



The Center for Women's Global Leadership (US), in collaboration with Action Aid International (South Africa), Action Canada for Population and Development/ACPD (Canada), Center for Health and Gender Equity/CHANGE (US), Center for Reproductive Rights (US), Fundación para Estudio e Investigación de la Mujer /FEIM (Argentina), Gestos- Soropositividade, Comunicação e Gênero (Brazil), International AIDS Women's Caucus, International Women's Health Coalition/IWHC (US), Latin American and Caribbean Women's Health Network/LACWHN, is pleased to submit the following briefing paper in reference to *Resolution 2005/84* (adopted by consensus on 21 April 2005) calling for the UN Secretary General to prepare a report on steps taken to promote and implement programs to address the urgent HIV-related human rights of women, children and vulnerable groups in the context of prevention, care and access to treatment as described in the Guidelines on HIV/AIDS and Human Rights for the Human Rights Council.¹

As partners and allies in a forthcoming campaign to focus global attention on the intersection of gender-based violence and HIV/AIDS, we welcome the attention in *Commission on Human Rights Resolution 2005/84* to gender-specific aspects of HIV/AIDS in its human rights dimensions and trust that this report will encourage the Human Rights Council to continue to take up human rights abuses in the context of the HIV/AIDS pandemic in a consistent and ongoing fashion. As women's rights, sexual and reproductive rights and health, human rights, HIV positive women's and development organizations, we hope that this submission will help define and identify some of the critical issues surrounding the intersection of gender-based violence and HIV/AIDS from an analytical perspective that sets gender equality and women's empowerment at the core of any effective initiative. We contend that inadequate attention has been paid to gender-based violence and HIV/AIDS as intersecting and mutually reinforcing health and human rights crises. At the same time, as we suggest, there are promising practices being spearheaded by women's rights organizations that deserve greater support and attention, particularly as models to be replicated and/or scaled up. We believe both the analysis we offer and the examples we provide are critical components of steps taken "to promote and implement, where applicable, programmes to address the urgent HIV-related human rights of women, children and vulnerable groups in the context of prevention, care and access to treatment," (paragraph 14), the key feature of the Secretary-General's progress report to the Human Rights Council.

Our briefing paper offers an analysis and recommendations in the following areas: first, we set out the importance of understanding the intersection of HIV/AIDS and gender-based violence. We stress that gender-based violence is rooted in gender inequality, and has a lethal dynamic by itself and in combination with HIV/AIDS. Next, we provide information about how differences in race, ethnicity, language, sexuality, age, and many other social factors have a significant and differential impact on the effect of both gender-based violence and HIV/AIDS on the lives of women and girls in various communities. Third, we highlight some of the key obstacles and challenges to comprehensively addressing the intersection of gender-based violence and HIV/AIDS, and the barrier this presents to effective prevention, services and advocacy. Fourth, we emphasize the importance of a comprehensive, gender and human rights sensitive-response to both HIV/AIDS and gender-based violence, providing some of the key elements of such an approach. The potential heightened risk of violence against women and girls engendered by strategies such as "provider initiated" testing practices that are not fully gender-sensitive and human rights-based underscores the urgency of "globalizing" such a comprehensive approach. Finally, we conclude by offering examples of promising practices from colleagues in several countries. In each section, building on the collective knowledge and experience and analysis of the signatory organizations and their colleagues from many regions, we provide recommendations that address the particular area of concern in each section. We draw from recently published materials and statements made by experts in these fields.

I. HIV/AIDS and gender-based violence: intersecting health and human rights crises

Around the world, women are facing a catastrophic assault on their bodies, rights and health as a result of the prevalence of both HIV and the unrelenting omnipresence of violence against women. Each constitutes a crisis on its own. The alchemy of gender-based violence and HIV produces a particularly potent poison. Increasingly, women are dealing with the way violence puts them at greater risk of contracting HIV while women who are HIV+ are more likely to be targets of violence because of additional layers of discrimination and stigma they face.. Elements of the AIDS testing and treatment machinery may also bring risk, such as the danger of violence connected to disclosure of HIV+ serostatus or coercive testing in the guise of VCT (voluntary counseling and testing), or the insidious treatment of women as vectors of disease, as in the case of PMTCT (prevention of mother-to-child transmission) programs that fail to treat pregnant HIV+ women as patients or clients with rights, or only as, and nothing more than, child-bearers.

