policies and services across sectors. There is solid evidence that comprehensive post-rape care can be effectively offered in resource-poor settings *(53–56)*. Models for providing care range from stand-alone "one stop shops", which include all needed services and personnel in one location but are expensive to operate and only appropriate when a high client load is assured, to integrated services offered within hospitals of other health facilities. These are generally lower cost to operate and can be implemented in facilities without a high client load, but require a larger investment in training personnel at start-up and increased efforts to ensure consistent quality of service. While the evidence base is still emerging, some preliminary reports do show improvements in PEP completion through integrated services.

The Liverpool Voluntary Counselling and Testing (VCT) case-study describes an integrated post-rape care service in Kenya.

3. Programmes where reducing violence against women and reducing HIV risk are regarded as joint outcomes of interest

A number of interventions and programmes have attempted to jointly address the risk of gender-based violence and HIV *(57–66)*. Interventions evaluated have ranged from individual counselling protocols *(57)* to small-group interventions with women *(58, 63, 64)* or men *(60, 61)*, to community programmes *(64)*, to multipronged national media and policy advocacy campaigns *(67, 68)*. The effectiveness of such interventions has ranged depending on strategy, but the expanding evidence base is encouraging.

A number of the case-studies included here describe such interventions, including the adaptation of Soul City for Mozambique, the One Man Can campaign in South Africa and Programme H.

4. Studies addressing the risk of violence against women in the context of HIV counselling, testing and care, and projects evaluating incident violence against women as a potential adverse or beneficial outcome of an HIV-prevention intervention

A small number of programmes have explored the potential for increased risk of VAW as a potential adverse outcome of an HIV-prevention policy or programme. Published evaluations include services for prevention of mother-to-child transmission (PMTCT) in Zimbabwe *(69)* and Zambia *(70)*, partner notification in New Orleans *(71)*, home-based antiretroviral care in Uganda *(72)*, and the introduction of condoms into a prison system in Australia *(73)*. None of these published studies showed an adverse impact, but it is unknown to what extent this may be influenced by publication bias.

A few additional behavioural HIV-prevention trials in the United States have also explored reductions in VAW among trial participants, and found that the small-group or counselling programme under study did indeed lead to a decrease in VAW among participants *(74, 75)*. Again, such findings may be subject to publication bias.

The case-studies here include the South Africa HIV/AIDS Post-test Support Study, which is exploring strategies for reducing the risk of violence associated with HIV testing of women seeking antenatal care.

5. Programmes that aim to reduce HIV risk among survivors of violence against women through providing support with behaviour change and HIV risk reduction

A small handful of randomized controlled trials and quasi-experimental studies conducted in major cities in the United States have explored the potential impact of small-group interventions or structured individual therapy for reducing HIV risk among survivors of childhood sexual abuse

or other types of gender-based violence. Half of these studies targeted HIV-negative survivors *(76–78)*, and half HIV-positive survivors *(79–83)*. While most programmes showed at least some reduction in risk behaviour or improvements in mental health in the interventions compared to controls, there are few data available yet to assess the applicability of these intervention strategies in other settings or contexts, particularly in developing countries.

6. Reports describing assessments of the differential impact of HIV-prevention interventions by the violence status of participants, including both analyses that were planned a priori and post hoc analyses

Another handful of HIV behavioural prevention trials from the United States have published analyses specifically exploring the impact of the intervention on trial participants who were survivors of partner violence or sexual violence *(84–87)*. Findings from these analyses have been mixed and seem to depend on the type of intervention under study. This is a potentially important area for further research, or for additional analyses of data from existing studies, as we seek to generate evidence of the best strategies for reducing HIV risk among women survivors of violence.

Strengths and limitations of the current evidence

The two large-scale cluster randomized controlled trials of community-level and structural interventions that jointly address VAW and HIV, IMAGE and Stepping Stones, have both shown enormous promise. While the traditional biomedical "gold standard" of double-blinded placebo-controlled trials is both impractical and inappropriate for evaluating these types of large-scale interventions, the community randomization approach used offers strong confidence in trial findings, and both strategies show promise from which to build future programmes.

A range of evidence also supports the idea that both one-stop and integrated care models can effectively offer comprehensive post-rape care in resource-poor settings, and that such comprehensive care can improve adherence to PEP. There is also evidence to support attention to VAW in counselling, testing and HIV care programmes. There is strong support for the premise that violence and fear of violence can impact on post-test outcomes for HIV-positive women, and that programmes – especially mandatory and opt-out testing programmes – need to monitor these impacts.

A range of other individual-level, small-group, clinic-based, community and media interventions and the intersection of VAW and HIV show great promise, but additional evidence is needed. The current evidence base suffers from a lack of geographical and cultural diversity, with the majority of existing research either based in the United States or supported by United States institutions. Within the developing world, research from South Africa is predominant, with relatively few studies from other parts of Africa, and limited representation of intervention research from other regions. Little published work evaluates policy-level or health-systems interventions, and a considerable body of evidence is confined to the informal grey literature where it is difficult to access and synthesize.

While much remains to be learned, current evidence is more than adequate to guide policy, programmes and interventions in beginning to tackle joint action on VAW and HIV, and also to serve as a base from which future strategies can be developed. Future work on VAW and HIV should be guided by what is currently known. However, ongoing efforts to comprehensively evaluate and disseminate findings from new programmes will be essential to building the evidence base even further, and to improving global efforts to tackle the joint epidemics of VAW and HIV.

Case-studies

The following diverse case-studies, drawn from examples presented at the meeting, show how the joint VAW and HIV programming and strategies have been approached in different contexts – across global regions and types of HIV epidemics, and in a range of cultures. Because the evidence base on this issue is still emerging, case-study projects have different levels of evaluation. As noted above, some programmes lend themselves to evaluation in community randomized controlled trials, and results of those trials are available (or in progress). Other trials are still preliminary, or in progress. Some programmes, such as media campaigns, require different evaluation strategies. We have focused on presenting some key examples of the best programmes currently available.

These case-studies thus represent both current evidence-based good practice and promising new ideas with emerging evaluation.

Addressing gender equality, violence against women and HIV through community engagement and women's empowerment

Engaging communities in critical reflection and dialogue to transform gender norms: Stepping Stones

Stepping Stones is a community-development intervention that aims to improve sexual health through building better, more gender-equitable relationships. Stepping Stones was developed by Alice Welbourn in 1995 and is delivered through a series of small-group, participatory learning activities based on adult education theory, Freirian models of critical reflection, the use of theatre and techniques from assertiveness training. Stepping Stones works by eliciting and building on the existing knowledge of participants, and encourages them to reflect on the context of their lives. Sessions are ideally delivered to four peer groups, each of one sex and a similar age, in groups of around 20 participants; the four separate older and younger men's and women's groups can be brought together in peer-group meetings for dialogue. Stepping Stones has been adapted for use in over 40 different countries, and translated into at least 13 languages. Most versions involve at least 50 hours of intervention over 10–12 weeks, delivered in at least 15 sessions (see www.steppingstonesfeedback.org for further details). *(111)*

The long-term impact of the Stepping Stones approach on disease incidence and behavioural outcomes was evaluated in a randomized, controlled effectiveness trial of the second-edition, South African adaptation. This cluster randomized trial was carried out in 70 villages (35 intervention and 35 control) in the Eastern Cape province of South Africa *(43, 88)*. Each village cluster recruited two peer groups of approximately 20 male and 20 female youth participants, aged 15–26 years. While this adaptation of Stepping Stones showed no statistical impact on HIV incidence, it was associated with a 33% reduction in new HSV-2 infections among all (male and female combined) intervention participants compared to the controls (risk ratio [RR] 0.67; 95% CI 0.46–0.97). Among the young men, Stepping Stones reduced reported perpetration of IPV across two years of follow-up, where perpetration was defined as more than one act of physical or sexual violence towards an intimate partner. At 12 months, there was a 27% reduction in reported perpetration that was marginally statistically significant[3]; this increased to a 38% reduction that was statistically significant at 24 months[4]. The study also demonstrated significant reductions in male participants' engagement in transactional sex[5] and problem drinking at 12 months[6].

