16 Ideas for addressing violence against women in the context of the HIV epidemic

a programming tool

World Health Organization

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Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
FSW	female sex workers
GBV	gender-based violence
HIV	human immunodeficiency virus
HSV-2	herpes simplex virus 2
PEP	post-exposure prophylaxis
PMTCT	prevention of mother-to-child transmission
PTSD	post-traumatic stress disorder
RCT	randomized controlled trial
SRH	sexual and reproductive health
STI	sexually-transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UN	United Nations
VAW	violence against women
VCT	voluntary counselling and testing
WHO	World Health Organization

Introduction

Women account for half of all adults living with the human immunodeficiency virus (HIV) *(1)*. In sub-Saharan Africa, the region most severely affected by the pandemic, women constitute a majority – 58% according to the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates for 2012 *(1)*. Young women aged 15–24 years are twice as likely as their male counterparts to be living with HIV *(1,2)*. In other regions, including those with concentrated epidemics, specific groups of women such as sex workers, injecting drug users, and intimate partners (e.g. wives, girlfriends) of clients of sex workers and/or men who have sex with men face increased risk and vulnerability to HIV *(1)*. While women face physiological reasons for greater risk of HIV acquisition than boys and men, strong evidence indicates that gender inequality also increases their vulnerability to HIV. Evidence has established that violence against women is associated with an increased risk of HIV among women as well as within specific populations, such as sex workers *(3,4)*. Anecdotal reports of women living with HIV suggest that they may also experience violence due to their status.

Recognizing the importance of gender inequality, and particularly violence against women, in increasing women's vulnerability to HIV, several international organizations and donors have prioritized the need to address gender inequality and violence against women within their HIV strategies. These include: the *UNAIDS strategy* (2011–2015); the World Health Organization (WHO) *Global health sector HIV/AIDS strategy (2011–2015)*; the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) gender equality strategy and the gender strategy of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) *(5–8)*. The agreed conclusions of the 57th Commission on the Status of Women (2013) and the *Political Declaration on HIV/AIDS* (2011) also specify the need to address violence against women in the HIV response *(9,10)*.

Rationale for a programming tool on violence against women and HIV

HIV programmes are a critical entry point for addressing violence against women for several reasons. There are common underlying factors such as gender inequality that contribute to both epidemics. HIV and acquired immunodeficiency syndrome (AIDS) services provide an entry point for women experiencing violence to mitigate HIV risks and vulnerabilities, and for women living with HIV to mitigate violence risks associated with HIV. Addressing violence can reduce barriers women face in accessing HIV prevention, treatment, care and support services.

Positive change in both violence against women and HIV outcomes can be achieved through even small efforts to jointly address the dual epidemics. This tool responds to the need for presenting evidence-based options for addressing violence against women in the varying contexts of HIV epidemics. The need arises from:

- strong evidence demonstrating the links between violence against women and HIV;

- emphasis placed by the United Nations (UN), donors, civil society and an increasing number of countries on addressing violence against women in the context of the national AIDS response;
- the importance given to addressing violence against women and gender equality as critical enablers (i.e. to enable equity, efficacy and sustainability of interventions and promote human rights) and as a development synergy for an effective HIV response in the AIDS Investment Framework *(11,12)*;
- lack of guidance on evidence-based approaches for countries to address violence against women in the context of their national AIDS response.

Purpose, intended users and scope

The publication aims to help users to:

- identify core values based on gender equality and human rights, as well as sound principles to apply in designing strategies and programmes;
- learn about the existing evidence base and programmatic examples for addressing violence against women in the context of HIV epidemics;
- generate programming ideas on what can be done to address violence against women in HIV programmes, including in national AIDS plans, programmes and policies.

It is not a blueprint or guideline, with recommendations for or against particular strategies. Rather, it introduces users to *16 programming ideas* based on a synthesis of evidence from systematic and other literature reviews, reports and UN publications on interventions to address the intersections of violence against women and HIV.

The intended users of this tool are:

- policy-makers, managers of national HIV programmes from relevant line ministries;
- donors;
- national and international nongovernmental organizations and community-based organizations;
- United Nations agencies and programmes;
- institutions conducting intervention research and providing technical support for violence against women and HIV programmes.

The current publication helps intended users in considering 'what' are some effective or promising strategies to consider. It does not provide detailed guidance on 'how to' implement them. It intentionally focuses on specific forms of violence that are most common in women's lives globally, that are most relevant for the HIV epidemic, and for which there is more evidence on promising interventions: intimate partner violence, sexual violence by non-partners and violence experienced by women in selected key populations, such as sex workers. Specific forms of violence faced by women living with HIV, such as forced sterilization, are addressed in a separate forthcoming UN document. The scope of this document includes adolescent girls (15–19 years of age) to the extent that this age group is addressed in interventions with young women, even though it is not explicitly stated. It does not address violence against children, conflict-related sexual violence, or violence faced by men and transgender people.

Evidence, core concepts and guiding principles

How widespread is violence against women?

Violence against women is a widespread and costly public health problem. It is rooted in gender inequality and is a violation of women's human rights that exists in all parts of the world. Violence against women has serious consequences for women's health that include fatal and non-fatal injuries, unintended pregnancies, induced abortions, sexually transmitted infections (STIs) including HIV, and mental health problems (e.g. depression, anxiety, suicide) among others. Global and regional estimates on violence against women published by WHO show that one in three women worldwide have experienced either physical and/or sexual violence by an intimate partner or non-partner sexual violence in their lifetime. This figure ranges from 27% in the WHO European Region to 46% in the African Region. Adolescent girls (15–19 years of age) and young women (20–24 years of age) also experience high levels of intimate partner violence in their lifetime with a prevalence of 29% and 32% respectively *(13)*.

Box 1 Definitions *(14–16)*

Violence against women (VAW): Any public or private 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 with the family or general community. It includes sexual, physical, or emotional abuse by an intimate partner (known as 'intimate partner violence'), family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers); sexual trafficking; forced marriage; dowry-related violence; honour killings; female genital mutilation; and sexual violence in conflict situations.

Gender-based violence (GBV): It describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with 'violence against women'. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they don't conform to or challenge prevailing gender norms and expectations (e.g. may have feminine appearance) or heterosexual norms.

Intimate partner violence: Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse[1] and controlling behaviours.

Sexual violence including rape: Any sexual act, attempt to obtain a sexual act, unwanted sexual comment or advance[2], or acts or attempt to traffic, or acts otherwise directed against a person's sexuality using force or coercion, by any person regardless of their relationship to the victim, in any setting including, but not limited to, home and work.

1 While psychological abuse is conceptually included in the definition, it is not usually measured in studies cited in this document, in part because the work done to measure it has been less advanced than measurement of physical or sexual violence.

2 Studies, have less often included unwanted sexual comment or advance and acts or attempts to traffic as measures of sexual violence compared to forced or coerced sexual acts.

The association between violence against women and HIV

Research conducted in different countries has documented associations between HIV and physical and/or sexual violence, both as a risk factor for HIV infection and as a potential consequence of being identified as living with HIV *(3, 4, 17–22)*.

Box 2 Key studies illustrating the links between violence against women and HIV

- A systematic review and meta-analysis of studies across different HIV epidemic settings shows that intimate partner violence poses a 1.52 fold increase in risk of HIV among women (*13*).
- Analysis of data from a longitudinal HIV study (from 2001 to 2009) in Uganda shows that women (15–49 years of age) who had experienced intimate partner violence (physical and/or sexual and/or verbal) were 1.55 times more likely to subsequently acquire HIV than those who had never experienced such violence. The study estimated that 22% of new HIV infections could be attributed to intimate partner violence (*23*).
- In a longitudinal study in South Africa, young women (aged 15–24 years) who reported multiple episodes of intimate partner violence were 1.51 times more likely to acquire HIV compared to women with one or no episodes of intimate partner violence. Women who scored low on a gender equity scale were 1.51 times more likely to subsequently acquire HIV compared to all other women. The study estimated that 12% of new HIV infections could be attributed to intimate partner violence and 14% to low gender equity (*19*).
- In a cross-sectional study in Moscow, Russia, female sex workers who experienced physical violence from clients in the past year were 3 times more likely and those who received threats of violence from their managers were approximately 3.5 times more likely to be at risk for HIV or other STIs compared to those who did not experience violence or receive such threats (*24*).
- In a cross-sectional study of 28 000 married women (aged 15–49 years) in India, those who had experienced both physical and sexual violence from intimate partners were nearly 4 times more likely to be HIV positive than those who had experienced no violence (*18, 25*).

The links between violence against women and HIV

There are four potential ways to explain the links between violence against women and HIV:

1. Common risk factors – gender inequality being central – underlie both violence against women and HIV transmission (Figure 1).
2. Indirect pathways link violence against women to a range of HIV-related outcomes (Figure 2).
3. Direct transmission of HIV as a result of rape (Figure 2).
4. Violence can be a consequence of women living with HIV disclosing their HIV status and facing stigma and discrimination.

1. Gender inequality as a common determinant of violence against women and HIV

The first pathway illustrates how gender inequality (see Box 3) is a common determinant of both violence against women and HIV transmission (Figure 1).

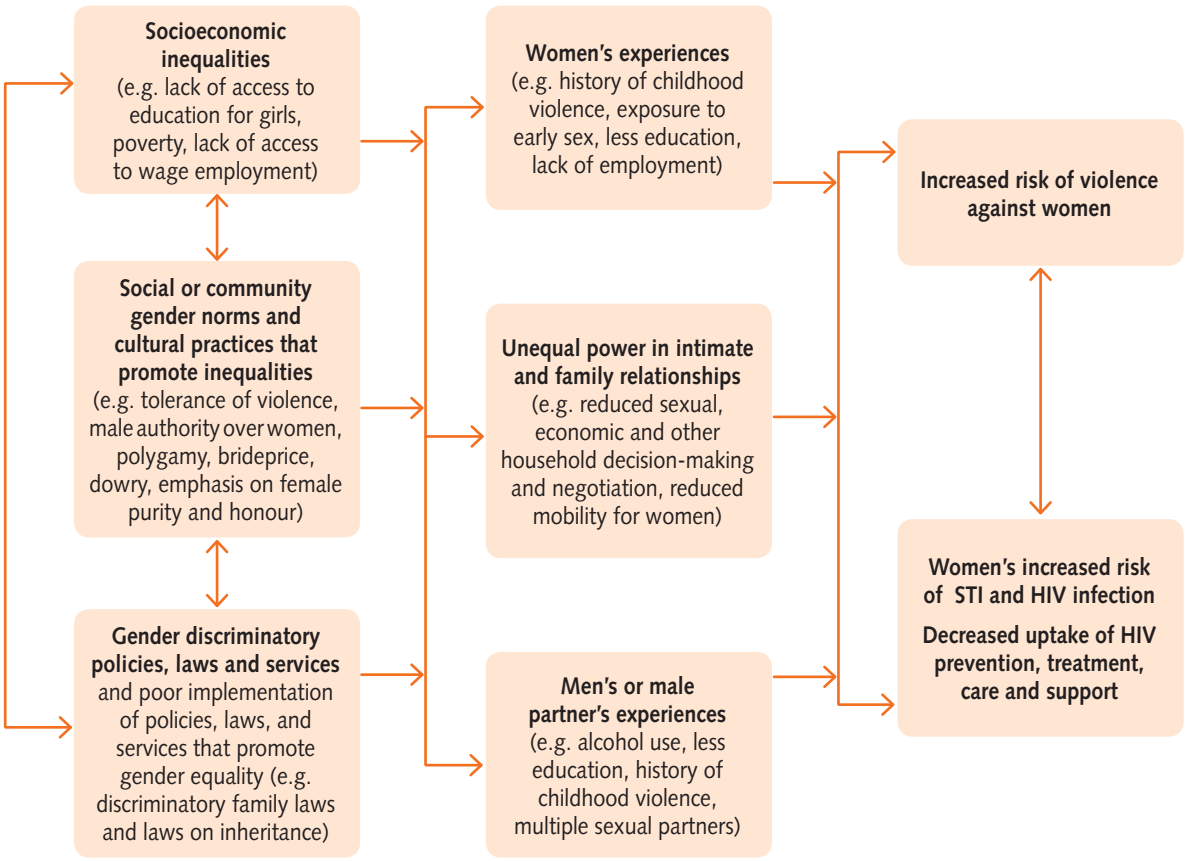
Box 3 Definition of gender inequality *(26)*

Gender inequality: Refers to gender norms and roles, cultural practices, policies and laws, economic factors, and institutional practices that collectively contribute to and perpetuate unequal power relations between women and men. This inequality disproportionately disadvantages women in most societies. It plays out in women's intimate relationships with men as well as at family, household, community, societal, institutional and political levels. Many women lack access to and control over economic and other resources (e.g. land, property, access to credit, education) and decision-making power (e.g. in sexual relations, health care, spending household resources, making decisions about marriage). This lack of power makes it difficult for women to negotiate within, or leave abusive relationships or those where they know they could be at risk for HIV and/or other STIs.

Evidence suggests that multiple factors, operating at different levels, are associated with women's risk of intimate partner violence and HIV. For example:

- Studies suggest that women who are exposed to violence in childhood (e.g. witnessing parental violence, experiencing childhood abuse) or those who make an early sexual debut (often coerced) are at increased risk of intimate partner violence and HIV later in life *(14,27–30)*. These are labelled as 'women's experiences' in Figure 1.
- Studies suggest that men's experience or witnessing of violence in childhood, harmful use of alcohol and having multiple concurrent partners are associated with perpetration of violence and increased risk of HIV infection *(28,31–33)*. These are labelled as 'men's experiences' in Figure 1.
- Studies suggest that male control over women's behaviour (e.g. controlling women's access to health care, threats, restricting mobility) is associated with intimate partner violence and negative HIV outcomes *(14,19,21)*. These are labelled as 'unequal power relationships' in Figure 1.
- Studies show that attitudes (among men and women) condoning violence against women, acceptance of norms that legitimize male control over women, and feminine norms that condone female submission are associated with increased risk of women's experience of intimate partner violence, male perpetration of violence against women, increased HIV risk-behaviours, and decreased access to HIV information and services for women *(14,28,31,34)*. These are labelled 'social or gender norms and cultural practices' in Figure 1.
- Evidence further suggests that women's lack of empowerment and discriminatory, inadequate or poorly implemented laws and policies that perpetuate women's low status in society (e.g. low levels of education, lack of access to employment, unequal property and inheritance rights) are underlying determinants for both violence against women and HIV *(28,35)*. In Figure 1 these are labelled as 'socioeconomic inequalities' and 'gender discriminatory laws and policies'.