According to one of the foremost experts on women and HIV/AIDS, “violence against women is a cause of HIV” as well as a consequence. A recent article in Clarín, a national newspaper in Argentina, notes that “[s]exual violence directly increases women’s risk of HIV infection, be it through rape within or outside a relationship, trafficking of women, sexual exploitation and commerce or sexual violence committed in armed conflict. All of these, according to [Mabel] Bianco [founder of FEIM, Fundación para Estudio y Investigación de la Mujer, Buenos Aires, Argentina], are forms of violence that expose women to HIV transmission. Only 10 percent of sexual abuses and rapes are reported. Women who do not report sexual abuse or rape are also not accepting prophylactic treatment after possible exposure to HIV and this is how the probability of infection increases.”

A report in the UN-sponsored IRIN/PLUSNEWS, makes this point painfully clear:

A Zambian nongovernmental organisation (NGO) revealed this week that it records eight cases of rape of young girls every week at its centre in the capital, Lusaka. The statistics were released by the Young Women's Christian Association (YWCA) of Zambia to mark the start of the global campaign, '16 Days of Activism Against Gender Violence', which runs from 25 November - International Day for the Elimination of Violence Against Women - until International Human Rights Day on 10 December. Katembu Kaumba, YWCA's executive director, said alongside the abuse of girls, the organisation's shelter in Lusaka also recorded 10 cases of rape of adult women every week... 'Nationally, the figure is much higher - about 12 every week,' said Superintendent Presphord Kasale, who heads the Victims Support Unit of the Lusaka Division of the Zambia Police Service.²

Noting the linkage between violence against women and HIV and AIDS, the UN Special Rapporteur's 2005 report to the UN Commission on Human Rights stressed that “[t]he lack of respect for women's rights both fuels the epidemic and exacerbates its impact.”³ However, governments, donors, multilateral institutions, international organizations and many civil society actors have failed to fully integrate programming for gender equality and women’s empowerment into their HIV/AIDS, or indeed, their gender-based violence programming.

The situation is exacerbated by the all-too-frequent lack of accountability and political will by governments and donors: only in rare instances have states fully committed to protecting and promoting women’s human rights in relation to violence or HIV prevention, including development of policies encouraging swift investigation of abuses and direct punishment for perpetrators. Government actors are generally unwilling to address abuses committed by soldiers, police and other agents of the state, as well as the sexual violence that takes place within the family, community and other traditionally “private spheres.”⁴ This latter point is of particular concern to women, as much of the violence they face takes place within this *private* arena and is inflicted by non-state actors, like husbands and other family members. Among donors, the level of funding for efforts to address gender-based violence remains extremely small,⁵ while the integration of violence against women programming in the much larger pot of funding for HIV/AIDS is scant and hard to find.⁶

Recommendations

- The Human Rights Council, in its Universal Periodic Reviews of the human rights records of Member States, should ascertain whether governments have eliminated discriminatory laws and policies that restrict women's rights and the rights of people affected by HIV/AIDS and passed and implemented laws promoting the human rights of all. .
- The UPR process should also track whether governments have passed and implemented laws and policies that promote and protect the human rights of women, HIV positive people in general and women specifically, those affected by HIV/AIDS, and activists, including by ensuring that acts of discrimination and violence are investigated and punished, and that all NGOs and individual activists can enjoy rights to assembly, opinion and freedom of expression. Such laws should ensure that the sexual and reproductive rights of women and girls are protected and promoted, including their right to make decisions regarding their sexuality free from violence, discrimination and coercion.
- In its Universal Periodic Review of countries' human rights situations, the Human Rights Council should pay particular attention to governments' efforts to address and reduce stigma and discrimination against survivors of gender-based violence and people living with HIV/AIDS. The Council must monitor governments efforts to ensure that health and other services, and other interventions, do not adversely single out people living with HIV/AIDS, and that HIV+ people as well as victims/survivors of gender-based violence play a core role in governments', bilateral donors', multilateral institutions' and civil society organizations' gender-based violence and HIV/AIDS programming.