[3] Adjusted risk ratio (aRR)=0.73; 95% CI 0.50 to 1.06; *P*=0.10.

[4] aRR=0.62; 95% CI 0.38 to 1.01; *P*=0.05.

[5] aRR=0.39; 95% CI 0.17 to 0.92; *P*=0.03.

[6] aRR=0.68; 95% CI 0.49 to 0.94; *P*=0.02.

Stepping Stones, with its focus on community dialogue and building gender-equitable relationships, is the only behavioural intervention in Africa that has been shown in a randomized controlled trial to impact on a biological outcome. It is also the only intervention with men outside North America to show a decrease on reported male perpetration of violence. There is supportive evidence regarding the impact of Stepping Stones on male perpetration from evaluations in other settings *(89, 90)*.

Combining gender and HIV training with microfinance: comprehensive women's empowerment through IMAGE

The IMAGE study tested the effectiveness of a multifaceted, multilevel structural intervention in reducing VAW and HIV in rural South African communities. IMAGE simultaneously targeted poverty and economic inequalities and gender inequalities. It offered microfinance loans administered by the Small Enterprise Foundation to older women in the intervention communities, and paired the loans with a year-long participatory gender-training programme *Sisters for Life*. Programme participation was mandatory for women who received loans, and began with six months of a structured participatory group curriculum, followed by a six-month community-mobilization phase in which natural leaders selected from among the participants led the development of village action plans around VAW and HIV.

IMAGE was initially evaluated in a community randomized controlled trial conducted in eight rural communities in the Limpopo province. Programme impact was assessed for three cohorts: direct programme participants and matched controls (cohort one), randomly selected household co-residents aged 14–35 years who lived with programme participants or matched controls (cohort two), and randomly selected members of the intervention communities (cohort three). Primary outcomes were experience of IPV in the past 12 months by a spouse or other sexual intimate (cohort one), unprotected sexual intercourse at last occurrence with a non-spousal partner in the past 12 months (cohorts two and three) and HIV incidence (cohort three). Secondary outcomes included a range of measures of economic well-being, social capital, gender equality, HIV awareness and sexual behaviour.

In outcomes assessed at 24 months post-baseline, experience of IPV was reduced by 55% among the direct programme participants (cohort one: aRR 0.45; 95% CI 0.23–0.91). The intervention did not impact the rate of unprotected sexual intercourse with a non-spousal partner in cohorts two or three, nor did it impact HIV incidence in cohort three. However, among the secondary outcomes assessed for the direct programme participants in cohort one, IMAGE showed an impact on the estimated value of selected household assets and communication with household members about sexual matters in the past 12 months. Subsequent post hoc analyses of approximately 220 cohort one participants aged 14–35 years at baseline (n=187 [85%] with follow-up data) suggested that among this younger subgroup, the programme positively impacted levels of HIV-related communication and uptake of voluntary counselling and testing. These secondary analyses also suggest that young intervention participants were less likely than young control participants to have had unprotected sex at last intercourse with a non-spousal partner in the past 12 months (aRR 0.76; 95% CI 0.60–0.96); this finding was based on data from 51 intervention and 45 control participants who reported intercourse with a non-spousal partner in the 12 months before the follow-up assessment.

When the impact of IMAGE was subsequently compared to the impact of microfinance without gender training and support for collective action, it was found that both the IMAGE model and microfinance alone improved household economic indicators. However, the combined intervention strategy used in IMAGE showed a trend in improvement among participants in measures of personal empowerment, reduced

HIV risk behaviour, reduced tolerance for IPV and increased skills in collective action when compared to microfinance without gender training *(91)*.

The IMAGE project is an important example of a combined health/development intervention model that shows that it is possible to successfully address structural drivers of HIV, including economic and gender inequalities and VAW, as part of HIV prevention. Furthermore it demonstrated that changes can be made within a project time frame.

Supporting and encouraging community activism: SASA! supports awareness and transformation of gender and power dynamics in Uganda (trial in progress)[7]

SASA! is a community-mobilization approach developed by Raising Voices in Uganda. SASA! arose from a recognized need for community interventions to address VAW and HIV programming through focusing on gender power imbalance as a root issue, and also from a need to support nongovernmental organizations (NGOs) that typically focus on only one of the pandemics (e.g. VAW or HIV) to work on the linkage through sustainable and systematic primary prevention programming.

Like IMAGE, SASA! is grounded in the socioecological model and works simultaneously across multiple levels of influence. SASA! also uses the "Stages of Change" model *(92)*, scaled-up to the phases of community mobilization, rather than individual-level change. SASA! encourages participants and communities to reflect on gender and power through explicitly exploring different dimensions of power. SASA!, which means "now" in Kiswahili, is also an acronym that stands for:

- **S**tart – maps onto the "precontemplation" stage of change[8] and cultivates knowledge and awareness of the idea of "power within";
- **A**wareness – relates to the "contemplation" stage of change; it extends knowledge and works to transform attitudes by critically evaluating how men's "power over" women and the community's silence about it drives VAW and HIV risk;
- **S**upport – is the stage of "preparing for action"; it encourages community members to join their "power with" others by reaching out to women affected by VAW and HIV, women and men trying to balance power in their relationships, and activists speaking out against VAW;
- **A**ction – focuses not just on the "action" stage of change but also on "maintenance"; it focuses on the "power to" take action against violence and enact new policies and practices to sustain positive change.

Activities reach out to all levels in the community (women, men, cultural and religious leaders, local officials, police, health-care providers etc.), to bring about changes in social norms through local activism, media, use of communication materials and training, and advocacy. All phases support NGOs to assess progress and evaluate impact in longer-term prevention with simple programme-monitoring tools.

SASA! is currently being evaluated by a community randomized controlled trial in Uganda, in a design similar to the IMAGE study, with four intervention and four control communities. The primary outcome to be assessed will be experience in the past year of physical and/or sexual violence by an intimate partner among ever-partnered women. Results are expected in 2012.

RHANI Wives: an intervention for married women in India

The RHANI Wives intervention study is a pilot project developed to address growing research documenting that those forming the largest proportion of HIV-infected women in India are monogamous wives, and that the wives at greatest risk for HIV at a national level are those reporting

[7] (http://www.raisingvoices.org/sasa/index.php)

[8] The "precontemplation" phase of the "stages of change" describes the time before a person or community has had an opportunity to recognize that there might be a problem that could be solved by behaviour change, and so has not "contemplated" changing or doing anything differently.

violence from husbands *(6)*. Further, husbands more likely to engage in both intimate partner violence (IPV) perpetration and extramarital sexual intercourse (most commonly with a female sex worker) are more likely to use alcohol frequently and to consume high volumes *(93)*. With recognition that many monogamous wives do not know of their husbands' extramarital sexual activities but are aware of their spousal IPV perpetration and problem or risky alcohol use, RHANI Wives targets wives residing in a high-HIV-prevalence locale and reporting IPV perpetration by their husband, or his heavy/risky alcohol use. There are indications that such husbands are less likely to participate in HIV-prevention efforts, prioritizing the need to intervene directly with these women.

RHANI Wives is an adaptation of a US HIV intervention, HIV-IP, a group intervention that documented significant HIV risk reduction among low-income urban Latinas in steady relationships *(94)* Similar to HIV-IP, RHANI Wives focuses on gender empowerment (including economic empowerment), HIV/STI risk reduction, and healthy relationships and relationship communication. It is being adapted to the Indian context on the basis of formative research and local input and developed as a 6-week multilevel intervention which includes:

- four individual sessions for wives focused on individual risk in the marital relationship and family, gendered counselling and problem-solving to reduce this risk, and support for local linkage to care to address issues of marital violence, husband's alcohol use and HIV/STI;
- two group sessions to build social support among local women contending with facing similar marital risks (i.e. HIV/STI, husband's alcohol use, IPV) and to build skills both in marital communication and for accessing local support services;
- linkage to local bank services for 6 weeks of financial education and, for those who meet the criteria, microfinance opportunities

Currently, the RHANI Wives intervention is being tested via a cluster randomized controlled trial with 300 women recruited from the Bhandup area of Mumbai, India. Clusters (n=12 clusters) chosen for this study are those with close proximity to red light areas (i.e. sex-worker venues) and those that have high STI/HIV rates but no HIV programme for at-risk wives. Intervention participants will be compared with control participants via survey assessments at baseline, post-test (6 weeks post-baseline), and 3-month follow-up (4.5 months post-baseline), as well as STI tests at baseline and 3-month follow-up. The evaluation is designed to assess intervention impact on sexual communication in marriage, marital condom use and incident STI. The RHANI Wives project involves a collaboration among academics, Indian NGOs and the Indian government to ensure the RHANI Wives intervention can be scaled-up, replicated and sustained, should it prove effective.