Figure 1: Gender inequality as a common driver of both violence against women and HIV/AIDS (Pathway 1)



2. Violence against women as an indirect factor for increased HIV risk, and a barrier to uptake of HIV services, poor treatment adherence and response

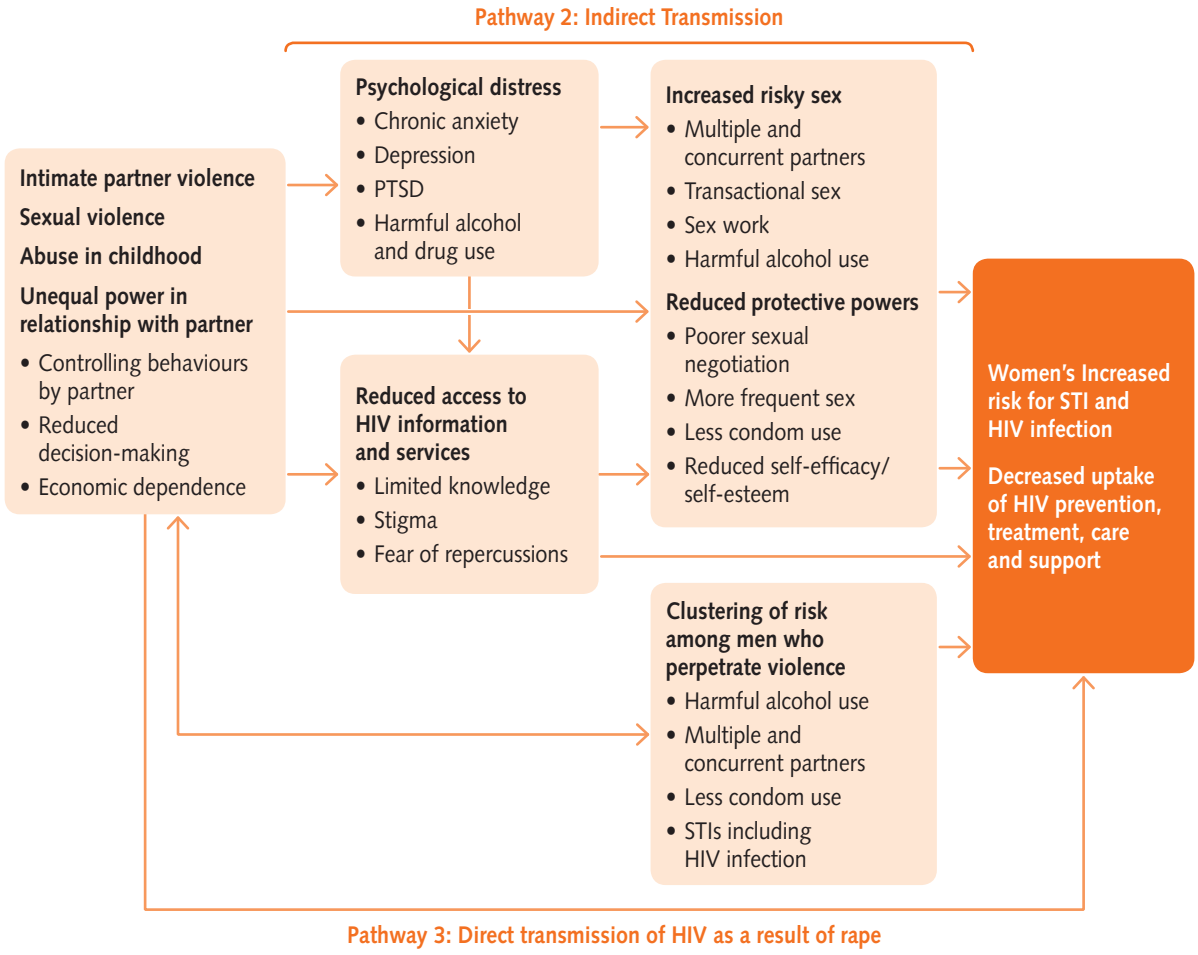
Figure 2 illustrates the existence of indirect pathways linking violence against women and HIV *(19)*.

- Studies show that women who were sexually or physically abused either in their childhood or adolescence are more likely to engage in risk-taking behaviours that are associated with HIV. This includes increased likelihood of engaging in transactional sex, early sexual initiation, having multiple sexual partners or unprotected anal sex, increased likelihood of harmful substance use (drugs or alcohol), and partnering with older and/or men who are themselves at higher risk for HIV infection *(19,21,22,30,36,37)*.
- Studies show that women who are in abusive relationships are less likely to negotiate condom use and practice safer sex *(19,21,38,39)*. The reduced ability to adopt protective behaviours may be linked to psychological trauma and distress experienced by women and to increased depression and other mental health problems associated with the trauma. Reduced ability to adopt protective behaviours can also be rooted in lower self-esteem and self-efficacy among women who experience violence *(40–42)*.
- Studies show that men who perpetrate sexual and/or physical violence are more likely than those who don't perpetrate violence to engage in risk-taking behaviours, including

having multiple sexual partners, engaging in harmful use of alcohol and drugs and coercing women into having unprotected sex. Hence, women in relationships with such men are also at increased risk of HIV acquisition (18, 22, 30, 43–46).

- Studies on uptake of HIV testing and counselling, barriers and outcomes of HIV disclosure show that fear of rejection, abandonment and violence by partners remain major barriers to testing, disclosure and uptake of and adherence to treatment for women in many parts of the world (47–53).
- Women who experience sexual violence are often stigmatized in communities, work places and other institutions including in health care. Women who experience sexual violence may not be taken seriously when they report it. Hence, they may hesitate to seek HIV and other services (54). Moreover, controlling behaviour by perpetrators (e.g. partners or non-partners) can compound their silence and prevent them from seeking services.
- Studies from the United States of America suggest that women living with HIV who are exposed to violence by partners and/or others and other traumatic and stressful life events may be at increased risk of non-adherence to antiretroviral therapy (ART), lower CD4 counts, and higher viral loads (55–58).

Figure 2: Indirect and direct links between violence against women, HIV risk and uptake of services (Pathways 2 and 3)



3. Sexual violence as a direct risk factor for HIV transmission

The third pathway highlighted in Figure 2 points to the possibility of direct transmission of HIV as a consequence of sexual violence or rape *(59)*. The risk of HIV transmission from a single incident of rape is small, even in settings with high HIV prevalence, but the risk may be elevated in cases of genital injury (e.g. degree of trauma, lacerations or tears in the vagina resulting from the use of force or objects), penetration by multiple perpetrators or anal penetration *(4,60)*. A woman's individual risk of HIV from forced sex may also be elevated when it occurs repeatedly within intimate relationships *(3)*. Girls may be at elevated risk of transmission because their vaginal tracts are immature and may tear more easily. Sex workers may experience sexual violence repeatedly. They may also be at increased risk of HIV associated with an elevated risk of HIV and others STIs among perpetrators *(4)*.

4. Violence against women as an outcome of HIV status and disclosure

Women living with HIV experience high levels of intimate partner violence and other forms of violence (e.g. forced sterilization). They also experience high levels of stigma (e.g. being shunned) and discrimination (e.g. forced evictions or refused treatment or care because of their HIV status) and other human rights abuses, which some studies define as a continuum of violence *(61)*. A 2004 review of rates, barriers and outcomes of HIV disclosure showed that among women who disclosed their HIV status, a majority reported positive outcomes and supportive reactions. However, between 3 and 15% of women in these studies reported experiencing violence at the time of disclosure *(48,62)*. A recent study in Ethiopia found that a majority of 385 women living with HIV who disclosed their status to their partners reported negative reactions such as anger, blame, end of relationship, abandonment and violence *(63)*. Another study among 289 women living with HIV in Nigeria found that those who disclosed their status to their partner were three times more likely to have experienced physical and emotional violence following diagnosis than those who had not disclosed *(64)*. Qualitative research from South Africa exploring the experiences of women living with HIV suggests that upon disclosure of their HIV status they experience a continuum of stigma, discrimination and violence ranging from blame, discriminatory behaviours (e.g. refusing to touch or eat food prepared by the woman) to verbal abuse (e.g. shouting, insults) to physical and sexual abuse *(65)*.

Guiding principles for programmes to address violence against women and HIV

The ways in which programmes are designed and implemented play an important role in their success. The key principles presented here emphasize both core values and sound programme design considerations *(26,66–69)*.

Core values

Programmes must:

- Be driven by a human rights approach. This means recognizing that violence against women violates the fundamental principle of equality between women and men that

is enshrined in international and regional human rights laws and instruments (e.g. *Convention on the Elimination of All Forms of Discrimination Against Women*, or CEDAW). It means challenging unjust or unequal distribution of power between men and women that underlies violence against women and HIV risk, and actively promoting an equitable balance of power between women and men. It means that programme staff, as duty bearers, are responsible for promoting and upholding human rights. This includes for example, upholding, respecting and supporting a woman's right to make her own decisions in relation to the violence she experiences (e.g. choosing not to leave or report an abusive relationship to authorities). It means giving women information and options they can use to make informed choices and decisions about their lives including reproductive decisions. It also means promoting the rights of sex workers to not be subjected to violence.

- Put women's safety first and ensure confidentiality of information. For example, the location, outreach and timing of programme activities and services must be planned in ways to minimize risk of further violence and stigma.
- As a minimum, do no harm. Interventions can result in a backlash against women from their partners, families and community members. It is important to be cognizant of this and include strategies to monitor unintended consequences, promote women's safety, and mitigate such backlash.
- Strive to promote gender equality. There are increasing calls for implementing '*gender transformative*' interventions to address violence against women, HIV and AIDS (see Box 4).
- Treat all people with respect, regardless of age, sexual orientation, gender identity, ethnicity, religion, class, occupation or HIV status.
- Facilitate meaningful participation of women and/or men in the design, implementation and evaluation of the interventions by strengthening their capacities and involving them as decision-makers.

Box 4 Definition of gender transformative approaches *(26, 70)*

Gender transformative approaches encourage critical awareness of gender roles and norms and include ways to change harmful to more equitable gender norms in order to foster more equitable power relationships between women and men, and between women and others in the community. They promote women's right and dignity; challenge unfair and unequal distribution of resources and allocation of duties between men and women; and consider specific needs of women and men. Such approaches can be implemented separately with women and girls and with men and boys. However, they are also being increasingly implemented with both women and girls and men and boys together and across generations – either simultaneously, or in a coordinated way in order to challenge harmful masculine and feminine norms and unequal power relations that may be upheld by everyone in the community.

Programming principles

In the planning and designing of interventions, the following principles should be considered (Figure 3).

Figure 3: Programming principles

EVIDENCE

Know your epidemics, know your response: Knowing the characteristics of both epidemics enables the adaptation of programmes for greatest impact. While national level data on violence against women may be limited, community- and site-based studies may exist and can help understand risk factors and populations most at risk. Formative research and data triangulation can help increase understanding of the links between HIV and violence against women by synthesizing data from various sources *(199).* Evidence on effective interventions can also be drawn from existing WHO guidelines on violence against women.

Evaluation: This helps build the evidence base and ensure that resources are directed to programmes that provide the greatest benefit. An evaluation plan needs to be developed and include measurable objectives that articulate results and indicators related to violence against women and HIV. Unintended/adverse outcomes of the intervention also need to be monitored and documented.

Theory and pathways of change: A theoretical framework and an understanding of the pathways of change will help map out the processes that can lead to reductions in violence against women and improvements in HIV outcomes *(105).* These pathways will be specific to different contexts. For example, in generalized HIV epidemics in southern and eastern Africa, the links between forced and early sexual debut and sexual risk-taking may explain young women's HIV risk. Whereas in settings with concentrated HIV epidemics, the association between violence against sex workers and lack of condom use may explain their risk of HIV. Interventions to empower women should be informed by theories of gender relations and women's empowerment (e.g. theory of gender and power, theory of gender stratification) *(122, 123, 200, 201).* Whereas interventions aimed at social norm or behaviour change should be informed by social and behaviour change models (e.g. social learning theory, diffusion of innovation) *(116, 203, 204).*

INCLUSION

Participatory approach: Interventions that use participatory methods (e.g. build community ownership, encourage community members to design and lead activities) can better meet beneficiary needs and produce more lasting outcomes. Engaging participants and communities in identifying problems, in critical reflection on the roots of the problems, and developing solutions can strengthen programme relevance, build enduring life and relationship skills, as well as help ensure the success of programmes in the long term *(68).*

Diversities: Understanding the diverse situations and needs of different sub-groups of women at risk of violence and HIV, and of men perpetrating violence, is critical. For example, younger women and adolescent girls may be especially vulnerable to specific forms of violence (e.g. sexual abuse from other family members or authority figures). Similarly, interventions to change gender norms may work better with adolescent boys who may be more open to challenging prevailing norms than older men.

Partnerships: Establishing partnerships with a wide range of stakeholders will help in designing a more comprehensive intervention with greater community ownership. Such partnerships can include nongovernmental organizations working on gender equality, violence against women, networks of women living with HIV, law enforcement institutions, faith-based leaders and social services.

DESIGN

Multiple entry points: Interventions that operate at multiple levels can have a significant impact on reducing violence against women and the risk of HIV. This may include intervening through health, law enforcement, justice and social welfare sectors, or at individual, community, institutional and societal levels. Programme planners may need to map the availability of relevant services, establish linkages and make referrals as appropriate.

Capacity development: Building the capacities and competencies of programme staff in understanding and addressing links between gender inequalities, violence against women and HIV is crucial. Programme staff need to respond sensitively and in ways that do not further stigmatize or blame women for their situation.

Systems approach: Programmes that strengthen existing community and health systems (e.g. personnel and infrastructure) are necessary for building strong social movements and fostering sustainable change. This requires strengthening local women's organizations, including those working on violence against women, women's rights, women living with HIV and other community-based organizations *(68).*

Planning: It is important to be realistic and plan for short-, medium- and long-term changes. For example, while improved awareness of violence against women may be achieved in the short term, changes in social norms at the community level and sustained reductions in violence against women may require longer-term planning and investment *(68).*

16 ideas for addressing violence against women and HIV

How to use this publication

Sections 1 to 4 present 16 programming ideas that jointly address violence against women and HIV through four sets of complementary strategies:

- Section 1: Empowering women and girls through integrated, multisectoral approaches (Programming ideas 1 to 4).
- Section 2: Transforming cultural and social norms related to gender (Programming ideas 5 to 8).
- Section 3: Integrating violence against women and HIV services (Programming ideas 9 to 12).
- Section 4: Promoting and implementing laws and policies related to violence against women, gender equality and HIV (Programming ideas 13 to 16).

Figure 4 (page 14) provides a summary of the 16 ideas in a 'programming wheel' that provides a quick and easy reference to get started. The four sections are ordered so that strategies move from the individual level (i.e. women), to the community and service levels, through to the structural level (i.e. laws and policies). Each section contains four programming ideas. Individual programming ideas describe the relevant intervention, provide a summary of the evidence, and assess the evidence for effectiveness of the approach. Country-based examples of respective interventions – including their main elements, beneficiaries, evaluation design, key results and lessons learnt – are summarized for each programming idea in Annexes 1 to 14.

Users can choose the strategy(ies) that is/are most relevant to their community or context (e.g. integrating violence against women and HIV services, or transforming cultural and social norms) and directly go to the programming idea(s) in that section. More than one programming idea can be implemented in synergistic or complementary ways (e.g. interventions can be designed to empower women and simultaneously work with men to change gender norms).

A note on evidence

Evidence on 'what works' or 'what is effective' is typically based on assessing the quality of evidence. Quality of evidence is based on type of evaluation design, potential biases, strength and consistency of effects on outcomes across one or more settings or programmes.

Evaluations based on randomized controlled trials[1] are considered stronger compared to quasi-experimental study designs.[2] Evaluations based on experimental designs (i.e. either randomized controlled trials or quasi-experimental designs) are considered stronger than non-experimental designs (i.e. where there is no control or comparison group) because with the latter it is difficult to rule out alternative explanations for observed changes or confidently attribute them to the intervention. Similarly, outcomes such as improvements in knowledge and attitudes towards violence against women and HIV are considered weak compared to reductions in perpetration or experience of violence and HIV prevalence or incidence, because improvements in knowledge and attitudes do not always translate into improvements in behaviours. It is also important to highlight the following points:

- The evidence for the impact of interventions to address violence against women in the context of HIV is still emerging. As yet, few interventions have been rigorously evaluated. Those that have been rigorously evaluated and shown to be effective in one setting have not been replicated elsewhere in order to establish consistency of effects across different settings.
- Many well evaluated programmes have been implemented in high-income settings, with fewer in low- and middle-income countries.
- Randomized controlled trials are not always practical or appropriate for designing complex (i.e. multi-component) interventions that are often context-specific and aim to make changes at the community, societal, institutional and/or policy levels. Several interventions have instead used cluster randomized controlled trials,[3] which still offer strong confidence in trial findings. Others, such as mass media interventions, have been evaluated using quasi-experimental or non-experimental designs *(71)*.
- In many low-resource settings, it is not always feasible to collect data on HIV incidence, as it requires more financial resources and a longer time frame to show change and impact. Hence, many programmes measure intermediate outcomes (e.g. partner communication about sexual and reproductive issues, sexual risk behaviours, condom use, uptake of HIV testing) that may be more amenable to change in the short or medium term. Intermediate outcomes for both violence against women and HIV interventions can provide important information about pathways that lead to change in perpetration or experience of violence against women as well as HIV transmission.
- Many interventions do not provide information about cost, which is needed to assess feasibility of implementing such interventions in different settings.

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1 Randomized controlled trials are a rigorous way of determining whether an intervention has had an impact on desired outcome(s). Individuals are randomly allocated to an intervention group and a control group; both groups are treated identically except for the experimental intervention; and outcomes for participants are analysed within the group to which they are allocated irrespective of whether they experienced the intended intervention. The analysis focuses on estimating size of differences in outcome(s) between the intervention and control groups.

2 Quasi-experimental study designs aim to evaluate the impact of interventions on outcomes, but do not randomly allocate individuals to intervention and control group. Quasi-experimental studies can use pre- and post-intervention comparison and also include non-randomly selected control groups. They are considered weaker than randomized controlled trials because of the possibility that intervention and control groups may be different at baseline and because of the possibility of confounding factors that cannot be accounted for in explaining outcomes.

