



STRENGTHENING RESISTANCE:

Confronting Violence Against Women and HIV/AIDS

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Over the last few months, the Center for Women's Global Leadership (CWGL) has been conducting research that builds on the growing recognition that the pandemics of violence against women and HIV/AIDS are fundamentally linked. Around the world, service providers, activists and policymakers are beginning to address the points of intersection, yet for many, making these links is a new process. Overall, activists from HIV/AIDS, human rights and women's movements on a global level are just starting to generate advocacy focused on ways violence against women and HIV/AIDS fuel each other, as well as the human rights violations that are both causes and consequences of the flourishing of each pandemic. Many are coming to the not-surprising conclusion that violence against women and HIV/AIDS must be addressed together in order to effectively challenge each. CWGL will publish a report entitled, "Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS" in August of 2006 in conjunction with the XVI International AIDS Conference in Toronto, Canada. "Strengthening Resistance" provides resources and recommendations and highlights initiatives of local activists worldwide as they respond to the twin public health pandemics of violence against women and HIV/AIDS. This synopsis addresses key issues, salient political and human rights challenges and some of the innovative strategies used to address them from CWGL's research and that of others.

How are violence against women and HIV/AIDS related?

Women around the world are at risk of death and injury both because of HIV/AIDS and violence – both of which are preventable. Women now account for nearly 50% of adults living with HIV/AIDS globally and regional percentages have been on the rise for several years. In Sub-Saharan Africa, 57% of infected adults are women while 75% of infected young people are women and girls. In Southern Africa, one in five pregnant women tests positive for HIV.¹ These alarming statistics in large part are a product of gender discrimination, as is the scourge of violence against women. Violence against women is defined in the United Nations Declaration on the Elimination of Violence Against Women (DEVAW) as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." Globally, statistics on violence against women are staggering: one in every three women has been beaten, coerced into sex, or otherwise abused in her lifetime², between 30% and 60% of ever-partnered women have experienced physical or sexual violence, or both, by an intimate partner³, and between 7 and 48 % of girls and young women globally age 10-24 years report their first sexual encounter as coerced.⁴ Research has also made clear that violence against women, and the broader gender inequalities that fuel it, have devastating impacts on women's health – including the compromising of women's abilities to protect themselves from infection and hampered access to information and services related to HIV/AIDS.

Effective responses to the HIV/AIDS crisis require specific attention to human rights, government accountability and gender-based violence. The threat and reality of violence, and especially forced or coerced sex, increases women's vulnerability to HIV infection. Violence and fear of violence limit women's abilities to negotiate safe sexual behavior, even in a consensual union. Women who are or who are even perceived to be infected with the HIV virus may face violence and/or abandonment. Fear of violence associated with gender discrimination and the stigma that often comes with being HIV + can dissuade women from seeking information about HIV/AIDS, getting tested for HIV, disclosing their HIV status, or seeking treatment and counseling. Children orphaned by AIDS are more likely to face violence, exploitation, stigma

and discrimination, all of which increase orphaned girls' risk of sexual violence. Since the threat of violence can affect women's willingness to be tested, it can also have a detrimental effect on HIV control, treatment, and prevention programs, including those that focus on mother-to-child transmission.

- A study done in the United States indicated that African-American women with abusive partners were less likely to use condoms than African-American women who did not have abusive partners. African-American women with abusive partners were also four times more likely to be verbally abused and nine times more likely to be threatened with physical abuse when they asked their partner to use condoms.⁵
- In conflict situations, women and girls are at greatly increased risk of physical and sexual violence. Many women and girls are subjected to gang rape, forced marriages with enemy soldiers, sexual slavery, and other forms of violence. One survey found that 67% of women who survived rape during the Rwandan genocide were HIV+.⁶
- A study done in Tanzania found that the major reason for women who tested positive for HIV not disclosing their status to their male partners was fear of their partners' reactions.⁷
- In India, the work of SANGRAM/VAMP, a collective that has successfully promoted condom use among sex workers and their clients, was severely compromised when male community members threatened lives of and police harassed the organization's members and clients.⁸
- In the Dominican Republic, HIV tests are often administered without patients' consent, with results revealed by public health officials to women's families without their permission, thereby exposing them to potential violence and abuse.⁹

Yet, despite the growing collection of evidence, it remains difficult to track with specificity a causal link between HIV infection and violence against women. In large part, this results from the nature of the issues involved: sex and violence are often considered private matters not to be discussed outside the family or the community. Data collection is often hindered because of these social factors, which can have a direct effect on women's willingness to report violence or their serostatus to police, other officials or health providers.