Service-based programmes

Post-exposure prophylaxis in the context of comprehensive post-rape care: Liverpool VCT [9]

Liverpool VCT in Kenya offers a case-study in the development, implementation, evaluation and scale-up of comprehensive post-rape care services. An initial diagnosis phase of operational research revealed that the state of post-rape care services in the community was characterized by poor community understanding of the boundaries between forced, coercive and consensual sexual intercourse; no regulatory framework, policies or standard documentation systems; inconsistent service delivery of both medical and psychosocial support interventions; and limited human and technical capacity.

In response, the programme developed and piloted a standard of care for rape survivors in three diverse district hospitals with VCT facilities. The standards

[9] (http://www.liverpoolvct.org/)

included protocols for physical examinations, legal documentation, clinical management and counselling; client flow pathways and job aides; and a post-rape carepackage including essential drugs (PEP, emergency contraception and STI treatment) and an evidence-collection kit. The standard also introduced a chain of custody for evidence, and standard data-collection and monitoring tools. In the initial evaluation phase, 84% of 784 survivors seen in three pilot sites arrived within the 72 hour window for receipt of PEP; 99% of those who were eligible received drugs. Notably, survivors who received initial trauma and HIV counselling were more likely to complete HIV PEP medication.

These services have since been scaled-up to create integrated post-rape care within HIV services in government facilities. The comprehensive package offered includes long-term psychosocial care, HIV pre- and post-test counselling, PEP-adherence counselling and preparation for interface with the criminal justice system. One important element in advocating for scale-up was a study to estimate expected costs for scaling-up the services within existing policy frameworks and standards. These estimates provided the basis for discussions with the Ministry of Finance and Planning to advocate for funding for scale-up. Generating cost and benefit analyses thus proved to be an important tool for approaching policy-makers to allocate funding for roll-out of the intervention.

Addressing violence in the context of antenatal care: the South Africa HIV/AIDS Post-test Support Study (SAHAPS)

The South Africa HIV/AIDS Post-test Support Study arose from the observation that some women experience violence and other negative social outcomes after HIV testing, and that fear of violence can be a major barrier to disclosure. Barriers to disclosure, as well as poor outcomes, are worse for women who test in pregnancy *(94)*. In response, SAHAPS is testing an expanded model for antenatal VCT care, in which women receive HIV counselling and testing integrated with clinical care for pregnancy and delivered by the same midwives, and additional post-test support in the form of counselling, support groups and legal counsel.

In this model, the first antenatal visit includes a video that raises awareness of decisions women will make regarding PMTCT, disclosure, infant feeding and partner testing. Through example stories, the video normalizes fear of violence and negative outcomes from disclosure, and discusses the benefits of immediate and delayed disclosure. This message and support is reinforced for individual women in post-test counselling, where counsellors ask all women five preset screening questions related to violence and disclosure. Depending on responses, the counsellors may support disclosure, or may encourage women to delay disclosure until safety can be ensured. Disclosure is then revisited at the 6- and 10-week counselling sessions postpartum. The 6- and 10-week counselling sessions also address infant feeding, partner testing, family planning, risk reduction and legal support. Legal rights are also introduced to women through outreach in the waiting room. Case-studies discuss rights related to violence prevention and response, child maintenance, custody, accessing pension funds of a deceased spouse and development of wills. Women who indicate a need are referred to a lawyer who is on site at clinic 2 days per week.

This enhanced intervention is being evaluated through a randomized controlled trial with 1500 women seeking antenatal care. Half will receive standard care, and half the enhanced intervention. The enhanced care model will be evaluated for potential impact on:

- sexual risk, including new STI (trichomona, gonorrhoea and *Chlamydia*), consistent and correct condom use, and partner uptake of HIV VCT;

- factors that affect mother-to-child transmission of HIV, including acceptance of HIV VCT, acceptance of antiretroviral drugs, adherence to infant feeding guidelines and family planning use;
- psychosocial outcomes, including perceived social support, emotional distress, and partner violence.

A simultaneous cost–effectiveness analysis will provide data to inform scale-up, should the enhanced intervention prove effective. Results from the trial are expected in 2011.

Addressing violence against key populations including female sex workers and women who use drugs

Avahan case-study: multilevel intervention to prevent violence and HIV among sex workers in Karnataka, India (Karnataka Health Promotion Trust)

Sex work in India largely lacks social and moral sanction and is perceived as illegal. (Some aspects of it may actually be criminalized.) Sex workers are harassed, stigmatized and disempowered; violence is a key manifestation of this stigma and discrimination. These experiences constitute important barriers that can prevent sex workers from accessing services and information. Preliminary survey evaluations of violence and sexual risks among female sex workers found that between 11% and 26% had been beaten or raped in the past year, with 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 *(96)*.

To address these problems, an intervention was designed and implemented at three levels: with sex workers as the primary stakeholders; with police, lawyers and media as secondary stakeholders; and finally through advocacy to transform the policy environment. Direct work with sex workers involved supporting them in developing an understanding of gender, sex work, violence and rights, building self-esteem and collective identity, and establishing a crisis-management system including counselling, medical and legal support. Work with secondary stakeholders included sensitization efforts with police, lawyers, media and civic groups. Work at the structural level included documentation of violence and advocacy with the district AIDS committee, police and elected representatives. Results of the project included a reduction in police violence against female sex workers, an increase in reporting of non-police violence (indicating increasing acknowledgement of other types of violence), and an increase of positive media coverage of sex workers. The crisis team was able to respond to 98% of reported cases within 24 hours. Additional evaluation work is ongoing.

Important conclusions arising from this project include the insight that in HIV prevention with sex workers, providing condoms and STI services is not enough. Addressing violence is a priority for sex workers and should be an integral part of prevention programmes and strategies. This should be addressed at multiple levels with multiple stakeholders.

Protirodh: CARE supporting sex workers in Bangladesh through solidarity, learning, networking, services and advocacy

In Bangladesh, CARE's programmes with sex workers on VAW and HIV grew out of its previous HIV programming. Similar to the project in India, CARE's Protirodh project in Bangladesh arose in part from an assessment showing that 94% of sex workers had experienced violence from a range of perpetrators including clients, gatekeepers, police, main partners and neighbours. The programme combines building solidarity and learning among sex workers with networking,

services and advocacy. It works with 7500 brothel-based and street-based sex workers to build skills in finance, advocacy, leadership and responding to violence and solidarity through support and self-help groups. The programme also supports an iterative cycle of learning and reflection on the power inequities that are the root of social exclusion, discrimination and denial of human rights. This work is supported by contextual and structural interventions to build a strategic network of support including: 105 committees of trained sex workers who identify cases of violence and provide survivors with counselling and referrals to other services; 62 community watchdog committees of shop owners, rickshaw pullers and guards, who alert women to violence and help to raise public awareness around violence; and seven support groups of health professionals, journalists, police and NGOs to ensure appropriate community-based legal aid, counselling and health care. The project also works to increase sex workers' engagement in advocacy at district and national levels, and connect them with national networks of human rights organizations. This has led to a draft bill on domestic violence to address the lack of its recognition as an offence.