3 Community or cluster randomized controlled trials are types of randomized controlled trials in which groups of individuals (e.g. units such as villages, or health facilities or schools) are randomly allocated to intervention and control groups instead of individuals. They are more appropriate when interventions are targeted to entire units (e.g. mass media campaign or providing microfinance loans to groups of women in a village) and there is greater likelihood that individuals in the same unit will influence behaviours of others.

- Many interventions or programmes do not provide sufficient information about the context in which interventions have worked, and also how they have worked among different sub-groups of participants. This makes it challenging to identify how best to design and adapt the intervention to the different contexts and needs of different sub-groups of beneficiaries.

Box 5 summarizes the criteria used for assessing the effectiveness of programming ideas 1 to 12.[1] The evidence base for addressing violence against women in the context of HIV is in the early stages of being established for the reasons described above. Therefore, many of the programming ideas described are considered *promising* rather than *effective*. However, this should not deter users from undertaking programming in this area. This tool should be used with an open approach to trying promising interventions and generating innovative new ideas. However, programme design must include a careful consideration of pathways of change, adaptation to the local context, and rigorous monitoring and evaluation. Where available, existing WHO guidelines also provide evidence-based interventions for some of the programming ideas.

Box 5 Criteria for rating the effectiveness of the programming ideas

Effective: Programming ideas that are supported by multiple, well designed programme evaluations that show reductions in perpetration and/or experience of violence against women (e.g. intimate partner violence or sexual violence) and/or improvements in HIV-related risk behaviours (e.g. condom use, reductions in transactional sex) or uptake of HIV services or HIV/STI prevalence or incidence. Programming ideas for which corresponding WHO guidelines or recommendations already exist are also included in this category.

Promising: Programming ideas that are supported by either: at least one well designed or several less well-designed programme evaluations that show reductions in perpetration and/or experience of violence against women and/or positive changes in knowledge or attitudes or beliefs or norms related to violence against women *and/or* improvements in HIV-related risk behaviours (e.g. condom use, reductions in multiple sexual partners) or uptake of HIV services or HIV/STI prevalence or incidence, or in HIV knowledge and/or attitudes.

Ineffective or effectiveness unclear: This includes: 1) programming ideas that are supported by one or more well designed programme evaluation that show no reductions in perpetration and/or experience of violence against women and/or no positive changes in knowledge, / attitudes, beliefs or norms related to violence against women; and/or no positive changes in HIV-related outcomes; or 2) programming ideas where there is insufficient or mixed evidence of improvements in violence against women and/or HIV-related outcomes.

Effectiveness undetermined: Programming ideas that do not have any or weak evaluations, but have potential because of a theoretical basis or known risk factors, or they have on-going evaluations.

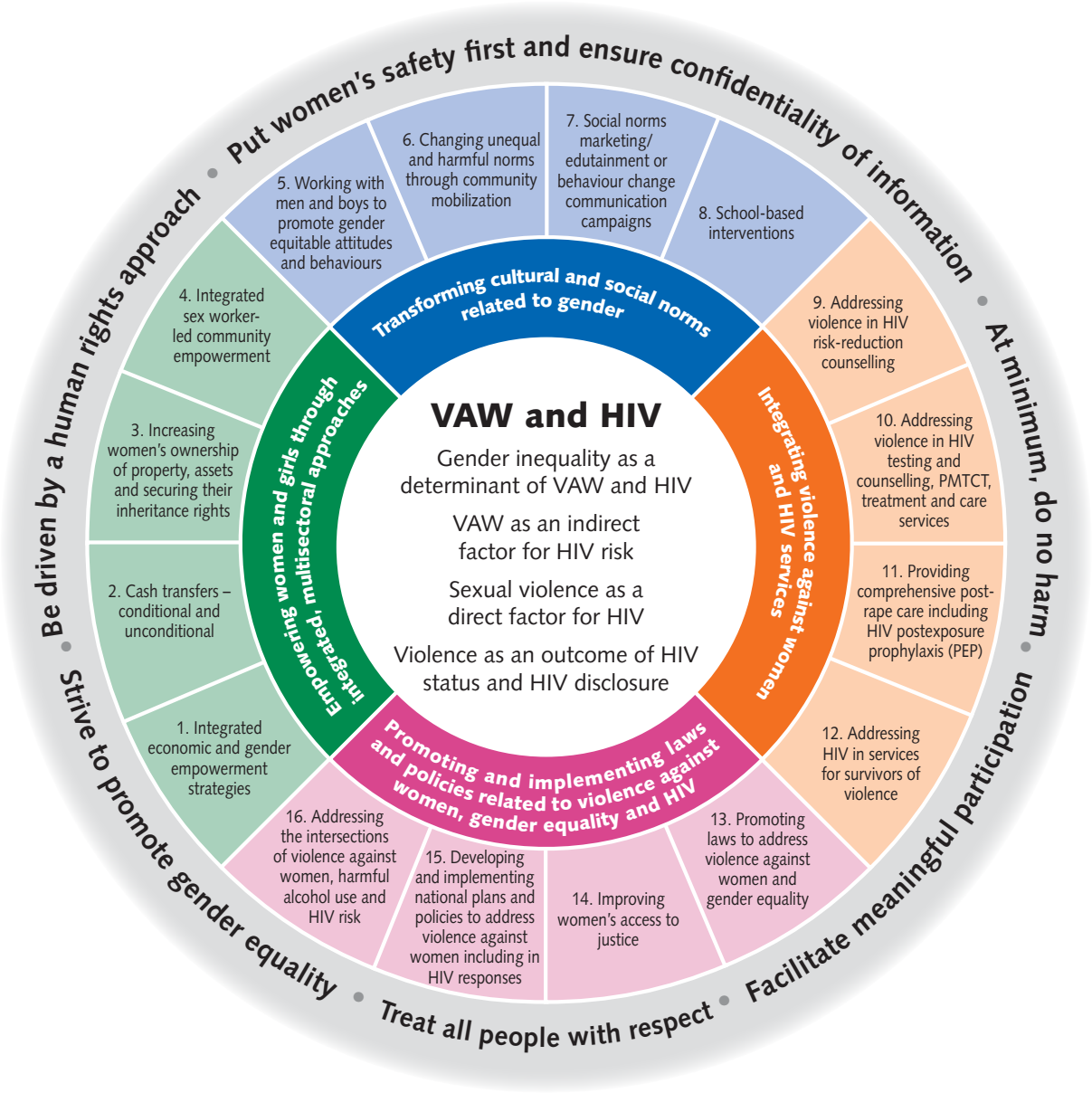
N/A: Not applicable

1 The final 4 programming ideas on laws and policies (i.e. 13 to 16) are not subject to the rating of effectiveness because policy interventions do not easily lend themselves to evaluations based on experimental study designs.

Below is a programming wheel that captures the core principles, broad strategies and approaches and the 16 programming ideas that fit within them.

Figure 4: Violence against women and HIV programming wheel

For further information on each Programming Idea, please click on the corresponding number.



Section 1

Empowering women and girls through integrated, multisectoral approaches

Empowerment of women is one critical strategy/approach to preventing violence and reducing women's vulnerabilities to HIV. Empowerment strategies can improve women's overall quality of life and well-being, enable them to practice safer sexual, reproductive and other health behaviours, and increase their confidence and ability to seek and obtain services. Hence, it can contribute to better health outcomes for women.

To date, interventions to empower women have focused largely on economic empowerment. Hence, the evidence base is more robust for such approaches. Economic empowerment can support greater voice, power, agency or status for women in their intimate relationships, help women leave abusive relationships by increasing their options, and/or reducing their need to agree to unsafe sex in the context of transactional sex[1] and sex work. In this section, four programming ideas are described that empower women to reduce their vulnerabilities to violence and HIV. These include:

- Integrated economic and gender empowerment strategies
- Cash transfers – conditional and unconditional
- Increasing women's ownership of property, assets and securing their inheritance rights
- Integrated sex worker-led community empowerment interventions

Box 6 What is meant by empowerment of women? *(72–74)*

Empowerment of women is a multidimensional long-term social process that enables them to gain control over their lives and act in their own best interest. It can be facilitated by enabling women to have access to resources (e.g. information, financial services, productive assets, educational opportunities, social networks) and the ability to control their lives (e.g. improved self-esteem, communication, negotiation and decision-making skills, mobility, skills to earn a livelihood).

Economic empowerment includes: increasing women's access to employment or jobs, financial services (e.g. microfinance and microcredit), property and other productive assets (e.g. safeguarding women's property and inheritance rights), supporting them in development of livelihood and other skills (e.g. vocational, literacy training), and cash transfers that may be linked to education or use of health services or behaviour change.

1 Transactional sex is defined as sex that is exchanged for actual or anticipated material gain (e.g. basic necessities such as transportation or a place to sleep, cash, material goods including gifts) *(202)*.

VAW HIV Programming Idea 1: Integrated economic and gender empowerment strategies

1

What it involves: Microfinance includes a broad range of services to individuals or groups who are usually unable to access more traditional financial services or credit (e.g. low-income clients including women) – often without collateral. Services can include loans, savings, insurance, financial, and transfer services (remittances) *(75)*.

A small but increasing number of interventions combine microfinance or other economic empowerment strategies (e.g. livelihood support or vocational training, financial literacy or training) with gender or life skills training and sexual and reproductive health or HIV education, service provision or community engagement. They are referred to as 'integrated' interventions.

Summary of the evidence: While interventions to empower women economically have generally been effective at improving the economic well-being of the household, their impact on preventing violence against women or improving HIV-related outcomes is mixed *(28, 76)*. In a systematic review of 41 studies that examined the impact of economic empowerment on violence against women, some studies showed reductions in partner violence and others showed an increase in partner violence associated with women's involvement in income generation *(76)*. Analysis of these studies suggests that the increase in violence may be linked to or occurring in situations where there is a transition in women's traditional gender roles, which can be threatening to men, make them feel powerless or inadequate and result in a backlash. It also suggests that while such an increase in violence may occur in the short term, violence may decline in the long term as men and communities become habituated to women's new gender roles *(76)*.

It is likely that beyond income generation, other context-specific factors influence whether economic empowerment is protective or increases risk of partner violence for women. Therefore, there may be a need to add training on gender empowerment and relationship negotiation skills and/or complementary community interventions (e.g. engaging men to promote equitable gender norms) in order to reduce the risk of gender-related conflict in the household. A literature review of integrated microfinance and HIV interventions, primarily from sub-Saharan Africa, some of which explicitly include gender empowerment components or discussions on gender norms, shows that such interventions have used a diversity of approaches and measured different outcomes *(77)*. This makes it difficult to draw definitive conclusions about their effectiveness and what has worked in different settings. However, a few (e.g. Intervention with Microfinance for AIDS and Gender Equity – IMAGE) have shown promising results in reducing experience of intimate partner violence, improved partner communication about safer sex, and increased uptake of HIV testing and counselling in some settings *(77)*. See Annex 1.1 for examples of these promising integrated interventions for empowering women.

Conclusion: Integrated economic and gender empowerment interventions, primarily from one or two settings in sub-Saharan Africa, show promising results in reducing partner violence and improving some HIV outcomes. They have been evaluated with relatively strong study designs. Therefore, this programming idea is considered to be promising in relation to both violence against women and HIV-related outcomes.

2

Programming Idea 2: Cash transfers – conditional and unconditional

What it involves: Cash transfers are social protection programmes often targeted to women in a household with the aim of reducing poverty, building human capital (e.g. sending girls to school) and enhancing food security. They operate in more than 40 countries, primarily in Latin America and increasingly in Africa and Asia, and are estimated to reach over a billion people from low- and middle-income countries. A number of these programmes provide a cash grant to the household conditional upon certain pro-social behaviours, such as women giving birth in institutional settings, keeping girls in school, ensuring children are immunized and reducing risky sexual behaviours (verified by STI tests). These are known as conditional cash transfers.

Summary of the evidence: There is increasing evidence that cash transfer programmes generally improve child health outcomes and uptake of services for pregnant women and children as well as increase school enrolment for girls *(78,79)*. A literature review of cash transfer programmes and their impact on prevention of sexual transmission for HIV suggests that they may hold promise in reducing sexual risk behaviour, particularly among adolescents and young women in low- and middle-income countries, by addressing structural risk factors such as poverty *(80)*. Two cluster-randomized trials, from Malawi and the United Republic of Tanzania, show that cash transfers – conditional on keeping girls (aged 13–22) in schools and on young adults (aged 18–30) remaining free from STIs respectively – can reduce STI and HIV prevalence and risky sexual behaviours *(81,82)*. However, these trials do not examine reductions in violence, nor do they challenge unequal power relations between men and women. The assumption is that enrolment and retention in schools would have a transformative effect on health-related behaviours of girls (for example by incentivizing girls to delay childbearing or marriage).

Conditional cash transfers have been criticized as placing an undue burden on women and perhaps exposing them to backlash from family and community members *(80,83)*. A few cash transfer programmes have examined partner/domestic violence as an outcome *(28,84)*. For example, evaluations of Mexico's PROGRESA/Oportunidades programme showed that while there was increased spousal violence in the short term, in the long term (i.e. five to nine years after the start of the programme) there was no difference in spousal violence rates among those women who participated in the cash transfer programme compared to those who did not *(85,86)*. A cluster-randomized controlled trial that examined the impact of Ecuador's cash transfer programme for mothers on domestic violence found ambiguous results. For women with more than primary school education, cash transfers decreased intimate partner emotional violence, but for women with primary school education or less, the effect of the cash transfer depended on their education relative to their partners *(86)*. See Annex 1.2 for examples of conditional cash transfer interventions.

Conclusion: The effectiveness of this idea for reducing violence against women is unclear because the evidence from Latin America is mixed and is based on weak evaluation designs. While conditional cash transfer interventions with strong evaluation designs from sub-Saharan Africa are promising in relation to improving HIV outcomes, they do not measure outcomes related to violence against women.

VAW HIV Programming Idea 3: Increasing women's ownership of property, assets and securing their inheritance rights

3

What it involves: Interventions that help women secure their inheritance rights to land, property (e.g. housing), or other assets include:

- training women about their rights in relation to property and inheritance;
- advocacy and training with police, judiciary and other government officials to uphold women's property rights;
- providing legal services to women whose rights are violated;
- providing community paralegal services including support for will preparation;
- advocacy with policy-makers, media and community leaders to change discriminatory laws and customary practices that prevent women from inheriting property.

Summary of the evidence: Women are often denied access to and control over land and property because of discriminatory inheritance laws or customary practices. Many women without land and property are left economically insecure and susceptible to poverty, as well as reliant on spouses or male relatives for survival. Qualitative research from Uganda, South Africa and South Asia shows that women's access to land and ownership of assets (e.g. housing) contributes to food security, more control over sexual decision-making, and their ability to leave abusive or violent relationships *(87,88)*. It can also enhance women's social status and decision-making role or bargaining power within the household. These factors in turn may contribute to improved health outcomes for themselves and their families *(89,90)*. Conversely, women who are left without land or property may engage in high-risk coping strategies including transactional sex, or sex work for survival and hence, face increased vulnerability to HIV. Research also shows that women whose husbands die because of HIV-related conditions are often denied access to property and inheritance by relatives. *(28,88,91,92)*.

Several interventions in African and South Asian countries have been implemented to empower women to demand their property and inheritance rights in the context of HIV *(93,94)*. While important lessons have been learnt from these interventions, none of them have been evaluated for impact on reductions in violence or on improvements in HIV outcomes. Instead, evaluations (mainly non-experimental designs) have focused on process measures (e.g. increased participation in will preparation; increased participation in community mobilization around property rights; increased knowledge of laws, rights and responsibilities). Therefore, no examples of this programming idea are provided in the accompanying annexes.

Conclusion: Interventions to increase women's ownership of assets and property and secure their inheritance rights have not been evaluated to assess violence against women and/or HIV outcomes. Therefore, this idea is considered as effectiveness undetermined, and needs to be rigorously evaluated.