II. The diversity of women and girls: social factors and risk

We welcome the resolution's attention to differences that impact or exacerbate the effect of HIV/AIDS and may result in additional stigma and discrimination. For example, the resolution notes with concern that "an estimated 95 per cent of all people infected with HIV live in the developing world, mostly in conditions of poverty, underdevelopment, conflict and inadequate measures for the prevention, care and treatment of HIV infection, and that marginalized groups in these societies are even more vulnerable to HIV infection and the impact of AIDS...."

However, such a multi-faceted analysis must go further and deeper. Gender inequality and violence against women often inhibits women's and girls' ability to take full advantage of crucial – even life-saving – services. First, women victims/survivors of violence have different experiences and different options available to them than girls who are victims/survivors. Age is a key factor in determining risk and vulnerability to both gender-based violence and to HIV/AIDS: a recent study by the WHO found that as many as 30% of women in some locations reported that their first sexual experience was coerced or forced.⁷ The younger the women were at the time of sexual initiation, the higher the chance that it was violent.⁸ Moreover, HIV/AIDS is fast becoming *a girls' epidemic*: The WHO notes that "[y]oung people (aged 15-24) account for half of all new HIV infections, and of infected youths, two-thirds are female. In parts of sub-Saharan Africa, teen girls are six times more likely to be infected than male peers. The burden of care also falls on girls who may leave school to care for sick relatives.⁹

Furthermore, age-related risks do not only correspond to youth. Patterns of wife-inheritance in some communities have been noted to fuel the spread of HIV.¹⁰ In some communities, older women, in particular, may be targeted for rape in connection to HIV/AIDS. For instance, during a recent trip, UN special envoy on HIV/AIDS in Africa, Stephen Lewis, reported hearing disturbing statistics: "Rapes of women and girls were escalating every month, and half the girls sexually assaulted were under 12."¹¹ Lewis noted that an even more startling pattern also emerged. He commented "a significant number of women aged 65 to 80 were also raped. The men who did it were confident they could have unprotected sex with them without getting AIDS"¹²

Other elements of social location also impact on women's and girls' vulnerability to both violence and HIV/AIDS. Women who are HIV positive face a range of real or potential human rights abuses – from non-consensual testing and disclosure of results, to stigmatization, isolation and shunning by their families and communities, to threats of or actual violence committed against them. Marginalized racial, ethnic or cultural status exacerbates the risk of contracting HIV/AIDS. In the United States, for example, the Kaiser Family Foundation reports that “[r]acial and ethnic minorities have been disproportionately affected by HIV/AIDS since the beginning of the epidemic, and minority Americans now represent the majority of new AIDS cases (71%) and of those estimated to be living with AIDS (64%) in 2003” with African-Americans and Latinos accounting for a disproportionate share of new AIDS diagnoses.¹³ Moreover, women of color are particularly hard hit with African American women accounting for 67% of estimated new AIDS diagnoses among women in 2003, while Latinas account for 16%.¹⁴

Discrimination and a hostile legal and political environment seriously circumscribe efforts to address the health and rights of marginalized communities. Cases such as HIV outreach workers being arrested on sodomy charges, or as sex workers (using evidence of carrying condoms as an indication of prostitution) are simply the tip of the iceberg.¹⁵ Various forms of “minority” status also indicate risk. For example, the estimated HIV prevalence rate among self identified gay men in South Africa may be as high as 30%, while the rates for transgender individuals may be even higher. Amongst sex workers, available data from 2000 shows that slightly over 50% of sex workers were HIV-positive.¹⁶ In Nepal, an HIV prevalence rate among men who have sex with men of 3.9%,¹⁷ exists alongside a long-term and consistent pattern of serious violence and abuse of *metis* (transgender persons).¹⁸ Moreover, while women who have sex with women are generally considered to be a “low risk” group, the calculation changes when lesbians are targeted for violence.¹⁹ For example, due to the high incidence of rape, HIV/AIDS rates among black South African lesbians are reportedly as high as in the general population.²⁰ And even where HIV appears to be on the rise among lesbians, as in Thailand, prevention information is rarely addressed specifically to them.²¹