Adolescents who sell sex – issues of inclusion

Studies have indicated that the median age of entry into sex work is approximately 16 years *(97, 98)*. Young women in sex work have been found to face the highest levels of violence within sex work, violence and coercion to enter sex work, and HIV risk and infection *(38)*. However, those under the age of 18 years are rarely included in either violence-prevention or HIV-prevention efforts *(99)*. Identifying and recruiting minors who are in sex work may be hindered by current sampling methods involving those who, for both legal and profit-related concerns, may wish to conceal the existence of these vulnerable individuals. Exclusion of adolescents is probably a major barrier to the impact of sex-work-based interventions; thus, development of new approaches to identifying and assisting this high-risk subpopulation should be prioritized.

HIV prevention for drug-involved women

Adaptations of Project Connect[10]

Project Connect is a relationship-based HIV risk-reduction intervention that can be delivered to couples or to women alone. It was developed using a community-based participatory approach and is delivered to either women or couples in six two-hour-long private sessions by trained social workers. Content is based on the ecological perspective and the AIDS risk-reduction model. The sessions highlight how relationship dynamics are affected by gender roles and how social supports can help maintain safer sexual behaviour. The intervention delivered to a woman alone is identical in content and session format to the couples' intervention.

The primary target population for the intervention was originally developed and evaluated in New York City with women with primary intimate partners known to be at risk for HIV (has other partners, known to use injecting drugs, recent STI diagnosis). In this initial evaluation, both the couples' and woman-alone version of the intervention each significantly increased the proportion of protected vaginal sexual acts; no significant differences were reported between the effects of the two modes of intervention delivery *(100–102)*. A later adaptation of Project Connect focused on drug-involved couples using a combination of empowerment and self-efficacy building strategies to help couples overcome resistance to risk-reduction behaviour. This version is currently being adapted for use and evaluation in Kazakhstan.

Lessons learned through developing and adapting Project Connect include the need to include safety planning for women experiencing violence as an

[10] (http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/project-connect.htm)

integral part of assessment and intervention, and the need to ensure that drug-using women have access to services for IPV (for example, in many settings, drug-using women are denied access to shelters). Finally, HIV-prevention messages need to help women assess the level of danger in their partner's reactions to a request for condom use or a refusal to have sex, and also to disclosure of HIV-positive serostatus or STI diagnosis. Interventions should help women plan disclosure or partner notification and understand how to safely undertake new prevention options in their relationships

Mass media

Taking communication for social change to a new context: Mozambique as a case-study for adapting Soul City

The Soul City Institute for Health and Development Communication is a NGO, originally based in South Africa, which focuses on community and social change through an "edutainment" model that involves the creation of deeply engaging and entertaining media presentations that also educate the audience. Soul City's multifaceted mass media programmes focus on health and social change, and include work on the interface between gender, VAW and HIV, among other issues.

The Soul City Institute for Health and Development Communication offers a model for international roll-out of communication for social change. The emphasis in the roll-out is on building local capacity for effective social change communication. To that end, rather than set up new Soul City offices, the programme recruits independent local NGOs and supports them with training and resources to build a sustainable, self-reliant and locally branded communication platform. Capacity-building efforts include training in edutainment methodology and social mobilization, training in media-specific technical skills, mentorship, organizational development, fund development and exchange visits with other partners in the region. The country partners in turn bring local legitimacy; understanding of the social, political and cultural context; and access and language skills. The advantage of the Soul City model over models in which international NGOs run local offices include real capacity-building, and culturally astute partners who can devise local solutions to local problems. Challenges include the potential for divided loyalties, issues of brand association and responsibility for impact, and building and retaining adequate local skills.

All Soul-City-affiliated programmes focus on communication for social change, a newer approach that draws on the social-ecological model and moves the focus of social change away from focus on individual behaviour to social norms, culture and creating a supportive environment. The programmes draw on "edutainment" methodology and rely on mass media television drama, radio dramas and print. Edutainment is the "art of integrating social messages into popular and high-quality entertainment media based on a thorough research process" *(103)*. Drama is a powerful means to educate, inform and influence social change because it can draw mass audiences, and move people emotionally through identification with characters. Drama allows for complex messages about individuals in context, as characters face complex choices.

Development of a coordinated mass media programme in a new country such as Mozambique begins with formative research including literature review and qualitative audience research. This informs design of an inclusive message to be implemented in each media component. Scripts and materials are pretested before being moved into production. In Mozambique, topics covered included VAW, HIV prevention including from mother to child, life skills and tuberculosis. Materials included a prime-time weekly TV drama,

a daily radio drama and a series of booklets, all supported by social mobilization and advocacy efforts. An independent evaluation found the programmes reached more than half of the country, although further evaluation is needed to assess impact.

Addressing gender equality through work with men

Supporting and encouraging men to make a difference: the One Man Can campaign[11]

The One Man Can campaign is a multifaceted, multisectoral, multimodal mass media and community mobilization campaign by Sonke Gender Justice in South Africa. One Man Can supports men and boys to take action to end domestic and sexual violence, reduce the spread and impact of HIV and AIDS and promote healthy, equitable relationships. The campaign's content and strategies are based on extensive formative research including focus groups, field testing, surveys and dialogue with women's rights organizations. The campaign's logo and messages are positive and upbeat and depict men as part of the solution.

As with many other case-studies here, the campaign is based on the social ecological model, like Soul City, and embraces communication for social and behaviour change. The campaign is built around a spectrum of change across multiple levels, including: building individual knowledge and skills, strengthening organizational capacity, building effective networks and coalitions, community education, community mobilization, and working with government to promote change in policy and practice. The campaign explicitly promotes activist and rights-based collective action and links with the historical anti-apartheid struggle and post-apartheid emphasis on building a human rights culture.

The One Man Can campaign includes a wide range of intersecting components, including: community-education workshops; training and technical assistance to partner organizations; engagement with key community leaders, including local government, religious and traditional leaders; use of media including digital stories, photovoice, cell phones, community radio and print media; community-awareness events ranging from street soccer to murals; and strategic advocacy and activism to hold public officials accountable. All activities are participatory and encourage men to both reflect on their own experiences and take action in their lives and communities. Community-education action kits focus on key constituent groups including fathers, teachers, coaches, faith leaders and youth.

Impact assessment is ongoing, but preliminary findings suggest that men who had attended at least one One Man Can event were likely to increase condom use, or intervene if they witnessed an act of gender-based violence. Men who had tested for HIV previously and those who had cared for someone ill with HIV/AIDS were more likely to test for HIV again *(104)*.

Finding points of entry to engage men: Program H

Program H is a community-education and social-marketing campaign originally developed in Brazil to promote gender-equitable attitudes and action among young men. The programme has since been expanded to India, the United Republic of Tanzania, Croatia, Viet Nam and other countries in Central America.

Program H works with young men, targeting the health and social needs of young men, based on both biological risk factors and risks resulting from the specific ways boys and men are socialized. In this way, it applies a gender lens to the realities of young men, and encourages men to see "what

[11] (http://www.genderjustice.org.za/onemancan/)

is in it for them" to change. The programme also looks for "points of entry" to encourage change, by identifying diversity both among men and between men. This approach acknowledges that even in settings where gender norms are rigid, some young men will question them, and that young men who otherwise have rigid attitudes about gender may have some domain in which they are more gender equitable. Based on the social ecological model, Program H works to leverage these natural points of entry into transforming masculinities through workshops to promote critical reflection, lifestyle social marketing to change community norms, advocacy efforts and impact evaluation.

In an evaluation study supported by Horizons, participants in Program H reported changes in styles of interacting with other men, with movement toward more cooperative, less aggressive interactions; increased ability to openly discuss sexuality; increased recognition of women as having sexual rights and sexual agency; increased worry about their own health needs; increased seeking of HIV testing; and delayed initiation of sexual activity with their current partner. Participants also scored better on the Gender Equitable Men (GEM) scale *(105)* and were more likely to have used (male) condoms at last sexual intercourse *(106)*.

Policy and practice recommendations

The following general and specific recommendations for policy and practice emerged from the working groups at the meetings.