4

VAW HIV Programming Idea 4: Integrated sex worker-led community empowerment

What it involves: Community empowerment is defined as a social action process that promotes the participation of individuals, organizations and communities to enable them to gain control over their lives in ways that improves quality of life and equity. It cannot be imposed from outside, but can be facilitated through processes to help individuals and communities empower themselves. It challenges unfair, unequal power relations between communities, institutions and government; catalyses actions to help individuals and communities gain access to resources and control over their lives; promotes collective identity and actions to bring positive changes; and brings change through dialogue, critical reflection and raising awareness *(95,96)*. In relation to sex worker communities, it seeks to create safe spaces, a sense of cohesion and collective identity among sex workers, and an awareness of sex workers' human rights. It builds a sense of agency so that sex workers can advocate for increased control over their own lives and bodies. It tackles unequal power relations between sex workers and those associated with sex work (e.g. law enforcement officers, managers of sex workers and establishments where sex work takes place, clients) who marginalize, oppress and violate their rights. Activities include:

- Collectivization (e.g. forming groups or organizations, building capacity for leadership, fostering ownership among sex workers) to fully lead and implement broad-based HIV interventions and advocate for their rights.
- Training and sensitizing gate-keepers and communities (e.g. police, clients, community members, health care providers, media) on laws and rights of sex workers and holding them accountable for violations.
- Providing legal, health, and social services for violence and establishing crisis response mechanisms to facilitate reporting and resolution of incidents of violence.
- Documenting abuse and conducting advocacy for changes in laws and policies that increase the risk of violence against sex workers.

Summary of the evidence: Cross-sectional studies show that physical and sexual violence against sex workers significantly increases their risk of STI and HIV infection and decreases likelihood of consistent (or any) condom use *(97)*. Evidence from India suggests that facilitating sex workers to report and resolve incidents of violence through community empowerment and crisis response systems may reduce violence and improve HIV outcomes *(98,99)*. A systematic review of community empowerment interventions with female sex workers shows protective effects on HIV and STI infection and improved condom use with clients *(100)*. See Annex 1.3 for examples of integrated community empowerment interventions with sex workers.

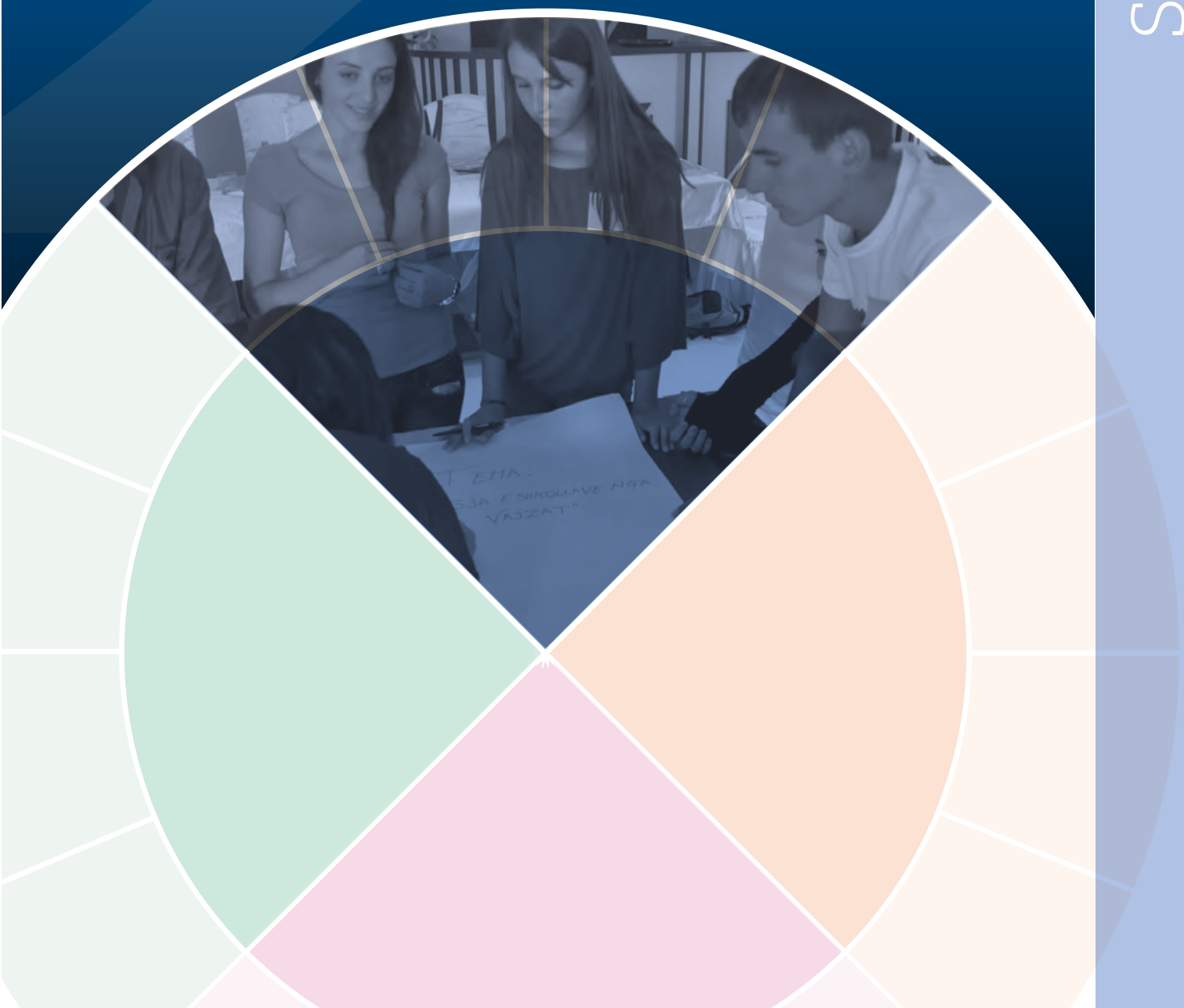
Conclusion: This approach is considered to have insufficient evidence of effectiveness in reducing violence against sex workers as integrated community empowerment has been evaluated for violence outcomes in only one setting and that too with a weak design. Separately, community empowerment with sex workers is shown to improve HIV-related outcomes in a systematic review of evidence, but the studies included in the review did not measure violence outcomes. It is ranked as effective for HIV-related outcomes and is a recommendation in WHO guidelines *(101)*.

Box 7 Lessons Learnt (Programming ideas 1 to 4)

- Economic empowerment strategies alone are not enough to empower women. Interventions that have integrated or linked economic empowerment of women with training and skills in gender equality and negotiating safer sexual relationships have demonstrated better outcomes for violence and HIV prevention, and may produce more lasting benefits (*102*).
- The unique needs and vulnerabilities of adolescent girls must be taken into account when designing economic interventions for them. Girls generally have less power, agency and access to resources than do boys or adult women (*103*). For example, microfinance may not be as effective for adolescent girls, as it may be unrealistic to expect them to have high repayment rates if they are not equipped in business skills. However, building their self-esteem and confidence and use of other economic empowerment strategies such as vocational training or livelihood skills can prepare them for running their own business enterprises later, and help build an awareness of their right to control their own bodies and sexual and reproductive choices. Adolescent girls also need support, mentoring and role models from adult women including their mothers and other older female relatives (*104*). Therefore, programming aimed at girls must include ways to also engage their families.
- In the short term, interventions to economically empower women can have a backlash effect against them from their partners, families and community members because they intentionally aim to change unequal power relations. It is important to be cognizant of this and include strategies to mitigate such effects, for example, by working with both men and women to change rigid gender norms (*105*).
- Participatory, peer-based approaches can serve as a mechanism for social support, solidarity and collective action among groups such as female sex workers in order to counter violence as well as foster a sense of self-confidence and self-esteem.

Section 2

Transforming cultural and social norms related to gender



There is strong evidence that beliefs and norms related to gender perpetuate violence against women and shape the vulnerabilities of women and men to HIV. In many settings, norms related to masculinity socialize some men to take sexual risks, dominate sexual interactions, or use violence as a way to assert their authority over women. Similarly, norms related to femininity encourage some women to be passive in their interactions with men (e.g. in negotiating safe sex, refusing unwanted sex or reporting violence). They prevent communities and societies from intervening with or supporting women who experience violence. These norms can be reinforced by religious beliefs and in turn reinforce harmful practices that increase women's vulnerability to violence and HIV (e.g. widow cleansing, bride price).

Changing social and cultural norms is therefore critical to preventing and addressing violence against women and HIV. Interventions aimed at transforming social norms seek to change negative behaviours by modelling alternative attitudes and behaviours, and by changing individual and collective perceptions about the acceptability of certain behaviours. Strategies to transform social norms are implemented at multiple levels, with different target groups and in different institutional settings. Four programming ideas (5 to 8) are presented below. These include:

- Working with men and boys to promote gender equitable attitudes and behaviours
- Changing unequal and harmful norms through community mobilization
- Social norms marketing/edutainment or behaviour change communication campaigns
- School-based interventions

Box 8 **What are gender norms? Examples of norms that perpetuate violence against women** *(66, 106)*

Gender norms refer to societal rules and expectations that govern relationships between and among women and men in the public and private spheres, and what is appropriate behaviour and conduct for women and men. Gender norms can change over time, or be different within specific cultural and social groups and communities. It is not necessary that all individuals hold the same internal beliefs as the norm. For example, despite some societies' acceptance of violence against women, not all men hold the same belief or perpetrate violence against their partners.

Examples of norms established in some communities, which support violence against women:

- A man has a right to assert power over a woman and is considered socially superior.
- A man has a right to physically discipline a woman for 'incorrect' behaviour.
- Physical violence is an acceptable way to resolve conflict in a relationship.
- Intimate partner violence is a 'taboo' subject.
- Divorce is shameful.
- Sex is a man's right in marriage.
- Sexual activity (including rape) is a marker of masculinity.
- Women and girls who act or dress in a certain way are "asking to be raped".

VAW HIV Programming Idea 5: Working with men and boys to promote gender equitable attitudes and behaviours

5

What it involves: This involves interventions to change norms and promote gender equality at the individual level through: i) group participatory education; ii) peer-based support; and iii) communication campaigns. They are aimed at boys and men including, youth leaders, fathers and sports coaches. Such efforts:

- Encourage participants to critically reflect (e.g. through role plays, story-telling and other interactive exercises) about masculinity and how it affects their lives, their relationships with women, and how it generates unequal power dynamics.
- Develop skills in expressing feelings without being violent, conflict resolution, promoting equity in couple relationships, and condom use.
- Provide safe spaces for men and boys through peer-based support groups to ask questions about masculinity, their health and other concerns affecting their lives.
- Incorporate communication campaigns that emphasize what can be gained by men changing their behaviour as well as offer male role models (e.g. celebrities, sports coaches) for positive behaviour change.
- Provide basic knowledge about HIV prevention, treatment, care and support, sexual and reproductive health and violence against women.

Summary of the evidence: A 2011 systematic review of 65 interventions on engaging men and boys to prevent sexual violence – mostly from North America, with only nine studies from low- and middle-income countries – showed significant results in reducing perpetration of sexual violence and/or other forms of violence in seven studies (*107*). Of the 47 studies that examined attitudes towards acceptability of violence, ten showed significant improvements in attitudes. Of the 25 studies that looked at gender norms, seven showed significant improvements towards more equitable norms. Another literature review (in 2007) on engaging men and boys for changing gender-based inequities in health showed that, of the 58 interventions from North America, Latin America, Sub-Saharan Africa and Asia, more than half showed positive changes in men's attitudes towards gender equality. In addition, some showed increased condom use (n=3), decreased self-reported STIs (n=1) increased contraceptive use (n=3), and increased use of sexual and reproductive health services by men (n=1) *(108)*. Of the 15 studies that included outcomes related to violence against women, only four interventions showed reductions in acceptability of violence or in perpetration of violence. See Annex 1.4 for examples of interventions with men and boys.

Conclusion: This approach shows consistent results in terms of positive changes for violence against women outcomes in several studies included in the two reviews. However, most of the studies used weak evaluation designs. Therefore, this programming approach is considered to be promising for addressing violence against women. It also shows positive results for HIV-related outcomes in several studies, albeit with weak designs and hence, it is promising also for HIV-related outcomes.

6

VAW HIV Programming Idea 6: Changing unequal and harmful norms through community mobilization

What it involves: Community mobilization refers to working with men, women, boys, girls, community or religious leaders, and institutions in a community over time in different ways to foster critical reflection and dialogue about harmful cultural and social norms, and inspire, encourage and support them in making positive changes in their lives. It encompasses activities such as: community meetings, activities and events (e.g. door-to-door discussions, dramas, poster discussions); training or sensitization sessions with different community members; and organizing collective actions (e.g. marches, petitions). Community mobilization efforts work better when they: engage the whole community; recognize that social norm change is a gradual process requiring concerted and sustained effort and repeated exposure to alternative ideas; foster critical reflection and dialogue around alternative values related to gender, sexuality, power and violence through participatory learning; and build and strengthen community ownership and social networks by mobilizing existing community structures, resources and organizations (*109*).

Summary of the evidence: Several HIV programmes have successfully used community mobilization strategies (*110*). For example, 'Stepping Stones' was developed as a community intervention to promote gender equitable norms and behaviours and HIV prevention. It has been used in more than 100 low- and middle-income countries (*66,111,112*). A systematic review of Stepping Stones interventions from Angola, Ethiopia, Fiji, the Gambia, India, South Africa, the United Republic of Tanzania and Uganda shows that: reported perpetration of violence against women, transactional sex by men, and herpes simplex virus (HSV-2) prevalence among women and men was reduced in South Africa; reported condom use increased in two out of eight studies; partner communication about HIV improved in three out of seven studies; gender equitable attitudes and behaviours improved in one out of five studies; and stigma against people living with HIV decreased in four studies (*113*). 'SASA!'[1] is a community mobilization approach developed by Raising Voices (a Uganda-based nongovernmental organization). SASA! encourages communities to reflect on gender norms, roles and power relationships by encouraging dialogue about the different dimensions of power. The beneficiaries include: women, men, young people, family members, neighbours, community elders and other stakeholders (e.g. health care providers, police, judges, teachers, business owners, religious leaders, policy makers and the media) (*114*). It is currently being evaluated using a cluster-randomized controlled trial in Uganda with eight communities (*114,115*). See Annex 1.5 for examples of community mobilization interventions.

Conclusion: The impact of Stepping Stones on reduction of violence against women and HIV outcomes has been established with rigorous evaluation design in only one setting. Nevertheless, its impact on HIV outcomes has been established across different settings, albeit with weaker evaluation designs. Evaluations of other models of community mobilization such as SASA! are not yet published. Therefore, this programming approach is considered to be promising.

1 Means "now" in Kiswahili. It is also an acronym for four stages of change towards alternative values and behaviours: Start, Awareness, Support and Action.

VAW HIV Programming Idea 7: Social norms marketing/edutainment or behaviour change communication campaigns

7

What it involves: This refers to campaigns to raise awareness about negative behaviours or practices, encourage dialogue about harmful social and cultural norms, and reinforce social and behaviour change messages at the societal and community level. They are variously referred to as 'awareness raising strategies', 'behaviour change communication', 'social norms marketing' or 'edutainment'. The format can involve popular songs, music videos, soap operas, use of celebrities to promote a certain message as well as other mass media approaches (e.g. social media, cell phones, community theatre, bill boards and posters). They attract large audiences with quality entertainment, while weaving in educational messages related to a health behaviour (e.g. using condoms), a social norm (e.g. non-acceptability of violence against women), or a fact (e.g. existence of a law or availability of a service). Some target a general audience, while others reach young women and/or men. Well designed campaigns are usually informed by social and behaviour change theories (e.g. the idea that drama can connect emotionally with audiences and help untangle complex issues such as attitudes related to gender equality) *(28,116–118)*. They are widely used in HIV programming and increasingly also in preventing violence against women. Such efforts can be used in tandem with community mobilization and interpersonal communication (e.g. group education, individual counselling) aimed at changing individual norms and behaviours. One advantage of such strategies is that they reach large numbers/proportions of the population.

Summary of the evidence: Several campaigns highlight the issue of violence against women. These include: the United Nations Secretary-General's 'UNiTE' campaign; Oxfam International's 'We can end all violence against women' campaign; the '16 days of activism against gender violence' campaign; 'One man can end domestic and sexual violence' campaign in South Africa; and the 'Men can stop rape' campaign in the United States. A literature review of violence against women campaigns suggests that many are not informed by social and behaviour change theories, and they are poorly evaluated (e.g. no baseline or comparison group, or only collect information on whether messages were remembered, but not changes in attitudes) *(118)*. Interventions such as '*Soul City*' in South Africa, '*Somos Diferentes, Somos Iguales*' (which includes the soap opera '*Sexto Sentido*') in Nicaragua, and '*Bell Bajao*' in India have increased awareness of violence against women as a widespread problem. However, they have had mixed impacts on changing personal attitudes and collective norms on the acceptability of violence against women. None of them measure reductions in violence against women as an outcome. *Somos Diferentes, Somos Iguales* has shown greater partner communication about HIV and condom use with casual partners among those exposed *(118)*. Some experts have concluded that such efforts may be useful in raising public awareness of violence against women, but may be more limited bringing social or normative or behaviour change *(28,118)*. See Annex 1.6 for examples of social norms marketing campaigns.