The former UN Special Rapporteur on violence against women, Radhika Coomaraswamy, documented the combined impact of gender and race in her extensive report on international, regional and national developments in the area of violence against women: 1994-2003, covering her years as Special Rapporteur. For example, in the case of violence against women in Costa Rica, the Special Rapporteur found that “[d]omestic violence against black women is more widespread, especially between couples made of a white man and a black woman. Black women tend to be more reluctant in filing complaints. It is a clear case of intersection of gender and race which multiplies the impact of domestic violence against women.”²²

Other institutional issues, such as profiling of particular groups (including in but not limited to situations related to the war on terrorism), historic and persistent discriminatory practices against racial and ethnic minorities by the police and other state actors, among other circumstances, can lead to perpetrators of violence against women in racially diverse communities acting with virtual impunity. Agents of the state often are protected against appropriate investigation and punishment.

Recommendations:

- In devising services and distributing resources, governments and donors must fully grapple with the fact that the category of “women and girls” encompasses a vast array of different groups of women and girls, whether identified by age, race, language, sexuality, indigenous or refugee status, etc. And this diversity also reflects specific and varying needs with regard to prevention of, protection from and response to both HIV/AIDS and GBV.
- Governments, donors and service providers must pay attention to the need to ensure women's informed choice and consent, and of the persistent threats of violence women face in their everyday lives. Critical to this sensitivity is an understanding of how access to services and other interventions varies according to a woman's race, sexuality, class, rural or urban location, age, status as indigenous, etc. Without careful attention to the import of such differences, health policies or practices can

create risk in women's and girls' lives, whether as a result of mandatory or forced testing, or breaches of confidentiality and rights to privacy, especially in relation to disclosure of HIV status and partner notification policies.

III. Obstacles and strategies

The lack of adequate human and financial resources cannot be underscored enough as both cause and effect of the compartmentalization of violence against women and HIV/AIDS.²³ This resource issue cuts through almost all of these critical challenges and serves as an example of how they are interlinked. Without adequate funding, research and campaigning may fail to reach potential impact, adequately document their experiences in a way that facilitates replication, and are unable to be scaled up. However, while more funding is crucial, it will only mitigate, but not arrest, either HIV/AIDS or violence against women, nor will it achieve gender equality, without a clear understanding and analysis of the impact of policy, programming and funding.

The current framework for HIV/AIDS funding (inclusive of the acronyms of VCT [voluntary counseling and testing], ABC [abstain, be faithful, use condoms], PMTCT [prevention of mother-to-child transmission] among others) fails to interrogate its gender bias, and therefore, often fails to reduce HIV infections among women, or mitigate its more general impact on women and girls. This includes, for example, PMTCT programs that treat women only in the context of childbearing, VCT programs that fail to understand that “voluntary” can become coercion in a context of gender inequality and a pervasive threat of violence, or that ABC initiatives generally ignore the fact that many women and girls are not in a position to negotiate the conditions of a sexual encounter. The current axiom of universal access to prevention, treatment, support and care will not reach its goals nor halt the feminization of the pandemic without a gender-sensitive realignment fully anchored in human rights norms and standards. Nor will a “results-based” focus that emphasizes quantity over quality necessarily protect the rights of women.

Recommendations:

- Governments, donors, multilateral institutions, international organizations and national civil society actors must support and facilitate greater communication among sectors, organizations and social movements. Such diverse participation in policy dialogues will enrich the possibility of devising and implementing the strongest responses to gender-based violence, HIV/AIDS and their intersection.
- Governments, with the support of donors, need to increase the level of resources for training legal and social service providers. For example, health care providers must be well-acquainted with human rights approaches to service delivery and health policy development, while judges, lawyers, policy and prosecutors must fully understand the importance of gender- and human rights sensitive responses to gender-based violence and HIV/AIDS.