HIV/AIDS and Violence Against Women: Interlinked Human Rights Concerns

Activists and researchers have long documented a range of human rights abuses immediately related to real or perceived HIV status, as well as to violence against women. Violations in both areas cut across a range of human rights, including those related to physical and mental integrity, dignity and security of person. Both transpire in the global North and South, and across socio-economic barriers. While the human rights implications of violence against women have been documented in some detail since the 1990s, rights implications of HIV/AIDS have been less explored to date. HIV-related human rights concerns include quarantine and other restrictions on movement; discrimination in health care settings, housing, employment and education; forced HIV testing (particularly that which involves targeting marginalized groups, such as prisoners, poor people, drug users, sex workers and immigrants)¹⁰; restrictions on prevention-related information and education about HIV transmission and threats to confidentiality in and denial of medical care. In each of these situations, women may experience abuses differently from men, and may be targeted in ways directly related to their gender. In particular, women are subjected to sexual violence and forced pregnancy, both of which can have specific HIV-related ramifications.

Violations are often interrelated, as specific abuses can fuel additional ones, with discrimination and gender inequality often at the core. For instance, women's rights to the highest attainable standard of health and to be free from discrimination are violated when their access to medical care depends on permission from or accompaniment of a male family member. When women's HIV status is disclosed without their consent, their rights to privacy are violated and they may suffer violence or further discrimination as a result. When policies restrict provision of evidence-based and scientific prevention information about HIV transmission (such as "abstinence-only-until-marriage" programs that primarily focus on condom and contraception failure rates), women's rights to education, information and to benefit from scientific progress are compromised. And when women's rights to assemble and participate in the public sphere are restricted, and when non-governmental organizations including women's and HIV groups are denied the right to legally function, the security of individual human rights defenders can be threatened.

The human rights framework has proven effective in focusing international attention on violence against women and providing women in diverse contexts with language, tools, and access to international law to hold governments accountable to prevent, investigate and punish perpetrators of violence. And while some governments have also made HIV-related human rights commitments (for instance, to create or amend legislation to reduce stigma and discrimination against HIV+ people), they have too rarely addressed the linkage between human rights, violence against women and HIV/AIDS on a policy level.¹¹

Activists across movements note that within service sectors, and especially within health, education and legal arenas, 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. Many activists argue that HIV/AIDS and violence crises are best addressed when there is stronger communication across movements and within the context of service provision, where providers grounded in HIV/AIDS and violence against women often know their own sectors in great depth, but too little about the "other" arena and too little about human rights contexts of their work.

Current Political Challenges and Innovative Advocacy

Significant challenges face HIV/AIDS and women's rights advocates as they attempt to strengthen linkages across their work. One Ugandan-based activist names a primary obstacle: working across movements. HIV has been virtually ignored by violence-related organizations, and, on the other hand, violence is seen as "too feminist" a concern to be incorporated into HIV organizations' agendas. "Violence organizations don't want to medicalize what they view as feminist issues," she explains. "They want their messages to be about feminism. Human rights [in their view] is not about disease. They don't want to be associated with HIV." HIV organizations, she adds, are no less reluctant to venture into violence prevention issues. "Issues of healthy sexuality are seen as too personal, and VAW as 'messy and complex'. They like to stay medically focused."¹²

Generally, the concerns of advocates in different movements are both elicited and paralleled by societal stigma and discrimination and often fueled by politically-motivated prejudices such as sexism, homophobia, and antipathy toward drug users, poor people and commercial sex workers. Those concerns are also informed by states' lack of political will: for instance, 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." The absence of a critical body of data on the causal link between VAW and HIV/AIDS also hinders state commitments in these areas.

But possibly the most critical obstacle facing advocates seeking to explore the nexus is state policy-based regulation of sexual and reproductive behavior of women and girls, young people, generally, and people living with HIV/AIDS. Regulations include "gag rule" restrictions on provision in schools, health clinics and community organizations of evidence-based and scientific information related to safer sex, abortion, contraception and condoms. Certain donor states also have forced organizations receiving funds to sign "anti-prostitution pledges," which can keep NGOs from being able to engage in effective prevention work, and threaten the human rights of women engaged in transactional sex.¹³ In schools, certain countries have promoted "abstinence-only-until-marriage" at the expense of comprehensive sexuality education, which teaches how best to protect against HIV and other sexually-transmitted infections. Promotion of abstinence-only is particularly troublesome, as many women face sexual violence and cannot control when and how to have sex with male partners.

In spite of these challenges, activists in all regions are employing creative strategies and programming to promote awareness of the links between HIV/AIDS and violence against women. Two particularly exciting initiatives are emblematic of the kinds of advocacy currently being launched: In the Horn, East, and Southern African region, advocates recently formed the Gender-Based Violence Prevention Network (there are presently 117 members in 16 countries), which quickly identified a need to focus on prevention strategies in combating violence against women. "Generally, there was a recognition that HIV/AIDS was spreading at such an alarming rate among women across cultures, that there had to be a link—that unless we started addressing the violence/HIV link, those numbers were not going to come down."¹⁴ The network's educational projects have

included development of education materials for regional distribution, drama performances for communities and seminars in prisons.