Combination interventions addressing both violence against women and HIV are essential

Multiple pathways to HIV risk require multifaceted prevention programmes that address the social context that gives rise to VAW. The unequal gender norms that give rise to VAW also increase men's risk of contracting HIV and of passing it on to their female partners. Violence against women and gender inequality are thus critical dynamics that help drive heterosexual HIV transmission, including in high-risk contexts such as sex work and substance use. HIV-prevention programmes should therefore address both the broader context of gender inequality as well as the risk of infection through acts of violence. Good-practice programmes for HIV-positive women work to mitigate both the ongoing impact of past violence and the risk of newly occurring violence. All good-practice programmes address the broader context of social, cultural and economic inequalities that give rise to both VAW and HIV risk. Not all programmes need to do everything, but it is important to plan for concerted action at the same time and in the same place, to develop synergies between and among programmes.

Addressing violence against women and HIV adds value to programmes

Addressing social, cultural and community-level determinants of health such as VAW has the potential to create synergies and increase the overall impact and cost–effectiveness of HIV programmes.

Joint programming can:

- contribute to progress towards other Millennium Development Goals (MDGs) *(108)*;
- improve the effectiveness and coverage of HIV-prevention programmes and thereby contribute to universal access to prevention, treatment, care and support;
- advance other areas of social and economic development, including reducing poverty and increasing educational attainment;
- advance the promotion and protection of human rights and thereby contribute to a decrease in VAW and increase in access to needed services;
- address other important health outcomes beyond HIV: STIs and infertility, unwanted pregnancy, maternal morbidity and mortality, child health, mental health, substance use, education and economic productivity.

According to UNAIDS, *combination HIV prevention* involves choosing the right mix of HIV-prevention actions and tactics to suit the unique epidemic in each country and matching the needs of those most at risk, just as the right combination of drugs and nutritional support is chosen for antiretroviral treatment. Combination HIV prevention needs investment in structural interventions and requires promotion of behaviour change while simultaneously acting to shift community norms and broader social and policy environments. Combination prevention highlights the synergies that are possible when programmes are coordinated and reinforce each other.

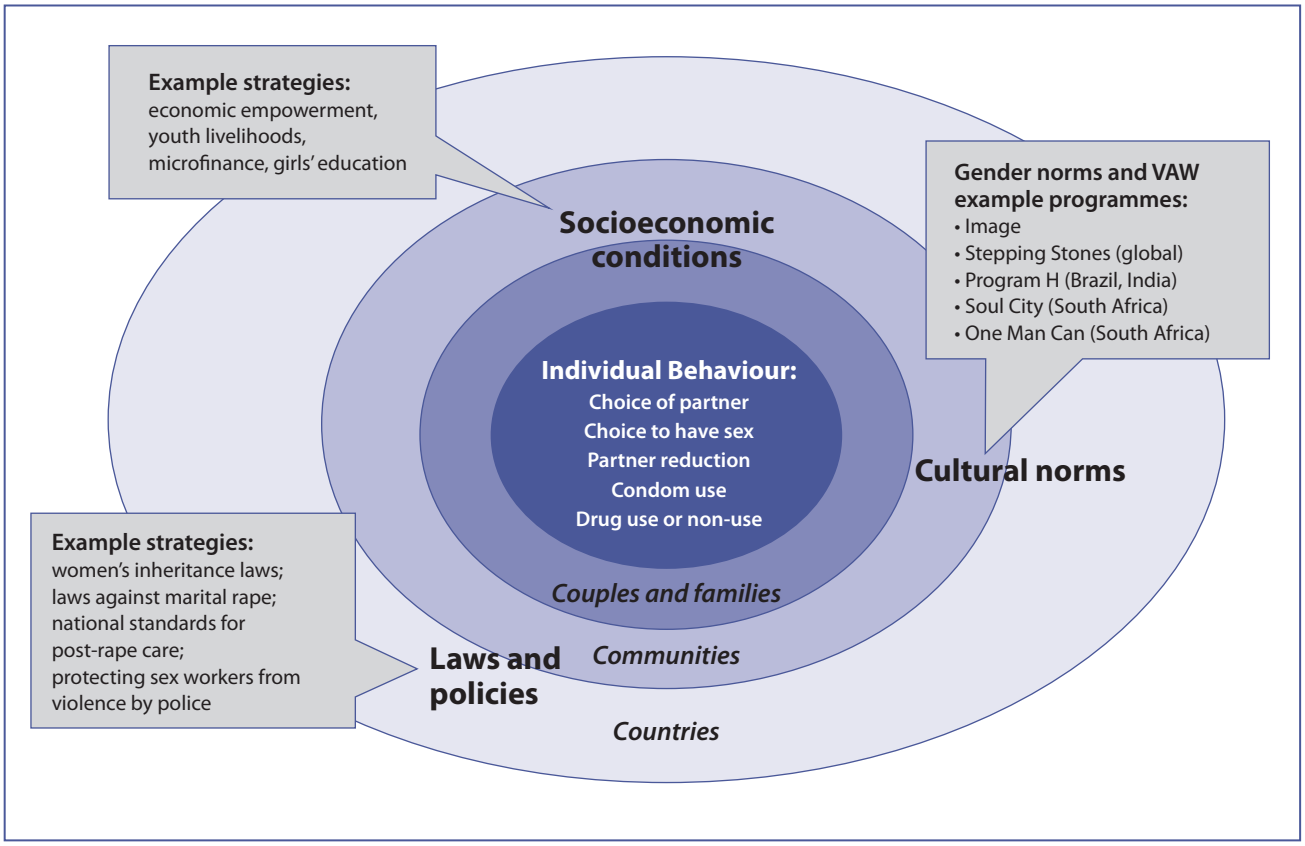
(Adapted from *UNAIDS Outcome Framework 2009–2011* (*107*).)

Addressing violence against women and gender inequality as key programmatic components of HIV prevention makes programmes more effective

Effective HIV prevention requires that VAW and gender inequality are jointly addressed as key programmatic cross-cutting issues. Such synergistic linking forms an important element of effective combination prevention for HIV.

Numerous studies have shown that individual choices and behaviours are embedded in many layers of social and community context (see Figure 2) – from marriages and extended families, to communities and countries. Violence against women and gender inequality place women at increased risk, both through direct risk of infection and through creating an environment in which women are unable to adequately protect themselves from HIV because they fear violence. Effective HIV-prevention programmes must therefore address key elements of the context that gives rise to HIV risk in order to have lasting impact. Any long-term solution to VAW and/or HIV prevention therefore requires that the social context and the gender inequalities that form a core element of this context are addressed. Gender inequality can be addressed at different levels and through different approaches – the strongest

Figure 2. Social-ecological model of individuals in context, with examples of possible point of entry for combination HIV-prevention programmes



synergy is often achieved by intervening on multiple levels simultaneously, using coordinated strategies that are mutually reinforcing.

For example, the IMAGE project in South Africa showed significant reductions in IPV and strong trends in reducing HIV risk behaviour, by combining a microfinance intervention to relieve women's poverty with a gender-training programme and support for gender transformation within communities, including a focus on reducing gender-based violence *(44)*. Similarly, the Stepping Stones study in South Africa showed important reductions in new herpes infections, as well as reductions in male perpetration of VAW and men's HIV-risk behaviour by engaging young people in rural South Africa in community training programmes that encouraged challenging gender norms *(42)*. Building on these examples, locally relevant ways of addressing structural drivers of HIV and VAW need to be developed and evaluated.

Cultural norms can change: experience shows that intervention programmes can have a measurable impact on gender norms and violence against women

While some people fear that tackling VAW is too difficult, or that transforming gender norms in a community is unfeasible or will take years if not generations, programmes like IMAGE and Stepping Stones demonstrate that well-designed programmes can have a tangible, measureable impact within programme time frames. Although "culture" has often been held up as a justification or explanation for behaviours that are harmful to both individuals and communities, in an increasingly globalized world, it is evident that culture is amenable to multiple influences, and is, in fact, changing all the time. Women's organizations and movements have long engaged with and challenged "culture" and "tradition", and some of these efforts have been very successful; such existing strategies and advocacy efforts offer a potentially rich resource for public health programming. The field of marketing and advertising has also been quick to innovate, shape and respond to shifting understandings of cultural values. Public health has been slower to engage in this domain, and yet there is a growing body of experience to suggest that it is possible to mobilize communities to challenge and change how women and girls are viewed and valued in society. These kinds of interventions need to be encouraged and well evaluated to build a stronger evidence base for interventions.