IV. The need for comprehensive, gender-sensitive and human rights-based responses

A gender- and human rights sensitive approach to HIV/AIDS and gender-based violence are essential to finding innovative and effective solutions. Addressing the human rights implications of HIV/AIDS and violence against women requires grappling with gender inequality and other forms of discrimination at all levels – from policy reform to community education. Moreover, the links between human rights, HIV/AIDS and violence against women must be made in practical ways that have immediate impact on women's lives. Women benefit most when “rights-based approaches,” including principles of non-discrimination, accountability, transparency, and participation are used in provision of services, as well as in advocacy efforts.²⁴

Take, for example, initiatives focusing on the prevention of mother-to-child transmission (PMTCT). The availability of medications that can block the transmission of HIV during pregnancy, childbirth and the postnatal period has created new opportunities to slow the spread of HIV/AIDS. Governments have begun

establishing programs to facilitate access to these medications for pregnant women. These initiatives enable pregnant women to reduce significantly the chances that their infants will be born with HIV. While the benefits of PMTCT programs are immense—for individual women, their children, and societies alike—it is crucial that governments implement these programs with a keen awareness of the experiences of all women living with HIV/AIDS and with respect for their human rights. PMTCT programs are primarily conceived as prevention programs for infants. This focus on prevention leaves the concerns of women living with HIV/AIDS largely invisible. In many contexts, the women are forgotten after they deliver healthy infants. In addition, in any health-care setting in which women are under the care of providers, however, women receiving treatment have rights as patients. These rights are too often overlooked.

These encompass their right to privacy and to physical integrity, including their right **not** to be tested without their informed choice or consent or to have their HIV status disclosed without their permission.

Recommendations:

- Governments must create or change legislation to promote non-discrimination, and also must commit to funding initiatives and programs that are equipped to address violence and HIV/AIDS in straightforward, meaningful ways, including, for example: the provision of post-exposure prophylaxis to survivors of sexual assault; medically accurate, evidence-informed information without restriction or censorship; and comprehensive sexuality education and detailed information about HIV prevention, treatment care and support. This includes a focus on the rights of women in their own individual right as citizens.
- Governments must commit themselves to working toward changing discriminatory attitudes and address “taboo topics,” including sexuality, sex work, drug use, and the rights of women to control their own bodies, sexuality and decision-making about families and parenting, in line with their international human rights obligations.
- Governments must uphold fundamental human rights standards in creating prevention, protection and actions to address gender-based violence and HIV/AIDS. These standards include requirements of informed consent, confidentiality and choice, provider-patient confidentiality, appropriate and accessible health, social and legal services without discrimination.

V. Promising practices: lessons from women’s rights and HIV/AIDS organizations

The progress of discerning and distilling promising practices is a lynchpin of an effective response. Governments, multilateral institutions and donors must engage in a dialogue with civil society in order to draw important lessons that will allow for governments and donors to provide the resources for scaling up effective gender and human rights based strategies, and to support the social movements within which these new, innovative and/or effective strategies are grown. A number of these innovative programs have been featured in *Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS*, a 2006 publication of the Center for Women’s Global Leadership.

From street theater to telenovelas/soap operas to traditional lobbying, activists in both gender-based violence and HIV/AIDS communities are beginning to focus attention to ways both crises interact in a negative spiral.²⁵ The use of media has, in several cases, provided promising results. Soul City in South Africa is one of the most well-known “infotainment” outlets addressing HIV/AIDS and, with some frequency, gender-based violence. Another is Puntos de Encuentro in Managua, Nicaragua. Their concern with exhibiting an integrated approach formed the basis for a *Sexto Sentido*, one of Nicaragua’s most popular soap operas. One storyline involves Gabriel, a young, popular character who discovers he is HIV positive as a result of his having had unprotected sex with Martha, an equally treasured soon-to-be divorced woman who has unknowingly contracted HIV from a philandering husband who refuses to wear a condom. Cultural stereotypes involving sex workers and other sexually active women, and myths involving condom use and the

virtues of machismo, are systematically undermined—and reframed—as the story progresses. And opportunities to revisit the issues presented are provided to those who view a special edition of the soap opera story, now being packaged for use with youth and other audiences around the country and abroad.²⁶