In Vietnam, The Institute for Social Development Studies and the Center for Studies and Applied Sciences in Gender-Family-Women and Adolescents partnered in order to blend expertise across movements. “*This is the first time we’re doing a joint partnership We’re strong on research and training, they’re strong on counseling and training. We’re strong on HIV/AIDS and they’re strong on gender-based violence. It’s quite exciting for us . . . it’s capacity-building for us both.*”¹⁵ The two organizations have shared funding to collect and analyze relevant telephone hotline data generated by reviewing thousands of calls to train counselors for their everyday work with clients of both constituencies. Data is also to be used to inform advocacy with the public through mass media. It is noteworthy that this partnership between organizations that had not previously worked together is the result of a health and human rights organization’s strategic intervention to bring VAW and HIV groups together in a number of countries.¹⁶

Yet, alongside this innovative advocacy rests a primary truth: much work still needs to be done by advocates and policymakers to surface the intersections of HIV and violence against women in service provision, law, policy and practices, including in development and integration of and programming in National Action Plans and specialized ministries, in budgeting processes and in resourcing of health services, care and education. Government officials, service providers and advocates alike must create and adequately resource policies and research projects that strengthen data collection and further surface the causal link between HIV and VAW. They also must ensure that grassroots organizing efforts are supported, and that the human rights of women are protected when they choose to organize, seek health care or disclose experiences of violence or their HIV status.

Resources For an extensive list of resources on violence against women and HIV/AIDS, see the comprehensive bibliography from CWGL’s *16 Days of Activism Against Gender Violence campaign Take Action Kit*, available online at: <http://www.cwgl.rutgers.edu/16days/kit05/kit.html>.

¹ UNAIDS. 2004. Report on the Global AIDS Epidemic and UNAIDS. 2005. Update on the AIDS Epidemic. Geneva, Switzerland: UNAIDS.

² Heise L L, Ellsberg M, and Gottemoeller M. 1999. Ending violence against women. *Population Reports, Series L, No. 11*. Baltimore, MD: Johns Hopkins University School of Public Health, Center for Communications Programs.

³ García-Moreno, C, Jansen, Henrica A.F.M., Ellsberg, M, Heise, L and Watts, C, for World Health Organization. 2005. WHO Multi-Country Study on Women’s Health and Domestic Violence against Women: Initial results on prevalence, health outcomes and women’s responses. Geneva, Switzerland: World Health Organization.

⁴ Krug EG et al., eds. 2002. World Report on Violence and Health. Geneva, Switzerland: World Health Organization.

⁵ Wingood G M and DiClemente R J. 1997. The effects of an abusive primary partner on the condom use and sexual negotiation practices of African-American women. *American Journal of Public Health*. 87(6): 1016-1018.

⁶ Human Rights Watch. 2004. Struggling to survive: Barriers to justice for rape victims in Rwanda. Vol.16, No.10(A). New York: Human Rights Watch.

⁷ Maman, s, Mbwapbo, J, Hogan, M, Kilonzo, G, Sweat, M, Weiss, E. 2001. HIV and Partner Violence: Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam, Tanzania. New York, NY: The Population Council.

⁸ Human Rights Watch. 2002. Epidemic of Abuse: Police Harassment of HIV/AIDS Outreach Workers in India. Vol.14 No.5(c). New York, NY: Human Rights Watch.

⁹ Human Rights Watch. 2004. A Test of Inequality: Discrimination Against Women Living with HIV in the Dominican Republic. Vol.16, No.4(B). New York, NY: Human Rights Watch.

¹⁰ Women (and men) of course can be members of any and a number of these groups simultaneously, and can be targeted for abuses (or experience protection from abuses) because of the linking of various social factors, such as race, socio-economic status, sexual orientation and age, in addition to gender.

¹¹ See the International Guidelines on HIV/AIDS (UNAIDS and OHCHR), the Declaration of Commitment from the 2001 UN General Assembly Special Session on HIV/AIDS for additional recommendations and commitments

¹² Lori Michau, co-director of Uganda-based Raising Voices, and coordinator of its Violence against Women Program

¹³ See the website of Center for Health and Gender Equity, <http://www.genderhealth.org/loyaltyoath.php?TOPIC=PRG>

¹⁴ Michau, see note 12.

¹⁵ Anh Van Nguyen, Institute for Social Development Studies, Vietnam

¹⁶ For more detail, contact the International Program on Health and Human Rights at the Harvard School of Public Health.

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