Specific recommendations

Recommendations for the United Nations

The following recommendations were put forward for UN agencies and policy-makers, to best use the capacity of the UN to leverage change in global good practice.

UN-supported HIV-prevention, treatment and care efforts should include an assessment of the impact on VAW and gender inequality

This assessment should acknowledge that an HIV programme can have both beneficial and harmful impacts on VAW and gender inequality, and monitor appropriate outcomes. A minimum standard, taking into account human rights agreements, for addressing the benefits or harms of an HIV programme on VAW and gender equality should be developed. Organizational competency for both addressing gender and VAW issues and evaluating VAW and gender-equality impact should be demonstrated by programme partners seeking UN support for their efforts.

The UN should support and advocate for active HIV prevention with young women and men that specifically incorporates prevention of VAW and gender-equality perspectives

Over half of new infections globally take place among youth under the age of 25 years *(109)*; this is the same group that generally shows the highest rates of both experience and perpetration of gender-based violence. HIV-prevention programming for youth must explicitly recognize and address the importance of VAW and gender inequality to HIV risk among youth, and the importance of childhood, adolescence and early adulthood as developmental periods when social norms around gender and sexuality are not only learned and adopted, but also often in flux. Interventions for young people should therefore incorporate a strong perspective advocating gender equality, non-violence and positive role models and peer socialization. Youth programming should also recognize the structural factors that shape youths' sexual relationships, specifically including the relative disadvantage faced by girls and young women in many settings, with regard to equal opportunities and rights to education and economic empowerment.

UN agencies should continue to support policy-makers to address gender inequality as a key driver of the HIV epidemic, as well as an important issue in its own right. Gender-equality initiatives should be integrated into national strategies, policies and implementation mechanisms

It is important that efforts to address gender equality should include multiple dimensions: programmes to empower women, programmes that work with men and boys for gender equality, and programmes that include women and men together to address challenges in broader communities. Countries should ratify and/or put into practice the global human rights treaties they have endorsed, in particular the Convention on the Elimination of all Forms of Discrimination against Women. Other regional treaties may also be relevant, such as the Convention of Belém do Pará on the elimination of VAW in Latin America and the Caribbean.

The UN should support the development of regional networks of organizations and capacity-building with a focus on supporting inclusion of gender equality and eliminating gender violence as an integral part of HIV programming

This should include encouraging donors to support South–South collaboration on dissemination and scale-up of good practice, including offering support for field visits, internships, and reciprocal capacity-building between organizations in the global South with expertise in joint VAW and HIV intervention.

National strategic planning

The following recommendations were offered for anyone involved in HIV programme planning at a national level.

- Implementing measures at all levels to promote gender equality and prevent as well as redress VAW should be incorporated as important targets in national HIV strategies and plans.
- Links between reducing poverty, increasing gender equality, reducing violence against women and girls and reducing HIV should be explicitly acknowledged and addressed in strategic plans for all relevant sectors.
- National strategic plans should formally recognize the community level as a key focal point of change.

There is a need for formal engagement with and support by government for NGOs' work on gender, violence against women and girls, and HIV issues in communities.

- Sustainable funding must be allocated for such programmes.

Funding decisions should, of course, follow principles of good practice, but also must recognize that long-term and sustainable change will require sustained financial commitment.

- It is necessary to both replicate and scale-up existing approaches that have been shown to be successful or promising. A solid evaluation component must be included and is key to building up the evidence base in this field.

Programmes with demonstrated effectiveness, such as Stepping Stones and IMAGE, or elements of those programmes that can be adapted, should be incorporated into national programmes. Building on these examples, other locally relevant interventions to address structural drivers must be encouraged and evaluated.

Programme design

- Programmes designed to reduce violence in the context of HIV prevention should consider the full range of diversity of persons experiencing and perpetrating gender-based violence.

Communities of people most at risk for violence and HIV infection are not homogenous, and often have internal power dynamics that require consideration. For example, younger sex workers may be subject to control or violence from older sex workers; transgendered people may suffer from discrimination or violence from men who have sex with men. Intervention programmes must make sure they protect those who are most disenfranchised among the disenfranchised or at-risk groups they serve.

- Integrating VAW into HIV programming should be informed by a human rights approach.

Key elements of participation, empowerment and reaching out to the most marginalized become especially important when dealing with potentially stigmatized populations such as sex workers.

Post-rape care

- It is important to ensure access to quality, comprehensive post-rape care services including PEP, according to WHO guidelines *(110)*.

All national HIV policy documents should recognize the need for comprehensive post-rape care, including PEP for HIV as appropriate, and emergency contraception, as well as attention to the mental health needs of survivors. The availability of these and other services with measurable indicators should be part of the standard of care.

- Post-rape care should be implemented, based on the various existing evidence-based models appropriate to the setting, and with multisectoral linkages.

In some settings, such as high-density urban areas that provide for a lot of patients, stand-alone

post-rape care facilities may be most appropriate. However, in other settings, integrated service delivery within existing health facilities may reach more survivors, be more cost-effective and provide better quality of care.

Sex work

- Programming must recognize that sex workers experience violence from a range of perpetrators.

Perpetrators of violence against sex workers include those within their sphere of work, including clients, individuals such as brothel owners or other go-betweens who control clients' access to sex workers or sex workers' access to clients (controllers) and law enforcement. Perpetrators also include long-term partners, relatives, neighbours and other members of the community. Programmes for sex workers need to address the full range of violence they may experience, to effectively interrupt links with HIV and adequately combat the violence they face.

- The programmatic response should not be limited to sex workers.

Programmes to benefit sex workers should include the full scope of those involved in sex work, violence and HIV prevention, including law enforcement personnel, clients, partners, controllers and family. Interventions also need to address stigma and discrimination against sex workers in the broader community, in the media, and in law and policy. There should also be recognition that sex workers may be female, male or transgender.

- Development of new approaches to identify and assist adolescents who sell sex as a high-risk subpopulation should be prioritized, as exclusion of adolescents is probably a major barrier to the success of sex-work-based interventions.

Monitoring and evaluation

- Gender equality and reducing VAW incidence should be monitored as positive process and outcome indicators related to reducing HIV risk.

Critical to implementing this recommendation will be establishing a baseline before the start of a programme. Baseline measures should be tailored to suit the intervention or programme and may include a range of assessments. Some examples could include current rates of violence following disclosure of HIV status, current rates of IPV or rape experience and/or perpetration within a community, baseline scores on the GEM scale *(105)*, status of current legislation, or number of health-care workers previously trained to offer improved care for rape survivors.

- Increased VAW violence incidence should be monitored as a potential adverse outcome of HIV-related interventions.

The roll-out of HIV testing and counselling policies or guidelines should have a detailed and better-resourced monitoring plan for adverse outcomes, including VAW and other forms of gender-based violence. Such monitoring is critical for mandatory and opt-out testing programmes.

- Reporting should be improved so that there is a systematic way of addressing the extent and progress or deterioration in the type and level of VAW, specifically including violence against sex workers and other key populations.

Implementing this recommendation may require tailoring data-collection instruments to be usable by the people most directly affected. For example, programmes by CARE have devised strategies for involving sex workers themselves as part of systematic reporting. They developed a pictorial intake form and system for recording the type and level of violence, perpetrators, and a 12-month life plan that identifies other support systems needed. Such strategies have the additional advantage of helping to build ownership of the information, actions and plans among sex workers. Similar strategies could be developed for other key populations such as women who use drugs.

Recommendations for a research agenda

While there is enough evidence to inform the action items recommended in this report, we need simultaneously to support the development of a stronger research and evidence base.