Another promising practice involves the pairing of HIV/AIDS and gender-based violence initiatives. One such endeavor involves the Institute for Social Development Studies (ISDS) and the Center for Studies and Applied Sciences in Gender-Family-Women and Adolescents (CSAGA), both based in Hanoi, Viet Nam, conducted with the support of the Program on International Health and Human Rights at the Harvard University School of Public Health in the US. ISDS and their violence against women services-focused partner, CSAGA, determined how they could best share resources to collect and analyze relevant data, as well as train counselors to use that information to inform their everyday work with clients. “Our objective became to see the linkages between HIV and violence and use those findings to provide training for counselors, and then, later on, conduct advocacy with the public through mass media channels,” says Nguyen of ISDS.²⁷

Since the inauguration of their hotline services in 1997, CSAGA had been keeping track of anonymous data on the types of calls its counselors had received. These hotlines have been quite active: on average, 3,000 calls per year have involved violence against women alone. Six notebooks containing summaries of counselors’ conversations with callers over the years also provided rich sources of data for research on both violence and HIV/AIDS. Interestingly, despite the rich amounts of data, and while overall findings have yet to be reported, the groups found few connections between the issues was made by counselors or callers. In fact, says Nguyen, “Very, very few of the summaries are about HIV *and* violence...In the counselor’s minds...there’s no linkage of the issues, so they don’t have a related question to ask—they just follow the complaint of the customer.” The information ISDS gleaned from both investigations is currently being used to help structure a focus group session with several longtime CSAGA counselors and a training session for their colleagues. An evaluation will be conducted at the end of this year.²⁸

A third example involves paying attention to the experiences of HIV+ women when designing responses and services. One such organization is Creación Positiva, a member of the International Community of Women Living with HIV/AIDS based in Barcelona, Spain. Creación Positiva delivers a wide variety of HIV-related services to area women and men, including individual and group support, research, and community-wide workshops on a broad range of topics. “In a typical year, we might work individually with about 35 men and 100 women,” says program coordinator Montse Pineda. “We connect with people by putting our flyers in hospitals, through our website, and by word of mouth. We have workshops on prevention and on sexuality—not safe sex, but comprehensive workshops on sexuality,” says Pineda. “In 2005, the organization conducted six of these [romantic love] workshops on November 25, the International Day Against Violence Against Women,” she adds.²⁹

Creación Positiva has been attentive to the connection between violence against women and HIV/AIDS since early on. “Because we have worked with women for many years, we saw that there was an important link between violence against women and HIV/AIDS,” says Pineda. “Many of the women we work with have lived with violence and we saw we had to make the issue explicit.” Today, as a result of their participation in the global 16 Days of Activism Against Gender Violence campaign and other activities, Creación Positiva’s influence now extends beyond the regional level in several respects. The organization, for example, has also published two research studies, “including the biggest study done so far in Spain on the needs of women who are HIV positive. The study included 258 women, and includes data on violence and HIV positive women. It was the only such study carried out for 2004 and 2005.” Other national work includes playing both advisory and research roles on a nationwide study of stigmatization. As Pineda puts it, “We are a reference point in Spain.”³⁰

Recommendations

- In devising interventions, governments, with the support of donors, multilateral agencies, international organizations must draw on the experiences of women’s rights and women and

- HIV/AIDS organizations and build their participation into the policymaking, implementation, monitoring and evaluation processes. This includes a policy process centered on advancing and protecting women's human rights. They must, for instance, promote women's status in both the home and the public sphere. They must also ensure that government clinics promote and protect women's rights and provide protection for women living with HIV/AIDS who might suffer abuse.
- Governments, with the support of donors, multilateral institutions, international organizations and a diverse range of civil society groups, must support community-wide education and information initiatives in order to combat the fear, silence and myths surrounding HIV/AIDS and gender-based violence.

With reference to the above recommendations, we further propose that the Human Rights Council continue to address these issues in full recognition of their urgency including through integrating them into the Council's Universal Periodic Review process, undertaking reports on urgent human rights dimensions of the intersection of gender-based violence and human rights, and, where appropriate, designating special sessions to address the multifaceted aspects of gender-based violence, including its human rights and HIV/AIDS dimensions.

¹ *Resolution 2005/84*, Paragraph 14.