Conclusion: Given the weak evaluation designs and limited impact of these campaigns on reductions in perpetration or experience of violence against women, this programming idea is considered as having insufficient evidence and hence, is unclear in terms of its effectiveness for violence against women outcomes, but is promising for HIV-related outcomes as it has illustrated some positive outcomes.

8

VAW HIV Programming Idea 8: School-based interventions

What it involves: Schools are a key entry point for institutionalizing efforts to promote equitable norms early in the life course, before other norms are fully ingrained in the lives of adolescents. School-based interventions may include, for example, the socialization of boys and girls towards more equitable attitudes and norms especially in sexual relationships. They may aim to prevent bullying, sexual abuse of children and teenagers, dating violence, and young men's perpetration of rape, as well as a focus on improving bystander behaviours (e.g. encouraging men to speak out against rape, stopping peers, interrupting incidents of violence, supporting survivors). They can include individual and group education activities, involving same-sex or mixed-sex groups and can use both interactive and didactic learning methods. Educational curricula (e.g. life skills education, comprehensive sexuality education, sexual and reproductive health and HIV education) can include: an emphasis on learning about consent in sexual relationships and empathy for survivors of violence; promote alternative ideas about masculinity and femininity, sexual orientation and gender identities; promote gender equitable attitudes and behaviours related to sexuality and violence; and help students learn how to become more proactive about taking actions to stop violence. School-based approaches can also include communication activities (e.g. posters, theatre), skills training in conflict resolution, implementing policies to create school environments that are safe from violence, and linkages to services for those who experience violence *(107, 119)*.

Summary of the evidence: The evidence base for school-based interventions and its impact on reducing violence against women is more robust for curriculum-based rather than policy-oriented interventions and hence, the latter are not reviewed here. An increasing number of school-based educational curricula are being implemented to address violence against women and to prevent HIV. A 2011 systematic review of engaging men and boys (see Programming Idea 5) to prevent sexual violence included 65 studies – 90% of which took place in school settings *(107)*. Most interventions focused on group-based educational curricula and most used teachers to facilitate the group education. Seven out of nine studies showed significant results in reducing perpetration of sexual violence and/or at reductions in other forms of violence. Of the 47 studies that examined attitudes towards acceptability of violence, ten showed significant improvements in attitudes showing less tolerance of violence against women. Of the 25 studies that looked at gender norms, seven showed significant improvements towards more equitable norms and attitudes. The review did not report impact on HIV-related outcomes and many of the studies were designed primarily to look at gender equality and violence against women. A systematic review of comprehensive sexuality education shows that these have been effective in improving sexual and reproductive health and HIV behaviours. However, their evaluations have not included outcomes related to improving gender equitable norms or violence against women *(120, 121)*. See Annex 1.7 for examples of school-based interventions.

Conclusion: Evidence suggests that school-based educational interventions on preventing dating violence (primarily in high-income settings), or promoting gender equitable norms and non-acceptability of violence are effective in reducing perpetration of violence against women. Its impact on HIV outcomes has not been evaluated and is therefore its effectiveness is considered to be undetermined.

Box 9 Lessons Learnt

Positive changes in social and cultural norms are possible:

- Experience shows that such interventions can have measurable impacts on gender norms, violence against women and HIV-related behaviours.
- Changes in attitudes and norms related to gender can take place in contradictory, unexpected and unintended ways. Messages about gender norms may be interpreted by young women and men in the context of their own personal, social and cultural realities and transitions into adulthood. This means that while there may be improvements in some aspects of gender equality (e.g. beliefs about acceptability of violence) there may be resistance to change in other aspects (e.g. beliefs about male entitlement to multiple sexual partners).
- The impact of these interventions is likely to be different for women and men. However, not many of the interventions that include both women and men have conducted separate analyses of how normative and behaviour change occurs separately for each group.

Content of messages is important:

- It is important to give explicit and positive messages about gender equitable norms, promoting health and healthy relationships rather than negative messages that shame and blame men.
- Changes are most likely to occur in areas where the content is directly focused on. For example, where content directly focuses on violence against women, equitable power relations, gender norms and sexual health, it may be more likely to impact all the issues.

Participatory methods that generate critical reflection can lead to better results:

- Methods that engage participants in critical reflection and dialogue about norms, and build behaviour change skills, are more likely to be effective in leading to change than those that merely acknowledge issues of gender equality.

Change requires sustained efforts over time and working at multiple levels:

- It is important that mobilizing individuals such as groups of men or women is not done in siloes. Changing norms at the individual level is more likely to be sustained if it is supported by broader social norm change. This requires multiple strategies to reach diverse stakeholders in the broader community in order to reinforce messages about positive norm change.
- Interventions to bring about normative and behaviour change related to violence against women require longer time frames for implementation and follow up in order to show sustained results.

Section 3

Integrating violence against women and HIV services

HIV prevention, treatment, care and support services are important entry points for integrating prevention and response or services for violence against women for several reasons. Women's experience or fear of violence can be barriers in their access to and uptake of HIV, sexual and reproductive health services. Services can do further harm and place women at increased risk of violence if they fail to maintain confidentiality or take into account the unequal or lack of autonomous decision-making power that women may have in their relationships with partners or other family members. For example, failure to consider violence and men's controlling behaviours in efforts to promote male involvement can further undermine women's safety and autonomy in decision-making about their health. Non-empathetic (e.g. telling a woman that she must accept abuse), stigmatizing (e.g. blaming a woman who has experienced rape for inviting it) and discriminatory (e.g. refusing to provide care) responses by health providers can compound the trauma and/or dangers faced by women who experience violence.

On the positive side, because most women seek sexual and reproductive health (e.g. antenatal care, family planning) and HIV services (e.g. prevention of mother-to-child HIV transmission or PMTCT) at some point in their lives, integrating violence prevention and HIV services offer an opportunity to: identify women in danger before violence escalates; provide emergency care; prevent or reduce negative health outcomes of violence (e.g. unwanted pregnancy, STIs, HIV, trauma); assist survivors to access other services (e.g. shelters, legal aid, support groups) and protections; and provide better care, information, advice and options (e.g. with respect to safer sex, HIV disclosure, breastfeeding), enabling them to make informed choices and decisions with respect to their health.

This section presents programming ideas (9 to 12) to integrate violence against women and HIV prevention, treatment, care and support care services – both at the health facility and community level. These programming ideas aim to reduce the risk of HIV, strengthen uptake and access to HIV services, and improve quality of care by taking into account the risk or experience of violence faced by women.

- Addressing violence in HIV risk-reduction counselling
- Addressing violence in HIV testing and counselling, PMTCT, treatment and care services
- Providing comprehensive post-rape care including HIV post-exposure prophylaxis (PEP)
- Addressing HIV in services for survivors of violence

VAW HIV Programming Idea 9: Addressing violence in HIV risk-reduction counselling

9

What it involves: Risk-reduction education and counselling with individuals, couples or groups is a core part of HIV prevention strategies. Violence against women can be integrated into HIV risk-reduction counselling by including specific messages about equitable decision-making with partners and regarding violence against women and its links to HIV; supporting women in developing skills to negotiate safer sex in the context of violence and unequal power relationships; providing referrals to support services (e.g. shelters, legal services); and supporting women with safety management when exposed to violence. They also need to address the links between harmful substance use (e.g. alcohol and other drugs), violence and HIV risk. Such efforts are based on models of social and behavioural change (e.g. social learning theory) and/or theories of gender relations (e.g. theory of gender and power) *(116,117,122,123)*. Entry points for integrating violence prevention activities can include any HIV prevention programme where risk-reduction education and counselling is offered to women; couples; key populations (e.g. sex workers, women who use drugs, women in prisons, partners of men who use alcohol or drugs); clients of antenatal services, STI and family planning services; adolescents; and people living with HIV.

Summary of the evidence: Several interventions in HIV risk-reduction counselling for individuals, couples or in groups, primarily from the USA, have incorporated strategies to address violence faced by women. These interventions have been implemented with female sex workers, women who use drugs, women in prisons, Latina and African-American women, and adolescent girls. Three randomized controlled trials in the USA show mixed results with respect to violence reduction outcomes. These include: a safety planning intervention for drug-using female sex workers in Miami, Florida; a counselling intervention for women involved with the criminal justice system in Portland, Oregon; and an enhanced negotiation intervention with African-American drug users in Atlanta, Georgia *(124–126)*. All three interventions showed reductions in unprotected sex or risk-associated behaviour. However, only the safety planning sex worker intervention in Miami and the enhanced negotiation intervention with African-American female drug users in Atlanta showed reductions in experience of sexual abuse. In low- and middle-income countries, pilot randomized controlled trials with small numbers of female sex workers in Mongolia and South Africa, and with married women in India show significantly less exposure to violence among those who received HIV risk-reduction and violence prevention counselling at follow up, compared to baseline levels *(127–130)*. It is important to note that these interventions aim to primarily influence HIV-related outcomes and violence reduction is usually a secondary outcome of interest, which weakens the possibility of getting positive results for violence. Examples of interventions that have integrated violence prevention in HIV risk-reduction counselling are provided in Annex 1.8.

Conclusion: Well-designed evaluations of individual counselling and safety planning interventions, primarily from the USA, show mixed results on violence against women outcomes. They are however, considered effective in reducing HIV-related risk. Pilot interventions on integrated violence prevention and HIV risk-reduction counselling from low- and middle-income settings are promising, but need to be evaluated beyond the pilot phase. Therefore, this approach is considered as promising for preventing violence against women and effective for HIV-related outcomes.

10 VAW HIV Programming Idea 10: Addressing violence in HIV testing and counselling, PMTCT, treatment and care services

What it involves: Women accessing HIV services have to make decisions related to HIV testing, disclosure of status, infant feeding, treatment for themselves and their child(ren), and contraceptive use. HIV testing and counselling, PMTCT, and treatment and care services can address violence by *(131)*:

- training providers to recognize signs of violence against women; assess women's risk of violence; and provide women-centred care (e.g. being non-judgmental, empathetic listening, ensuring confidentiality, helping women access information and resources);
- identifying women with signs and symptoms indicative of partner violence (i.e. clinical inquiry), and providing them appropriate clinical care and referrals to support services;
- advocating to women, their partners, family members and the wider community about gender equality in sexual, health and HIV-related decision-making;
- helping women who fear or experience violence increase their safety and to access support services (e.g. for legal services, shelters, women's nongovernmental organizations, support groups);
- teaching women partner communication and negotiation skills, taking into account unequal power in decision-making and fears or experience of violence;
- monitoring and supporting women living with HIV for subsequent violence;
- ensuring that the male partner is not present when the woman is asked about or discloses violence, as she may be subjected to further abuse by her partner as a consequence.

Summary of the evidence: The evidence-base for this approach comes primarily from studies designed to respond to violence against women. The outcomes are not preventing violence against women, but a range of quality of care and service delivery outcomes. The activities mentioned above are based on recommendations from existing WHO guidelines that are based on a systematic assessment of the evidence *(131)*. Evidence, mainly from high-income settings, suggests that interactive training of health care providers may improve identification of and clinical care and support to women experiencing violence, provided that systems of care and referral are in place *(132–134)*. A systematic review of interventions on universal screening of women experiencing intimate partner violence shows that screening is not effective in either reducing partner violence or improving women's quality of life and health outcomes *(135,136)*. Therefore, WHO guidelines recommend identifying women based on signs and symptoms indicative of partner violence rather than universal screening *(131)*. Evidence on interventions to support HIV disclosure, safety planning, and psychosocial support for women experiencing violence is limited. There are no examples for this programming idea in the accompanying annexes as there are, as yet, no evaluated interventions that directly assess HIV outcomes.

Conclusion: Integrating violence in HIV services is not-applicable (N/A) for preventing violence against women, as it responds to women who have already experienced violence. Existing WHO guidelines recommend integrating violence services in all health care settings including HIV testing and counselling, PMTCT, treatment and care services to mitigate the consequences of violence faced by women and to avoid exposing women, especially those living with HIV, to further violence. However, this has not been evaluated for impact on HIV-related outcomes therefore, it is considered as effectiveness undetermined.

VAW HIV Programming Idea 11: Providing comprehensive post-rape care including HIV post-exposure prophylaxis (PEP)

11

What it involves: Providing comprehensive post-rape care, including HIV PEP, to survivors of rape who seek care within 72 hours can help reduce the risk of HIV infection *(131, 137–139)*. Comprehensive post-rape care addresses the full range of health, psychosocial support, and police and legal justice needs of rape survivors. In the immediate term, it includes PEP for HIV and other STIs, emergency contraception, assessment and treatment of injuries and women-centred care (see programming idea 10). Longer-term needs for survivors include support for adherence to PEP, mental health care (e.g. for depression, drug and alcohol use problems) *(131)*. Health-care providers also play a critical role in collection and documentation of forensic evidence that can support criminal prosecution of perpetrators, if the survivor wishes to pursue this *(137)*. Survivors who decide to pursue criminal charges may need referrals to legal services and support for navigating the criminal justice system *(68)*. Therefore, provision of comprehensive post-rape care requires strong coordination and referrals between health, police, justice and social services.

Summary of the evidence: Studies show that PEP is more effective when delivered as part of comprehensive post-rape care services *(140,141)*. Comprehensive post-rape care remains inaccessible to the majority of rape survivors worldwide. Reasons include: limited availability of services; stigma and insensitivity faced by survivors; a lack of information and awareness about services; delays due to poor police procedures; limited coordination between police and medical services; and a lack of funding allocated to these services *(142)*. Evidence on effectiveness of PEP in preventing HIV is limited to one study. Policy discussions may need to reflect whether to offer PEP routinely (e.g. in high HIV prevalence settings) or after a risk assessment (e.g. in low HIV prevalence settings) *(131)*. Effectiveness of PEP depends on adherence, which may be a problem for women due to side-effects of the drug and the emotional consequences of rape. There is limited evidence on effective approaches for improving adherence support. A study from South Africa in which psychosocial support was provided to rape survivors, showed no impact on adherence to PEP *(143)*. Examples of post-rape care interventions are provided in Annex 1.9.

Conclusion: The approach is rated as not-applicable (N/A) in terms of its impact on preventing violence as it responds to women who have already experienced violence. WHO guidelines recommend offering comprehensive post-rape care services, including HIV PEP, to survivors of rape who attend within 72 hours of the incident. It is regarded as effective, albeit the limited evidence, in preventing HIV infection.

12

VAW HIV Programming Idea 12: Addressing HIV in services for survivors of violence

What it involves: This refers to the provision of HIV prevention information, education, counselling, as well as referrals to HIV services (e.g. treatment and care) to survivors of intimate partner violence and sexual abuse through other programmes and services that they already use (e.g. shelters, social services for survivors of abuse, mental health services, services for treating women engaged in harmful substance use). This can also include individual or group HIV risk-reduction education or counselling and trauma based cognitive behaviour therapy, e.g. PTSD for post-traumatic stress disorder (PTSD). Such interventions can also build skills in negotiating safer sex and partner communication, and offer support mechanisms from peers.