Expanding the evidence base

- Priority should be given to development and evaluation of innovative strategies that integrate gender-based violence and HIV with the goal of dual impact.

Including an evaluation component on any intervention or new strategy is greatly needed in order to build up a stronger evidence base on "what works" and how to make programmes more effective.

- Efficacy trials should be followed by effectiveness trials.

The strategy often used in developed countries, and particularly North America, is that interventions are initially evaluated through relatively small-scale, tightly controlled trials; this strategy is increasingly being applied in developing country settings, often implemented by researchers from developed nations with funding from their home country institutions. Where such trials offer evidence for efficacy, they should be followed by effectiveness trials to demonstrate "real-world" relevance and inform scale-up. Resources should be allocated for such effectiveness research. Where effectiveness trials have served as the starting point, as is the case for programmes such as Stepping Stones and IMAGE, research should focus on replication and adaptation for other settings.

- Evaluations of successful and promising interventions (e.g. IMAGE and Stepping Stones) should be replicated in other settings.

While IMAGE and Stepping Stones both demonstrate enormous promise, both trials were conducted in South Africa. While the evidence from these studies justifies further scale-up and roll-out within South Africa, these promising interventions, or elements of them, merit further testing through additional randomized controlled trials in at least two other settings to explore applicability across both cultural context and epidemic type.

- Additional programmes should explore the effectiveness and added value of combining VAW/HIV prevention with microfinance or other poverty-reduction initiatives.

More evidence is needed to understand the nature, scope, and value of the potential synergies available in combining HIV and VAW prevention with other forms of social development. Microfinance with gender-equality training has clearly demonstrated promise through IMAGE, and some other models have also shown preliminary evidence of promise, for example where seed funding for income-generation projects has followed the implementation of the Stepping Stones programme *(111)*. These or other strategies for economic empowerment of older and younger women – and young men – should be a particular focus of further investigation, with and without other empowerment components.

- Strategies and guidelines for effectively adapting proven strategies to new and different settings need to be better developed.

We need to develop a solid conceptual framework for identifying interventions that are potentially appropriate for use in a given context, taking into account the political, cultural, social and economic resources available in the setting, as well as the status of the HIV and VAW epidemics. Such conceptual frameworks could focus on isolating the key theoretical elements underlying the intervention, and how best to retain fundamental conceptual integrity while making the changes needed.

- It is important to support methodological innovations for new evaluation strategies and new ways of demonstrating programme impact, especially for community-based and structural interventions.

In addition to finding ways to collate and synthesize existing evidence, future research and evaluation efforts need to focus on developing and promoting new evaluation strategies that can increase confidence in the evaluation of complex, multilevel, community or national intervention strategies for which the traditional biomedical standard of randomized trials is simply inappropriate. Future efforts also need to develop a knowledge base for effective strategies to scale-up programmes with demonstrated effectiveness, and to adapt interventions and programmes that have proved effective in one setting to new cultural and epidemic contexts.

Post-rape care

- Support should be given to research to evaluate different models of psychological support for adult and child survivors of rape.

It is important to develop models of psychosocial and mental health care to support survivors and reduce the long-term impact of rape and child sexual abuse on mental health and HIV risk.

- New strategies for delivering post-rape care for children should be developed and evaluated.

Most existing research on post-rape care focuses on adult survivors, and in some cases on adolescents. More work is needed to understand how best to provide effective services for children, both in terms of managing their special physical and mental health needs, and in terms of supporting families or caregivers in caring for children after rape.

- Research to deepen understanding of and improve PEP adherence among survivors of sexual violence should be supported.

Understanding the kinds of practical and psychosocial support that will best promote PEP adherence, as well as other improved physical and mental health outcomes for rape survivors, is important. And again, considerations of the differences between adult, adolescent and child survivors are important.

- While maintaining a strong perspective that access to comprehensive post-rape care is an important human rights issue, the cost–effectiveness of various service-delivery models should be evaluated, to inform advocacy for expanded roll-out and scale-up of programmes.

It is important to understand the relative value of different approaches to post-rape care in different settings, and of stand-alone versus integrated models of service delivery.

Research in clinical settings

Priorities include:

- research on the best strategies for integration of supported disclosure in different HIV-testing settings;
- research on ways of incorporating discussions of gender equality and violence into VCT and post-HIV test support for those who test HIV positive;
- research on ways of incorporating interventions to change gender-inequitable norms of masculinity at the time of male circumcision;
- research on the implications of male circumcision (MC) for women, in accordance with the WHO recommendations on the impact of male circumcision on women.

While new evidence suggests that male circumcision does not increase the biological risk of male-to-female HIV transmission, further evidence is needed to understand the impact of male circumcision on relationship dynamics, sexual decision making and women's ability to negotiate condom use.

Conclusions/key messages

- Studies from around the globe confirm the links between VAW and HIV. These studies show that women living with HIV are more likely to have experienced violence and that woman who have experienced violence are more likely to have HIV.
- The relationship between VAW and HIV risk is complex, and involves multiple pathways. Violence against women places women at increased risk of HIV both through direct risk of infection and through creating an environment in which women are unable to adequately protect themselves from HIV.
- There is a growing body of well-evaluated, promising programmes that should inform our work on VAW and HIV prevention. These interventions, summarized in the report, fall into various categories, but generally address: gender-equality interventions, including those that seek to empower women economically and through gender-equality awareness, those working with communities and/or men and boys to challenge gender norms; comprehensive post-rape care; those that address VAW in the context of HIV testing; and those focused on violence against sex workers. Lessons learned from these interventions, in the form of broad principles of action, should be shared broadly and scaled-up. Simultaneously, increased support is required for research into strategies for adaptation and implementation of proven programs in new environments and differing conditions.
- Policies and programmes addressing gender inequality and gender-based violence will help achieve universal targets for HIV prevention, treatment and care. Investment in responses in these areas is an essential part of HIV programming.
- Long-term interventions that address structural factors, gender inequalities and harmful gender norms are essential if one is to reduce VAW and HIV; locally relevant ways of achieving gender and structural transformation need to be developed and evaluated. Some of the strategies reviewed here demonstrate that changes can be made within a project time frame. At the same time, there is also a need to move forward urgently to achieve shorter-term gains such as enhanced voluntary counselling and testing services and the provision of comprehensive post-rape care that addresses the psychological and physical health needs of sexual-violence survivors.
- A menu of actions addressing both long-term and short-term needs related to violence and HIV has the potential to have an impact upon not only MDG 6 (HIV), but all the health-related MDGs, including the reduction of maternal mortality and achievement of universal access to reproductive health and rights. In addition, this approach is at the heart of MDG 3 (gender equality and empowerment of women) and MDG1 (reducing poverty).
- There is an urgent need for funding to support more programme evaluation and research on interventions, and for developing new methodologies for evaluating complex interventions in order to continue to develop the evidence on effective interventions to address both VAW and HIV prevention.