² Nebert Mulenga, *Zambia: More than 10 girls raped each week*, IRIN/PLUSNEWS, Johannesburg, 27 November 2006, at http://www.irinnews.org/report.asp?ReportID=56528&SelectRegion=Southern_Africa#

³ Yakin Ertürk, 2005. "Integration of the human rights of women and the gender perspective: the intersections of violence against women and HIV/AIDS," Report of the Special Rapporteur on violence against women, its causes and consequences, UN doc: E/CN.4/2005/72 17 January 2005, paragraph 16, p. 7.

⁴ Cynthia Rothschild, Mary Anne Reilly and Sara A. Nordstrom, *Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS*, New Jersey, USA: Center for Women's Global Leadership, 2006, p. 7. Hereafter referred to as "Strengthening Resistance."

⁵ AWID and Just Associates, "Where is the money for women's rights? Assessing the resources and the role of donors in the promotion of women's rights and the support of women's rights organizations." (Toronto: AWID, 2006).

⁶ Action Aid International, 2006. *Show Us the Money: Is Violence Against Women on the HIV/AIDS Funding Agenda? Preliminary Findings*.

⁷ World Health Organization (WHO) 2006, *Multi-country study on women's health and domestic violence against women*, p. 51. Accessed at http://www.who.int/gender/violence/who_multicountry_study/en/.

⁸ *Ibid.*

⁹ WHO, "Women, girls and HIV/AIDS," *Advocacy Note*, World AIDS Day, 2004, p. 4.

¹⁰ HRW, *Double Standards: Women's Property Rights Violations in Kenya* (New York, 2003); International Center for Research on Women, "Reducing Women's and Girls' Vulnerability to HIV/AIDS by Strengthening their Property and Inheritance Rights." *Information Bulletin*, May 2006 (ICRW: Washington, DC, 2006).

¹¹ Olivia Ward, "World's women have an advocate, More than half the globe's people need their own UN agency: Stephen Lewis." *Toronto Star*, 1 July 2006.

¹² *Ibid.*

¹³ Kaiser Family Foundation, "The HIV/AIDS Epidemic in the United States." *HIV/AIDS Policy Fact Sheet*, 2005, p. 2.

¹⁴ *Ibid.*

¹⁵ In a recent article in *Medical News Today*, Anjali Gopalan of the Naz Foundation India Trust, an organization working on HIV care and prevention with diverse communities commented "The police harass health outreach workers working on HIV prevention among the gay community. Volunteers are prevented from distributing condoms among prisoners by officials who cite these antiquated laws." "Gay Rights Groups in India Protest Arrest of MSM, HIV/AIDS Advocates Say Antiquated Laws Hinder Prevention," *Medical News Today*, 13 January 2006, at <http://www.medicalnewstoday.com/medicalnews.php?newsid=36093>

¹⁶ UNAIDS/WHO. Epidemiological Fact Sheet South Africa

¹⁷ UNAIDS, *2006 Report on the global AIDS epidemic*, p. 516.

¹⁸ Documented by the Blue Diamond Society at <http://www.bds.org.np/>

¹⁹ Yakin Ertürk, "INTERSECTIONS OF VIOLENCE AGAINST WOMEN AND HIV/AIDS: Report of the Special Rapporteur on violence against women, its causes and consequences." UN Doc: E/CN.4/2005/72, 17 January 2005, paragraph 27.

²⁰ Swedish International Development Agency (SIDA), *Sexual Orientation and Gender Identity Issues in Development*, p.41 at http://www.sida.se/shared/jsp/download.jsp?f=SIDA4948en_Sexual+Orientation+web.pdf&a=4855

²¹ Alongkorn Parivudhiphongs, "Dare to Care, Bangkok Post, April 8, 2005

²² Radhika Coomaraswamy (Special Rapporteur on violence against women), 2003. Report to the UN Commission on Human Rights, International, regional and national developments in the area of violence against women: 1994-2003. UN Doc. E/CN.4/2003/75/Add.1, paragraph 1347.

²³ *Strengthening Resistance*, p. 7

²⁴ *Ibid.*, p. 14.

²⁵ Strengthening Resistance, press release.

²⁶ *Strengthening Resistance*, p. 21.

²⁷ *Ibid.*, p. 21.

²⁸ *Ibid.*

²⁹ *Ibid.*, p. 22.

³⁰ *Ibid.*, p. 23.