Summary of the evidence: A majority of interventions that target survivors of violence for HIV prevention through violence prevention and response services have been implemented in high-income countries (e.g. the USA). A review of domestic violence shelters in one state in the USA found that, while most shelters assessed sexual abuse history, few provided HIV prevention information and counselling or STI services. Many shelters did not have active HIV prevention programmes, as they did not see HIV as a priority and also faced human and financial resource constraints *(144)*. Three randomized controlled trials and one quasi-experimental study with women survivors of childhood abuse, all conducted in urban areas of the USA, provided individual or group education sessions ranging from 11 to 25 sessions spread between 6 weeks and 6 months. The content of these sessions included: trauma-based therapy, enhanced sexual health education and counselling for HIV risk-reduction, and adherence counselling for HIV positive women with histories of childhood sexual abuse. Three out of the four interventions showed impact on risk-reduction (i.e. either reduced sexual risk taking or unprotected sex) *(145–149)*. A pilot quasi-experimental study conducted in Johannesburg, South Africa compared participatory group education on HIV prevention offered to abused women over 6 sessions with the outcomes of a 1-day workshop. The evaluation found similar improvements in HIV knowledge, risk-reduction intentions and condom use self-efficacy in both groups at the two-month follow up *(150)*. Most interventions providing HIV prevention services to women with a history of experiencing violence are based on small sample sizes, require significant and specialized human resources for intensive sessions over a long period of time, and have been applied in high-income settings where shelters and services for violence prevention and response are more widely available than in low- and middle-income country settings. Hence, it is unclear how feasible they are in resource-poor settings. Examples of interventions that address HIV in services for survivors of violence are provided in Annex 1.10.

Conclusion: This approach is not-applicable (N/A) for preventing violence against women as it focuses on HIV prevention among those who have already experienced violence. Given that these interventions were mainly with pilot interventions with small sample sizes and have not been implemented outside the USA, this approach is considered to be promising for HIV outcomes among women who experience violence.

Box 10 Lessons Learnt

- Where women are preoccupied with their personal safety, they may be less attentive to HIV prevention messages, face challenges in disclosing their HIV status, implementing risk-reduction, engaging in other preventive health behaviours and adhering to HIV treatment. Even where there is no violence, many women face unequal power in sexual relationships. Therefore, HIV prevention, treatment, care and support interventions need to understand the context of women's intimate relationships, identify women at risk of or experiencing violence, and tailor HIV information and services to take into account unequal power relations, women's safety, and histories of violence.
- Service providers may need training to understand how HIV and violence are linked, how to recognize and assess risk of violence based on signs and symptoms, and how to provide women-centred care to those who disclose their experience of violence.
- Putting in place comprehensive post-rape care services requires a policy framework, infrastructure, medical equipment and supplies training, and referral mechanisms as part of ensuring quality of care. It also requires support for adherence to PEP. Each setting may need to consider which model of service delivery is more appropriate for them. For example, in low-resource settings, it may be more appropriate to integrate post-rape care in existing services and facilities.
- Women can be reached with integrated violence prevention and response and HIV services through either HIV services or through services for abused women. While providing HIV prevention, treatment and care to women who use services for violence (e.g. shelters) has been implemented in the USA and seems promising, in low- and middle-income settings, support services to respond to violence against women are not widely available. Therefore, this approach may need to be further tested in such settings for feasibility.
- Referral mechanisms between health services and other supportive services need to be strengthened in order to better tailor, support and meet the needs of women who experience and disclose violence in HIV settings.

Section 4

Promoting and implementing laws and policies related to violence against women, gender equality and HIV

Laws and policies that protect women from violence are important for signalling non-tolerance of violence against women, protecting survivors from further acts of violence, and providing justice to survivors. Laws and policies that promote gender equality more broadly are also important, as they create an enabling environment and increase the likelihood of success and sustainability of efforts to reduce violence against women and vulnerability to HIV. While laws alone cannot stop HIV and AIDS, punitive and discriminatory laws – and law enforcement practices – can deny justice for people living with and at risk of HIV. Such laws can create environments in which individuals may not be able to protect themselves from HIV or be able to access HIV prevention, treatment, care and support *(151)*. For example, laws criminalizing sex work increase sex workers' vulnerability to violence. Similarly, laws that criminalize HIV transmission or non-disclosure disproportionately affect women who may not disclose their status due to fear of violence or are unable to demand condom use because of violence *(151)*. Many countries also have religious and customary laws and practices (e.g. widow inheritance, widow cleansing) that perpetuate violence and discrimination against women, and are often in conflict with national laws and policies.

Even where there are good laws, they are often inadequately enforced. Common enforcement problems are: lack of coordination among courts and other services; reluctance by police or prosecutors to investigate cases or protect women in danger; unwillingness or inability of the judiciary to enforce laws due to lack of capacity; lack of resources and specialized knowledge; corruption, bureaucracy, and victim-blaming bias within the police and justice systems; lack of awareness of the laws among the public; and public distrust in formal justice mechanisms. As a result, women who experience violence not only distrust, but are further victimized by the very systems designed to protect them. Therefore, there is a need to strengthen enforcement and implementation of national policies, plans and protocols to guide health, legal, education and other sectors' responses to violence against women. Policies to reduce harmful use of alcohol are also important for both preventing violence against women and the risk of HIV. Studies demonstrate that problem drinking is associated with risk of HIV infection as well as with risk of partner violence *(28,33)*.

The following four programming ideas (13 to 16) include:

- Promoting laws to address violence against women and gender equality
- Improving women's access to justice
- Develop and implement national plans and policies to address violence against women including in HIV responses
- Addressing the intersections of violence against women, harmful alcohol use and HIV

Programming Idea 13: Promoting laws to address violence against women and gender equality

13

What it involves: Law reform needs careful research and analysis of how various laws, provisions within the laws, and religious and customary laws and practices might impact women's vulnerability to violence and HIV. Promoting law reform involves advocacy activities, including strategic communication, building alliances and partnerships, budget tracking and analysis, and mobilizing civil society. It requires investing in and ensuring the active involvement of civil society, such as women's organizations and networks; sex work organizations; and women living with HIV. It also requires active engagement with and strengthening capacities of professionals from the legal, health and education sectors. It can include litigation activities, participating in drafting and amendments of laws, and dialogue with key law-and policy-makers. Equally important is advocacy aimed at religious and community leaders to encourage them towards prohibiting religious and customary laws and practices that increase violence and discrimination against women.

Summary of evidence: Nearly 125 countries have some legislation criminalizing at least some forms of violence against women (e.g. domestic partner violence, sexual violence, child sexual abuse, sexual harassment). Despite this progress, there continues to be many weaknesses in specific provisions, definitions of what constitutes violence against women, sanctions and penalties, and requirements for evidence for establishing a crime in many countries. For example, only 52 countries recognize rape within marriage as a crime, making it difficult for women to protect themselves from sexual violence within marriage and negotiate safe sex *(151)*. Legal reforms to protect women from violence have shown some evidence in increasing the reporting of violence and improving the quality of police and judicial response. However, no studies have directly examined the impact of law reforms on overall rates of partner violence, arrests, prosecutions, and convictions, particularly in low- and middle-income countries *(28)*.

There is insufficient evidence on whether efforts at law reform alone have had an effect on preventing or reducing violence against women and their vulnerability to HIV. Part of the challenge is that pathways by which laws influence individual behaviours and practices are complex and impact is not experienced in the short term. However, case studies on law reforms highlight that there is an inherent value in the reform process itself as campaigns to pass or amend legislation serve as important platforms for public discussion and can strengthen partnerships among civil society, government officials, parliamentarians, and other stakeholders (e.g. judiciary, police) *(28)*. Modelling analysis on impact of various HIV interventions shows that changes to the legal and policy environment, including those aimed at reducing violence against women and stigma and discrimination against people living with HIV, can substantially reduce the annual number of new HIV infections *(152)*. See Annex 1.11 for examples of law reform efforts.

Conclusion: While laws alone cannot reduce or prevent violence against women, most experts who work on violence against women agree that laws addressing violence against women and gender equality are instrumental in bringing these issues out into the open (i.e. changing the culture of silence and stigma), dispelling the idea that violence is a private matter and sending a message about what is socially acceptable.

14 Programming Idea 14: Improving women's access to justice

What it involves: Efforts to improve women's access to justice can include:

- training police and judiciary about relevant laws affecting violence, women's human rights and the rights of key populations affected by HIV, better policing and procedural practices, and supportive responses to survivors;
- establishing women police units, domestic violence, or family courts to administer justice;
- increasing collaboration, referrals, and coordination among law enforcement and social services through coalition building and policy changes – known as 'coordinated community response';
- increasing women's literacy and awareness of the laws, their rights, and access to legal services including through paralegals;
- strengthening forensic systems for better documentation of evidence that can be admitted in courts (see *WHO Guidelines for medico-legal care for survivors of sexual violence*) *(137)*.

Summary of the evidence: Countries such as Costa Rica, Nicaragua, South Africa, and the USA have implemented coordinated community responses. While such models have improved coordination of services and redress for women who come forward to report violence (i.e. increasing arrests, cases resulting in prosecution), they have not increased women's use of services or reduced overall levels of partner violence *(28,153)*. The lack of buy-in at the senior level and sustained efforts have resulted in police and judiciary training in Latin America and the Caribbean having limited impact on practice with respect to family violence. Where it has worked, it is due to the participation of peers in trainings, the use of protocols mandated from the top, and training that has been integrated into pre- and in-service curricula *(153)*. Police and judiciary training has also focused on reducing human rights abuses of key populations vulnerable to HIV *(151)*. Very few of these have been evaluated, and also being part of multi-component HIV programmes makes it difficult to disentangle the impact of police and judicial training components from others *(98)*. In several countries (e.g. Argentina, Brazil, Colombia, Costa Rica, Ecuador, Nicaragua, Peru and Uruguay), special police units staffed by female officers have been established to encourage women to come forward and to offer them more sensitive services. However, evaluations have shown that female police officers do not necessarily have better attitudes towards victims of violence than their male counterparts. Moreover, these units are underfunded, they lack equipment, the female officers are not properly trained, and they are often part of a dysfunctional overall justice system. Hence, they have limited impact on quality of care and redress received by women *(28,153)*. Finally, interventions to increase rights literacy of women, community awareness of laws and provide women legal services have largely not been evaluated, making it difficult to draw conclusions about their effectiveness. See Annex 1.12 for examples of interventions to improve women's access to justice.

Conclusion: Evidence suggests that improving access to justice for women who experience violence may require improving the 'whole systems' approach, as isolated efforts to train police and judiciary or increase female officers may have limited impact in the context of dysfunctional justice systems.

Programming Idea 15: Developing and implementing national plans and policies to address violence against women including in HIV responses

15

What it involves: A number of countries (e.g. Argentina, Liberia, Mexico, the Philippines and the United Republic of Tanzania,) have developed multisectoral national plans and policies on violence against women, as well as sector-specific policies and operational protocols to guide responses of the health, legal/justice, education, and other sectors. These plans and policies provide a framework for guiding the various sectors in terms of: their actions; roles and responsibilities; coordination mechanisms; budget allocations; and accountability mechanisms. A national framework is critical for strengthening the implementation of legislative frameworks on violence against women. Practical guidance to develop national plans on violence against women or integrate violence against women in national AIDS plans highlights the following activities: reviewing existing policy and legislative frameworks; compiling relevant data on violence against women and HIV linkages; convening multisectoral stakeholder groups; building capacity of policy-makers and managers to address violence against women and HIV linkages; and conducting evidence-based advocacy *(154–156)*.

Summary of the evidence: The work to develop and implement national plans on violence against women or integrate violence against women into national HIV plans is only just beginning in many settings. As yet, there is no evaluation of the impact of national plans and policies on violence against women outcomes. A gender equality assessment of 20 national HIV strategic plans from eastern and southern Africa[1] showed that only eight of them explicitly articulated gender-based violence as a priority and included interventions to either provide services or prevent gender-based violence. Of these, only four countries (i.e. Mozambique, Rwanda, South Africa and the United Republic of Tanzania) included interventions for prevention and services for gender-based violence *(157)*. It is unclear how many plans have concretely allocated resources for gender-based violence activities or how they are being implemented. Implementation is frequently problematic, due to budget constraints or a lack of political will. An analysis of the implementation of national violence against women plans from Central American countries[2] between 2001 and 2003 found that policies had not even been widely disseminated *(158)*. For example, in several of these countries, health providers were unaware of the policies or their specific content. In some cases, national policies posed unintended adverse consequences. For example several countries, including Guatemala and Panama, require health providers to report cases of family violence to legal authorities. This places providers in a position of betraying confidentiality of their clients, and potentially reduces women's willingness to disclose violence *(158)*. See Annex 1.13 for examples of national plans to address violence against women.

Conclusion: National policies and plans provide an important framework for guiding and coordinating multisectoral responses to violence against women in the context of HIV. Implementation of existing commitments to violence against women in national plans and policies, needs to be further strengthened.

1 Angola, Botswana, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Madagascar, Mauritius, Mozambique, Namibia, Rwanda, Seychelles, Swaziland, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

2 Belize, Bolivia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama and Peru.

16 Programming Idea 16: Addressing the intersections of violence against women, harmful alcohol use and HIV risk

What it involves: Addressing the intersections of violence against women, harmful use of alcohol and HIV risk is an emerging area of programming. It can include:

- policies to reduce alcohol availability, such as restricting hours and days of sale, implementing a rationing system, introducing minimum purchase-age policies and reducing the density of retail outlets;
- policies to regulate the prices of alcohol and increase taxes;
- policies to ban alcohol advertising and marketing (e.g. in movies, through merchandise, events, internet, podcasts, mobile phones);
- early identification of problem drinking and counselling interventions in health care settings.

Summary of the evidence: The relationship between harmful use of alcohol and violence is complex. Alcohol is not considered to be a cause of partner violence, but rather a contributing factor. Not everyone who drinks is equally at risk of committing violence. In many cultures there are high rates of violence against women even though alcohol is considered taboo. Studies show that drinking, especially binge drinking by men, may increase the frequency and severity of intimate partner abuse, and that the risk of partner violence is elevated on days when men drink *(28,66)*. Studies show that excessive alcohol use by male partners is strongly associated with HIV infection. A systematic review of 86 studies in sub-Saharan Africa found that alcohol consumption is consistently associated with unprotected sex, multiple partners, coercive sex, and transactional sex. The meta-analysis showed that drinkers have 1.57 times the risk of acquiring HIV compared to abstainers, and problem drinkers have 2.04 times the risk compared to abstainers *(33)*.

A meta-analysis of 112 studies shows an inverse relationship between high prices and taxes on consumption of alcohol and heavy drinking *(159)*. A meta-analysis of 23 interventions involving early identification (i.e. screening) and brief counselling by health care providers, implemented in primary care settings from the USA, also shows promise in reducing men's problem drinking *(160)*. However, these two meta-analyses did not include impact on partner violence or HIV outcomes. Other studies from Australia and the USA show that policies to reduce availability of alcohol (e.g. to curb density of alcohol outlets, reduce opening/selling hours) can potentially lead to fewer alcohol related problems, including domestic quarrels and assaults *(66)*. Community interventions to change drinking norms are an emerging area, with ongoing interventions in sub-Saharan Africa (e.g. Namibia, South Africa) *(161,162)*. See Annex 1.14 for examples of interventions for this programming idea.

Conclusion: Addressing the intersections of alcohol use, violence against women and HIV is an emerging area for programming. Evidence from high-income countries suggests that policies to reduce access to and availability of alcohol can reduce problem drinking, and may reduce situations that trigger violence (e.g. domestic quarrels). However, evidence on impact of these strategies on actual reductions in violence against women and on HIV-related outcomes is lacking.

Box 11 Lessons Learnt

- Laws that are based on international human rights standards for addressing violence against women, promoting gender equality, and protecting the rights of communities affected by and living with HIV from discrimination can create an enabling environment for reducing women's vulnerability to violence and HIV.
- In many countries, law reforms have not necessarily yielded changes on the ground for women, in part because laws are not adequately operationalized or enforced and national policies and implementation plans are not adequately resourced.
- Improving women's access to justice may require strengthening the broader justice system. This may require strengthening capacities of the police, judiciary, paralegals, and forensic experts to: recognize the problem of violence against women; reflect on their own biases including against key populations affected by HIV; and interpret laws and respond appropriately. Strengthening coordination, referrals, and linkages among different sectors providing services to women who experience violence (e.g. legal, police protection, health care, safe space, psychosocial support) is also necessary.
- Efforts to train police, judiciary, forensic experts and others need buy-in from senior management. Such efforts may need to be integrated into pre- and in-service curricula, and into law enforcement and legal practices in routine procedures and protocols. It is not necessarily true that female police or judges are, by virtue of their sex, automatically more sensitive to women survivors of violence.
- National policies, protocols and plans are useful mechanisms for guiding, resourcing, coordinating and ensuring accountability of national responses to violence against women. While a number of good practices are emerging in developing such plans, policies and protocols, their implementation lags behind due to lack of political will and lack of resources.
- Policies to reduce the harmful consequences of alcohol represent an emerging area of intervention to reduce violence against women and HIV risk. More evaluations are needed to assess the impact of policies and of individual and community interventions to reduce problem drinking on violence and HIV risk, especially in low- and middle-income countries.