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Annex 1: Agenda and List of participants

Day 1:

Chair: Charlotte Watts

Time	
9:00–9:30	***Welcome and introduction*** *Claudía García Moreno, WHO* *Kristan Schoultz, UNAIDS* Meeting context, goals and deliverables
9:30–10:40	***Session 1: Where are we now?*** *Aziza Ahmed, Harvard University* Literature review on evidence of links between VAW and HIV *Kristin Dunkle, Emory University* Systematic review of interventions to address VAW and HIV Discussion and setting the stage, What do we mean by "evidence"? What are the strengths and weaknesses in the current case for interventions? What are the limitations of the reviews? What are the key messages emerging from the reviews?
11:00–13:00	***Session 2: Community intervention case-studies*** *Rachel Jewkes, MRC, South Africa* Stepping Stones *Julia Kim, UNDP (South Africa)* IMAGE *Evelyn Letiyo, Raising Voices, Uganda* SASA! Community mobilization *Alice Welbourn, Discussant* Short Stepping Stones video, *Salamander Trust*
14:30–16:00	***Session 3: Promoting gender equality: challenging constructions of gender through working with men and boys*** *Dean Peacock, Sonke Gender Justice, South Africa* One Man Can campaign Report back on MenEngage meeting *Marcos Nascimento, Promundo, Brazil* Working with young men in Rio de Janeiro/Brazil to achieve gender equality *Gary Barker, ICRW* Structural interventions for gender equality Preliminary data from the International Men and Gender Equality Survey (IMAGES) *Julia Kim, Discussant*
16:30–17:00	***Discussion*** Review and discussion of the day's presentations and issues raised

Day 2:
Chair: Claudia García Moreno

Time	
9:00–9:15	***Welcome and review of Day 1*** *Kristin Dunkle*
9:15–10:45	***Session 4: Intervening in health-care settings*** *Suzanne Maman, UNC* Addressing violence in the context of antenatal care in Durban, South Africa *Lilian Otiso, Liverpool VCT, Kenya* Scaling up of post-rape care services in Kenya *Jill Keesbury, PopCouncil* One-stop centres for post-rape care *Rachel Jewkes, Discussant* The role of PEP and comprehensive post-rape care
11:00–12:30	***Session 5: Addressing GBV and HIV among sex workers*** *Parinita Bhattacharjee, Karnataka Health Promotion Trust, India* Interventions to reduce violence among female sex workers in Karnataka, India Video: *Nyaya Sanjeevani – a community response to crisis Developed by Swathi Mahila Sangha and Karnataka Health Promotion Trust, with funding support from USAID* *Sandhya Rao, SANGRAM, India* Interventions to reduce VAW and HIV among sex workers *Jay Silverman, Harvard* Additional considerations for intervention regarding HIV and GBV in sex work settings *Theresa Hwang, CARE* Empowerment approaches with sex workers in Bangladesh *Kristin Dunkle, Discussant*
14:00–15:00	***Session 6: Other interventions*** *Leyla Ismayilova, Columbia University* A couple-based/relationship-based HIV intervention for drug-involved women *Anita Raj, Boston University* Developing a prevention intervention for married women in India *Dag Rekve, WHO* Interventions to reduce alcohol use/misuse *Alice Welbourn, Discussant*
15:00–16:30	***Session 7: Policy and programme recommendations for national governments and international agencies (GROUP WORK)*** Group discussion to develop preliminary recommendations ***Group 1:*** *Community interventions* ***Group 2:*** *Integrating joint GBV and HIV intervention in health-care settings* ***Group 3****: Interventions and programmes for sex workers* ***Group 4:*** *Changing gender norms around GBV and HIV*
16:30–17:30	Feedback from groups and discussion

Day 3:
Chair: Rachel Jewkes

Time	
9:00–9:15	***Welcome and review of Day 2*** *Claudia García Moreno, WHO*
9:15–10:45	***Session 8: Challenges of integration, adaptation and scaling-up*** *Susan Settergren, RTI* Addressing gender-based violence in HIV/AIDS programmes: experience of the US President's emergency plan for AIDS relief *Denise Namburete, NWETI, Mozambique* The adaptation of Soul City to Mozambique *Julia Kim, UNDP* Opportunities and challenges for mainstreaming the issues into existing national policy structures *Jonathan Mwansa, Discussant*
11:00–12:30	***Session 9: Identifying gaps and areas for further research*** Review of recommendations by working groups and identification of gaps Rapporteur report back and review of recommendations
13:30–15:00	***Session 10: Draft recommendations*** *Revision of draft recommendations and consensus building on key messages*
15:00–15:30	***Wrap-up and way forward*** *Claudia García Moreno, WHO*

List of participants

Temporary advisers

Aziza Ahmed
Harvard School of Public Health, USA
Email: ahmed@hsph.harvard.edu

Gary Barker
International Center for Research on Women, USA
Email: gbarker@icrw.org

Parinita Bhattacharjee
Karnataka Health Promotion Trust, India
Email: parinita@khpt.org

Kristin L. Dunkle
Behavioral Sciences and Health
Education and Centre for AIDS Research
Rollins School of Public Health
Emory University, USA
Email: kdunkle@emory.edu

Theresa Y. Hwang
CARE, USA
Email: thwang@care.org

Leyla Ismayilova
Global Health Research Center
Columbia University, USA
Email: li61@columbia.edu

Rachel Jewkes
Medical Research Council
Gender and Health Research Unit, South Africa
Email: rachel.jewkes@mrc.ac.za

Jill Keesbury
Population Council, Zambia
Email: jkeesbury@popcouncil.org

Evelyn Letiyo
Raising Voices, Uganda
Email: evelyn@raisingvoices.org

Suzanne Maman
The University of North Carolina at Chapel Hill
Gillings School of Global Public Health
Department of Health Behavior and Health
Education, USA
Email: smaman@unc.edu

Jonathan Kaunda Mwansa
The University Teaching Hospital
Department of Paediatrics and Child Health, Zambia
Email: mukwanov@yahoo.com

Denise Namburete
NWETI, Mozambique
Email: d.namburete@nweti.org.mz

Marcos Nascimento
Promundo, Brazil
Email: m.nascimento@promundo.org.br

Lilian Otiso
Liverpool VCT, Care and Treatment, Kenya
Email: lotiso@liverpoolvct.org

Dean Peacock
Sonke Gender Justice, South Africa
Email: dean@genderjustice.org.za

Anita Raj
Department of Community Health Sciences
Boston University, USA
Email: anitaraj@bu.edu

Sandhya Rao
SANGRAM, India
Email: sandhya.1012@gmail.com

Susan Settergren
RTI International, USA
Email: sks@rti.org

Jay G. Silverman
Associate Professor of Society,
Human Development and Health
Harvard School of Public Health,
USA
Email: jsilverman@hsph.harvard.edu

Alice Welbourn
Salamander Trust, United Kingdom
Email: alice@salamandertrust.net

Charlotte Watts
Sigrid Rausing Professor
Director, Gender Violence and Health Centre
London School of Hygiene and Tropical Medicine,
United Kingdom
Email: charlotte.watts@lshtm.ac.uk

UN agencies

Lynn Collins
United Nations Population Fund (UNFPA)
Email: Collins@unfpa.org

Nazneen Damji
United Nations Development Fund for Women (UNIFEM)
Email: nazneen.damji@unifem.org

Adrienne Cruz
International Labour Organization
Email: cruza@ilo.org

Susana Fried
United Nations Development Programme (UNDP)
Email: susana.fried@undp.org

Camilla Gendola
International Labour Organization
Email: gendolla@ilo.org

Julia Kim
United Nations Development Programme (UNDP)
Email: juliakim@undp.org

Judy Polsky
The Global Coalition on Women and AIDS
UNAIDS
Email: polskyj@unaids.org

Marian Schilperood
United Nations Refugee Agency (UNHCR)
Email: SCHILPEM@unhcr.org

Kristan Schoultz
The Global Coalition on Women and AIDS
UNAIDS
Email: schoultzk@unaids.org

Lotta R. Sylwander
United Nations Children's Fund (UNICEF), Zambia
Email: lsylwander@unicef.org

Therese Vall
Associate Programme Officer (SGBV)
United Nations Refugee Agency (UNHCR)
Email: Vall@unhcr.org

WHO secretariat

Islene Araujo de Carvalho
Department of Gender, Women and Health
Email: araujodecarvalhoi@who.int

Manjula Lusti-Narashimhan
Department of Reproductive Health and Research
Email: Lustinarashimhan@who.int

Claudia García Moreno
Department of Reproductive Health and Research
Email: garciamorenoc@who.int

Tonya Nyagiro
Department of Gender, Women and Health
Email: nyagirot@who.int

Christina Pallitto
Department of Reproductive Health and Research
Email: pallittoc@who.int

For more information, please contact:

Department of Reproductive Health and Research
World Health Organization
Avenue Appia 20, CH-1211 Geneva 27, Switzerland
Fax: +41 22 791 4171
E-mail: reproductivehealth@who.int
www.who.int/reproductivehealth

ISBN 978 92 4 159986 3

World Health Organization

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