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Annex 1.1. Examples, programming idea 1: Integrated economic and gender empowerment strategies

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Limpopo Province, Rural South Africa *(163–167)*	Primary beneficiaries: Poorest women > 18 years of age Secondary Beneficiaries: Youth and men (14–35 years of age)	Loans to women residing in low-income households to be repaid over 10–20 week cycles Participatory gender and HIV training during loan meetings that included discussions on gender roles, cultural beliefs, relationships, communication, gender-based violence and HIV infection. 10 training sessions conducted every two weeks over six months Community mobilization of youth and men to address community and male norms conducted over 6–9 months	Cluster-randomized controlled trial in eight villages pair-matched. One village in each pair randomly selected for intervention Past-year experience of physical or sexual intimate partner violence, HIV infection, sexual behaviour, partner communication, uptake of HIV testing and counselling, household economic well-being, and nine indicators on gender equity/empowerment	A 55% decrease in intimate partner violence among programme participants Women (<35 years of age) 46% more likely to communicate about sexual issues with partners All participants reported greater involvement in collective action, social groups and progressive attitudes towards gender equality A 64% increase in young women and men (14–35 years of age) accessing VCT A 24% decrease in young women and men (14–35 years) reporting unprotected sex at last intercourse with non-spousal partner Limitation: No effect on HIV infection rates	Women in intervention group were better able to challenge social norms around acceptability of violence, to leave violent relationships and create and mobilize support groups for those experiencing abuse. They also reported greater confidence, higher levels of autonomy in decision-making and enhanced relationships with intimate partners Intervention was scaled up from 855 participants in the trial phase to 2598 clients in a two-year period after the trial. A cost-effectiveness analysis estimated US$7688 per DALY averted in the trial phase and US$2307 per DALY averted in the two years of scale up. The authors concluded that the intervention was cost-effective in its trial phase and highly cost-effective in the scale up. These estimates are conservative as they do not include the health and development benefits beyond IPV reduction. The intervention is being replicated in the United Republic of Tanzania
Shaping the Health of Adolescents (SHAZ), Phase II Peri-urban communities outside Harare, Zimbabwe *(168)*	Adolescent girls (16–19 years of age) who are poor, orphaned and out-of-school	Life skills training including negotiation and strategies to avoid violence Sexual and reproductive health (SRH) services for all including condom and contraceptives, STI treatment, education about pregnancy, voluntary counselling and testing (VCT) Livelihood development including financial literacy, vocational training and micro-grants Integrated social support including mentoring, guidance counselling and reunions	Randomized controlled trial. Life skills training and SRH services provided to both intervention and control arms. Livelihood development and integrated social support provided to girls randomized to the intervention group Outcomes: Personal experience of violence, violence in the household, food security, risky sexual behaviour, HIV infection, HSV infection, pregnancy, unintended pregnancy	A 58% decrease in personal experience of physical and sexual violence over two years reported by programme participants Increase in equitable gender norms and decrease in food insecurity Limitation: No significant difference in HIV, HSV, pregnancy rates or unintended pregnancies between intervention and control groups	Phase I was a stand-alone micro-credit intervention. It failed because of low repayment rates by girls. Recognizing a difficult economic environment, Phase II emphasized life-skills and livelihood development instead The collapse of the Zimbabwean economy, the exploitation of girls by adults in relation to livelihood opportunities and the lack of social support from extended families proved to be particularly challenging in influencing the desired outcomes The intervention is being evaluated for impact on HIV positive adolescent girls and there is ongoing operations research to adapt and scale up

Annex 1.2. Examples, programming idea 2: Cash transfers – conditional and unconditional

Intervention and Location	Description of Beneficiaries	Content of Intervention	Evaluation Design & Outcomes	Results & Limitations	Conclusions
PROGRESA/ Opportunidades Mexico *(85, 86)*	Mothers of 25 million children from poor communities in rural Mexico – targeted to those with children attending primary and lower secondary school	Cash transfers from US$ 7 to 62.50 directed to mothers in eligible households, conditional upon children's school attendance, health checks and participation in health clinics for all family members	Non-experimental design (no comparison group) – two serial cross-sectional household relationships surveys in 2003 and 2006. Analysis compared beneficiaries to non-beneficiaries Outcomes: Intimate partner physical, sexual and emotional violence	Results of 2003 survey, measuring short-term impact: beneficiaries 33% less likely to experience physical partner violence than non-beneficiaries, but 60% more likely to receive threats of violence and emotional abuse from partners Results of 2006 survey: no difference in violence outcomes between beneficiaries and non-beneficiaries. Small cash transfers decreased violence by 37%, but violence increased in households where woman entitled to large transfers Limitation: Lack of baseline data; non-randomization; selection bias; no HIV outcomes; and violence, women's empowerment or gender equality not explicit objectives	In households where men had higher levels of education (and presumably more egalitarian gender attitudes) and where cash transfers involved small amounts, there was a decrease in violence. However, in households where men held more traditional gender attitudes and where the amount of cash transfers to women were large, men's primary breadwinner status was threatened resulting in men trying to reassert their authority through the use of violence In the long term, however, the intervention did not seem to have either a benefit or a negative impact in terms of prevailing violence among beneficiaries
Bono de Desarrollo Humano (BDH) Ecuador *(84)*	In 2003, BDH was rolled out gradually to all mothers from households in the two lowest wealth quintiles in the entire country	Cash transfers of US$15/ month, which were meant to be for mothers whose children met certain health and schooling requirements. However, in practice, these conditions were not implemented, making BDH an unconditional cash transfer	Cluster-randomized evaluation; 118 parishes from 6 provinces (3 coastal and 3 highland) randomized into treatment (79 parishes) and control groups (*39*). Baseline survey conducted in 2003–2004 with 3426 eligible mothers of which, only 2354 women living with partners eligible for the analysis on domestic violence. Follow up conducted in 2005–2006 with 2028 women living with partners of which, only 1254 were asked domestic violence questions. Outcomes: lifetime physical violence, current emotional violence, male controlling behaviour all stratified by education	The cash transfer programme had no effect on any of the outcomes of domestic violence or controlling behaviours for mothers with six years or less of education For mothers with more than six years of education, the cash transfer significantly decreases the likelihood of emotional violence by 8% and male controlling behaviours by 14% For mothers with more than six years schooling, but who have less education than partners, the cash transfer leads to an even larger significant decrease in emotional violence by 27% , controlling behaviours by 17% There is no significant effect of the cash transfer programme on physical violence for any group of mothers The cash transfer programme significantly increases emotional violence by 9% for mothers with six years or less of education where they are as educated as their partners Limitations: high attrition rate, no information about current physical violence or sexual violence, no data on HIV-related risk behaviours, indicator for physical violence based on one aggregate question	Like other studies on associations between women's income and domestic violence, this one is ambiguous about the impact of a cash transfer-based economic empowerment on partner violence The impact of cash transfer on domestic violence may be driven by the household dynamics, community and other contextual factors The study authors conclude that increasing women's income may lead to opposing forces where, for some women who have outside marriage options, it may improve the relationship, but for others, their partners may use violence in order to exert even more control

Annex 1.3. Examples, programming idea 4: Integrated sex worker-led community empowerment

Intervention and Location	Description of Beneficiaries	Content of Intervention	Evaluation Design & Outcomes	Results & Limitations	Conclusions
Avahan project: Integrated violence prevention intervention Karnataka, India *(98, 99)*	Primary beneficiaries : Female sex workers (FSWs) from four districts in Karnataka state, Southern India Secondary beneficiaries: Police, owners of sex work establishments, lawyers and media	Creation of safe spaces (e.g. drop-in centres) and sex workers' collective. Working with sex work establishments to improve security and safety for sex workers Establishment of 24-hour crisis response teams to respond to violence (i.e. offer immediate support, counselling, medical and legal help) , help sex workers avoid dangerous situations, document incidents Conduct advocacy (e.g. sensitization) and training with police, lawyers, media, elected representatives and other stakeholders regarding HIV prevention, empathy to sex workers, clarification of laws related to sex work Peer education and training of sex workers, including emphasis on increasing sense of self-worth, self-esteem, establishing collective identity, legal rights and negotiating safety In one district, discussions were also initiated on violence by intimate partners and self-regulatory boards have been established to address violence associated with trafficking	Programme monitoring from 2004 to 2009 of reported incidents of violence by perpetrator and by type of abuse Qualitative interviews with sex workers, lodge owners, police and other stakeholders associated with the sex trade Two serial cross-sectional interviewer administered integrated biological and behavioural surveys First with 1882 female sex workers 12–16 months after programme initiation A follow up survey with 1970 female sex workers at 33–37 months after programme initiation Outcomes: beaten or raped in the last year by client or intimate partner; always used condom in past month, presence of an STI; and condom breakage in the past month	Programme monitoring data showed: Decrease in all forms of reported incidents of violence by all perpetrators, especially police Increased reporting of intimate partner violence, which could be due to increased acknowledgement of this violence Main perpetrators of violence at the start of the programme were police, followed by anti-social elements, intimate partners, and lastly clients Crisis management teams responded to 98% of reported incidents of violence within 24 hours Results of the two surveys showed: A 30% decrease in reports of being beaten or raped in the past year Violence reductions associated with greater likelihood of: • No condom breakage in past month [AOR:[1] 1.93, 1.46–2.57] • No gonorrhoeal infection [AOR: 1.93, 1.13–3.30] • No anal sex [AOR: 3.70, 2.67–5.12] It was also associated with reduced likelihood of reporting unprotected sex acts with clients [AOR: 0.42, 0.32–0.54] Limitations: No baseline data; no comparison group; no randomization; measures of violence rely on self-reports of being beaten or raped rather than specific acts of violence, which could result in underreporting	Addressing violence is a priority for sex workers and should be an integral part of HIV prevention programmes and strategies. This should be addressed at multiple levels with multiple stakeholders Community mobilization, empowerment and collectivization of sex workers are core elements of such a structural intervention A staged progression of community-led response that expands to actions taken at multiple levels can show synergistic results on violence reduction over time Addressing intimate partner violence among sex workers may be more challenging, as it seemed to increase over time. This could be because of increased awareness of this form of violence and hence reporting, or a backlash from intimate partners who may feel threatened by sex workers becoming empowered

1 AOR: adjusted odds ratio

Annex 1.4. Examples, programming idea 5: Working with men and boys to promote gender equitable attitudes and behaviours

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Integrated gender-based violence and HIV risk-reduction intervention Cape Town, South Africa *(169, 170)*	African men of Xhosa cultural heritage (n=475) from two township communities in Cape Town	A small-group training of five three-hour sessions designed to simultaneously reduce gender-based violence and HIV risk behaviours The sessions helped men examine meanings of masculinity, consequences of gender violence and HIV, explore alternative attitudes and behaviours, and practice problem-solving and skills in condom use and sexual communication Participants were also trained to become advocates with their peers and others in their community	Quasi-experimental design with two communities followed up at one, three and six months Control groups received attention-matched alcohol and HIV intervention – a single three-hour session Outcomes: AIDS knowledge; AIDS related stigma; risk-reduction behavioural intentions; sexual and substance use risk behaviours; domestic violence perpetration	No differences between groups at follow-up for AIDS knowledge and AIDS stigma. At follow-up, compared to control group, men in the intervention group were more likely to: • express intentions to reduce risk (6 month follow-up) • talk with partners about condoms (1 month follow-up) • have been tested for HIV (1 month and 3 month follow-up) • show reduced negative attitudes towards women (1 month follow-up) • have reduced self-reports of hitting a sexual partner (6 month follow-up) Limitation: no randomization; communities not matched for baseline level of violence; weak measures of gender-based violence; generalizability limited to the Xhosa community	The intervention did not demonstrate evidence for efficacy in reducing unprotected sex, reducing number of partners or increasing condom use The pattern of risk behaviour changes suggests that the alcohol/HIV prevention intervention offered greater potential for sexual risk reduction than that realized in the GBV/HIV prevention intervention. These results suggest that future research may need to examine more complex integrated models, such as a tripartite intervention approach that integrates alcohol reduction, gender violence prevention, and HIV risk-reduction
Yari-Dosti: Promoting gender equity to reduce HIV risk and gender-based violence among young men India *(171, 172)* Adaptation of 'Program H' in Brazil involving participatory education and community campaign for promoting equitable gender norms *(173)*	Young Indian men (16–29 years) from three urban slum communities in Mumbai (N=875) and two rural poor communities in Uttar Pradesh (N=600)	Yari-Dosti (meaning friendship or bonding among men) involves peer-led, participatory group education, hourly sessions held every week over six months Topics include: gender equality and sexuality; STI/HIV risk and prevention; partner, family, and community violence; reproductive system; alcohol and risk; and HIV-related stigma and discrimination In Mumbai, a life-style social marketing campaign reached 100 000 residents, promoting messages of relationships without violence, egalitarian attitudes, a view of women and girls as deserving of respect and shared responsibility for sexual and reproductive health	Quasi-experimental trial: three arms in Mumbai – one arm with group education and lifestyle marketing campaign, one arm only group education, and a control arm In Uttar Pradesh, there were two arms – group education vs control Outcomes: attitudes towards gender norms (gender equitable man scale – GEM); HIV knowledge; perpetration of physical and sexual violence; condom use; number of sexual partners; stigma; self-reported STI Surveys: before and six months post-intervention	At 6 month follow-up, compared to control group, intervention participants reported significant: • improvement in attitudes towards gender equity (i.e. scores reflected more towards the high gender equity end of the GEM scale) • increase in partner communication about sex, STI, HIV and condom use • increase in condom use at previous sex with all partners • decline in self-reported recent partner violence Gender equitable attitudes (GEM scale score) was associated positively with decreased risk of STI /HIV behaviours in the intervention group Limitations: Selection bias due to non-randomization, lack of bio-markers to validate self-reports of STI, and validation of self-reported change in violence needed through interviews with intimate partners of men	Changes in attitudes and behaviours towards gender equality are a gradual and complex process. Initially many men denied their own biases and actions, or that it existed in society. As they progressed through the sessions, they acknowledged their own and societal attitudes and behaviours as inequitable. There is a need to reinforce group education with other societal level efforts A similar intervention was undertaken in Ethiopia, with a three-arm quasi experimental design in three low-income communities in Addis Ababa with young men 15–24 years. This intervention showed similar results as the Yari-Dosti, with improvements in gender equitable attitudes, reductions in violence perpetration and improvements in STI and HIV related risk behaviours Collectively, the results of Program H in Brazil and its adaptation in India and Ethiopia provide compelling evidence for this type of approach for individual level change

Annex 1.5. Examples, programming idea 6: Changing unequal and harmful norms through community mobilization

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Stepping Stones South Africa *(174–176)*	70 villages in the Eastern Cape province of South Africa Mostly poor youth (N=2776; 49% men), unmarried, both in and out of school	A community intervention to improve sexual health, gender equitable norms, communication and relationship skills Training involves participatory learning to build knowledge, risk awareness and communication skills, and stimulate critical reflection about gender norms, power relationships with intimate partners, other family and community members Each intervention village recruited two peer groups of 20 male and 20 female youth participants (15–26 years) Training sessions are parallel for single-sex, similar peer age groups of women and men and involve a total of 17 sessions (~50 hours)	Cluster randomized controlled trial with 35 intervention and 35 control villages. Control villages received a single three-hour training on HIV prevention Outcomes: HIV incidence; HSV-2 incidence; sexual risk behaviours; experience and perpetration of intimate partner violence, rape; unwanted pregnancy; depression; substance abuse Data collected at baseline, 12 and 24 months follow-up	Intervention participants experienced a 33% reduction in HSV-2 incidence Male intervention participants reported lower levels of violence perpetration (27% reduction at 12 months and 38% reduction at 24 months) Male participants also reported lower levels of risk behaviour (i.e. 61% reduction in transactional sex and 32% reduction in problem drinking) at 12 months follow-up Among women, no behaviour changes in the desired direction were reported and intervention participants reported more transactional sex at 12 months follow-up (but not 24 months) Limitations: There was no evidence that Stepping Stones lowered the incidence of HIV (adjusted incidence rate ratio 0.95; 95% CI 0.67–1.35)[2]	A process evaluation found that it helped men become less violent, and avoid anti-social and risky behaviours. Men were more empowered to communicate and showed positive changes in reducing acceptability of violence. While some women showed greater assertiveness and agency, their ability to challenge prevalent gender norms was limited Stepping Stones may be useful in bringing about changes in men as they are already more empowered, whereas, for women it may be more effective if combined with interventions at a broader societal level to empower them The original Stepping Stones programme recommends recruiting four peer groups of older and younger women and men, but the RCT costs made it impossible to do so.
Lifeline Free State, South Africa *(177)*	Primary beneficiaries: women in three townships in Matjhabeng, Welkom, Odelaalsrus and Virgina Secondary beneficiaries: community members in churches, schools, NGOs, women's groups	Community intervention to integrate HIV and gender-based violence involving social mobilization activities, training and development of local leadership, including efforts to engage churches, schools, women's groups and other structures Emotional wellness programmes through individual centres Gender-based violence services through a National Crisis Helpline, the National AIDS Helpline and the National Gender Wellness Helpline	Post-intervention community survey in targeted communities, sampling 304 women (15 years of age and older) selected randomly from households in the intervention communities Outcomes: gender-based violence awareness, knowledge; perceived level of risk for gender-based violence; awareness of legal rights; HIV and AIDS knowledge and attitudes; HIV and AIDS disclosure	Gender-based violence awareness levels were high among women, with 94% reporting having heard of gender-based violence Nearly 68% women felt that they themselves were at risk of abuse Lifeline was mentioned as a source of gender-based violence information by 16% of respondents and as a source of HIV information by 20% of respondents. These figures are comparable to the numbers who mentioned school, church, health facilities, and friends as information sources Limitations: Weak evaluation design with no baseline data or comparison group to address bias. Outcomes cannot be attributed to Lifeline. No data on reductions in partner violence	Because of the limitations of a descriptive study, there is a need for follow up data collection in the future with a comparison group in order to better assess the impact of social mobilization on gender-based violence outcomes. While the survey included HIV-related measures, no effort was made to correlate the gender-based violence and HIV measures

2 CI: confidence interval

Annex 1.6. Examples, programming idea 7: Social norms marketing/ edutainment or behaviour change communication campaigns

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Soul City, Institute for Health and Development South Africa *(178–180)*	Young and adult South Africans, women and men (national)	A behaviour change communication intervention that uses television soap opera as well as other media (e.g. print, radio) activities to conduct advocacy and social mobilization in South Africa It targeted specific behaviours including those related to violence against women and HIV. These issues were covered in Series 4 (domestic violence), Series 7 (masculinity norms) and Series 10 (alcohol and violence)	Pre- and post-intervention surveys; semi-structured interviews to assess advocacy strategy; analysis of national print and electronic media coverage; monitoring the 'Stop Woman Abuse' helpline calls over five moths Each round of survey included a sample of 2000 women and men (16–64 years of age) Outcomes: Awareness, knowledge, attitudes, seeking services, increased communication, social norms	65% survey respondents reported exposure to Series 4. Statistically significant: increased disagreement that domestic violence is a private affair; increased agreement that no woman deserves to be beaten or should put up with abuse No change with respect to agreement that it is culturally unacceptable for a man to beat his wife Qualitative data showed that the intervention contributed to enhancing women's and communities' efficacy, enabled women to make decisions around their health and facilitated community action Limitations: No data on reduced prevalence of violence; Limited time period for evaluating attitudinal change; No data on associations with HIV-related outcomes	Soul City is a popular, credible vehicle that has reached a majority of the population It has been effective in increasing health literacy, with reference to domestic violence, and HIV and AIDS The intervention facilitated the implementation of the *Domestic Violence Act* and increased access to support services (e.g. hotlines and domestic violence NGO services) It contributed to shifting norms by stimulating community dialogue. Soul City's effectiveness may partly be due to the fact that it deals with multiple issues comprehensively; multiple intervention components impact synergistically on individuals, communities and broader societal processes
Somos Diferentes, Somos Iguales (SDSI) Nicaragua *(181)*	Adolescents and young women in the country	SDSI is a communication for social change strategy implemented from 2003–2005 to promote young people's rights and individual and collective empowerment in relation to sexual and reproductive health and HIV Activities included: a national social soap opera TV series – *Sexto Sentido* – broadcast in the entire country; a nightly youth call-in radio show; distribution of communication materials to local groups; trainings for young people, and coordination with NGOs and service providers The content focused on HIV prevention, young people's sexuality, gender norms, gender-based violence, risk perception, and decision-making	Longitudinal study: Three surveys in 2003, 2004 and 2005 with same cohort of young women and men (13–24 years of age) in three cities Recruitment was equal from each of the three cities and included half women and men in each city (n=3099) Qualitative data: in-depth interviews, focus group discussions with participants, non-participants and key stakeholders Outcomes: attitudes towards gender equality, stigma reduction, risk perception, knowledge and use of services, efficacy for and HIV prevention	60% of survey participants reported 'greater' exposure to the SDSI Those with greater exposure to SDSI vs those with lesser exposure to SDSI had: more gender equitable attitudes; a 33% greater likelihood of knowing where to go for cases of domestic violence; a 48% greater probability of having been to a centre that attends to domestic violence in the past six months; and 11% greater likelihood of perceiving efficacy with friends to do something about violence Greater exposure to SDSI was also associated with increased likelihood of having communicated with partner about HIV, greater condom use with casual partner, but it was not associated with greater condom use with steady partners Limitations: No comparison group; no data on reductions in violence against women collected. The authors note that there were differences in outcomes by sex, but did not provide data disaggregated by sex	The authors describe a pathway for how greater exposure to SDSI is associated with interpersonal communication, self-efficacy and how these are associated with increased condom use The authors note that over time young people's perceptions about their social environment and efficacy to negotiate condom use worsened even though it was higher among those with greater exposure to SDSI Qualitative studies suggest that people exposed to SDSI interpreted the messages in their own social context and hence, this was as important a factor in considering the changes in outcomes as exposure to the intervention

Annex 1.7. Examples, programming idea 8: School-based interventions

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Safe Dates Program United States *(182–184)*	Adolescents in the 8th and 9th grades in schools in rural North Carolina	Safe Dates is a group education curriculum comprising of 10 interactive sessions of 45 minutes each, taught by health and physical education teachers; a theatre production and a poster contest based on the curriculum Community service providers (e.g. hotlines, social, mental and emergency health staff, police officers) were trained to support survivors of partner violence The content focused on changing dating violence norms, gender stereotyping, conflict management skills, help-seeking, and cognitive factors associated with help-seeking	Cluster-randomized controlled trial: 10 pair-matched schools, randomized to receive the intervention, or the control which provided only services to survivors of violence Sample, n=1700 eligible adolescents (49% boys). Post-intervention follow-up at one month, one, two and four years Outcomes: current victimization or perpetration of physical, sexual and psychological violence; acceptance of dating violence; perceived consequences of violence; attitudes towards gender roles; and help-seeking	At four-year follow up: statistically significant reduced likelihood of the intervention group experiencing (56%) or perpetrating (92%) physical and/or sexual violence At one-year follow up: intervention group significantly less accepting of dating violence, but no statistically significant difference in attitudes towards gender roles At one-month follow up: statistically significant improvement in attitudes towards gender roles Limitations: HIV-related outcomes not included	This is a rigorously evaluated intervention with long-term follow up. The effects of the programme were not modified or influenced by sex or race. Its impact on actual perpetration and victimization of violence is very encouraging The evaluation shows that changes in behaviour in terms of perpetration and experience of violence are seen over the longer term, whereas attitudinal changes started earlier The implications of such interventions in low- and middle-income resource settings are not known. A South Africa adaptation of this intervention is ongoing
Project Parivartan, India *(185)* Adaptation of the USA based Coaching boys into men intervention *(186, 187)*	Adolescent boys – athletes (10–16 years of age) playing cricket from schools in Mumbai Athletes from a low-income neighbourhood to form community cricket teams Cricket coaches and mentors affiliated with schools and the Cricket Association	The intervention raises awareness about abusive and disrespectful behaviours, promotes gender equitable and non-violent attitudes and teaches skills to speak up and intervene when witnessing harmful, abusive and disrespectful behaviours Activities include: training of 26 coaches and mentors (12 days over four months) in using a toolkit to facilitate discussions on issues of respect, insulting language, harmful and abusive behaviours towards women and girls, relationship abuse and gender norms; group discussions on toolkit topics with school and community athlete teams are facilitated by the coaches and mentors on a weekly basis before the game	Quasi-experimental: pre- and post-survey with comparison group; In-depth interviews with coaches, mentors and selected female relatives of coaches and mentors Sample, n=336 (half each from schools and community) athletes in the intervention group and 274 in the control group. Follow-up at one year Outcomes: attitudes towards gender roles and violence against women and girls; intention to respond to hypothetical scenarios of abuse against girls; actual bystander behaviours to witnessing abuse; violence perpetration; self-reported behaviour change	Compared to control group, intervention participants showed significantly more positive shift towards gender equitable attitudes Compared to community athletes, no change in intervention group's attitudes towards acceptability of violence against girls. There was no change in intervention group's bystander behaviours While community athletes showed some reduction in sexual harassment of girls, there was substantial difference in baseline between intervention and control groups Coaches and mentors reported more gender equitable norms after the intervention and were less likely to justify wife beating Limitations: No randomization; data on violence perpetration limited to sexual abuse only; no data on HIV-related outcomes	The mentors from schools and school-based athletes were older and hence, may have more rigid gender attitudes. This may explain why attitudinal change among school-based athletes did not change significantly Mentors for community athletes were younger and closer in age to the athletes and may have held less rigid gender attitudes. Hence, they may have been able to influence the community athletes Given the short duration of the programme, the sustainability of results is questionable, particularly given that unequal norms and attitudes are deeply culturally and socially rooted. To make changes, such efforts may need to be more widely institutionalized and reinforced with other channels of communication influencing the athletes, coaches and mentors

Annex 1.8. Examples, programming idea 9: Addressing violence against women in HIV risk-reduction counselling

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Women's wellness project Mongolia *(129)*	Female sex workers (18 years of age and older) accessing services from the National AIDS Foundation in Ulaan Bataar	A relationship-based STI and HIV group education intervention involving four weekly sessions, an enhanced intervention with two additional sessions on motivational interviewing (a collaborative counselling technique based on recognizing the motivations to change behaviours) compared to a wellness promotion control intervention The enhanced relationship based intervention included exercises and discussions on how to protect oneself from violence by a paying partner	Randomized controlled trial with sex workers (n=166) assigned to a treatment arm involving the relationship-based HIV and STI risk reduction intervention or an enhanced treatment arm with additional two motivational interviewing sessions or a control arm involving four weekly sessions on wellness promotion Follow-up at two weeks, three and six months Outcomes: lifetime and past 90 days intimate and paying partner violence, number of paying partners, number of unprotected vaginal sex with paying partner in past 90 days	In all three arms, physical violence, sexual violence and physical or sexual violence by any partner (paying and intimate) in the past 90 days significantly declined at three and six month follow-up No significant difference in odds of exposure to physical or sexual violence between the intervention and control arms Women from all three arms reported decrease in harmful alcohol use and in the proportion of unprotected sexual acts Limitations: small sample size; short-term follow-up period; could not disaggregate by paying and intimate partner violence	Low-impact interventions could potentially achieve reductions in violence experienced by women who exchange sex for money A hypothesis is that the peer group format of the intervention and control arm may have strengthened sex worker's peer networks and helped increase their protection and safety around commercial sexual activity. They may have also connected women with other community resources The finding that alcohol use was also reduced in all three arms suggests that women who are able to reduce alcohol may be better able to detect, avoid or diffuse potentially violent situations with paying partners. By reducing alcohol use and avoiding violent situations they may have been better able reduce unprotected sex
Raising HIV Awareness among Non-infected Indian Wives (RHANI), Mumbai, India *(130)*	Married women (18–40 years of age) reporting non-severe intimate partner violence and/or husband's problem drinking, residing in low-income/slum neighbourhood close to red light areas, Mumbai	It is an adaptation of a USA-based intervention with Latina Women that includes: empowerment counselling and building social support through four individual counselling and two small group sessions, delivered over six weeks; linkages to a local bank services for six weeks of financial education and microfinance opportunities; street theatre to generate community awareness of the non-acceptability of spousal violence The content of counselling focused on: HIV/STI knowledge, condom and safer sex negotiation skills, marital communication, gender norms, problem-solving and conflict resolution skills. Group sessions aimed to reinforce individual counselling, provide social support among women facing similar problems and provide referrals to local services	Cluster randomized controlled trial involving 13 clusters: 7 intervention (n=118) and 6 control (n=102) groups Baseline and three month post-intervention follow-up surveys Outcomes: any arguments with husband, past 90 days; physical violence by husband, past 90 days; sexual coercion by husband, past 90 days (if sex in past 90 days); ratio of unprotected sex to total number of vaginal sex acts with husband, past 30 days; any condom use with husband, past 90 days (if sex in past 90 days); condom use with husband at last sex (if sex in past 90 days); incident STI (based on testing)	Preliminary results of the evaluation show that: There was significant reduction in physical and sexual violence by husband in the intervention and control groups at follow up compared to baseline There was significant reduction in ratio of unprotected vaginal sex to total number of vaginal sex acts with husband both in the intervention and control arms at follow up compared to baseline There was no difference in physical or sexual violence by husband between intervention and control arms at both baseline and follow up. At follow up, there was significant reduction in ratio of unprotected to total number of vaginal sex between intervention and control arms at follow up Limitations: No HIV biomarkers collected, STI testing data are not yet available	Based on the preliminary results, the authors suggest that the intervention is promising in showing reductions in marital conflict and unsafe marital sex among at-risk wives However, there is a need to understand the mechanisms for change Given the focus of the intervention on marital communication, this may be a mechanism for reducing conflict and improving safer sex among intervention participants The full analysis of all outcomes needs to be available

Annex 1.9. Examples, programming idea 11: Providing comprehensive post-rape care including HIV post-exposure prophylaxis (PEP)

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Development, implementation, evaluation and scale-up of comprehensive post-rape care services, Liverpool VCT care and treatment Kenya *(188)*	Survivors of rape presenting at three district hospital sites with HIV (VCT) facilities	Establishing a standard of care for rape survivors including: protocols for physical exams, legal documentation, clinical management and counselling; client flow pathways and job aids; post-rape care package including essential drugs (PEP, emergency contraception, STI treatment) and evidence collection kit; protocol for a chain of custody for evidence; data collection and monitoring tools Training providers focused on changing their attitudes towards gender equality and abuse, strengthening their skills in history taking, clinical care, documentation and counselling	Monitoring data collected from 784 rape survivors who sought services between 2003 and 2007; conducting a costing of services. Outcomes: uptake of PEP, receipt of trauma counselling, client satisfaction and cost-benefit analysis	In the pilot phase from 2003–2007: 84% survivors seen at the sites arrived within the 72-hour window for the receipt of HIV PEP 99% of those who were eligible received drugs Survivors who received initial trauma counselling were more likely to complete HIV PEP medication The cost per person was estimated at USD 27 per patient, in line with services such as HIV counselling and testing Limitations: No pre-intervention or baseline data, indicators limited to a few output indicators, no measurement of HIV sero-conversion and adherence	A number of policy changes have been made at the national level including: national guidelines for medical management of rape, establishment of universal data collection form for presentation of evidence to courts, national training manuals and additional indicators in national monitoring and evaluation frameworks. The application of this approach has been scaled up to 13 facilities including the national referral and teaching hospital. A participatory policy development process, political commitment and flexibility to develop creative solutions have been key to the success of the programme
Refentse model for post-rape care South Africa *(189)*	Survivors of rape presenting at a 450 bed rural hospital in South Africa	A nurse-driven five-part intervention focused on: establishing a sexual violence advisory committee including hospital staff and senior management; adoption of a hospital rape management policy based on national rape management guidelines; training of service providers on common myths, clinical care and strengthening referral mechanisms; establishing a designated examination room; and conducting community awareness campaigns including distribution of information pamphlets at key HIV education community events	Pre-post intervention design that included a review of 334 hospital charts of survivors between 2003 and 2006, interviews with 109 patients and 16 service providers Outcomes: improvements in quality of post-rape care (forensic history and exam, provision of emergency contraception, STI treatment, referrals); the provision of PEP (access to VCT, provision of and completion of a full 28-day course); and efficiency and utilization of the service (number of service providers seen on first visit and volume of rape cases presenting to hospital per month)	Compared to pre-intervention, patients were: More likely to understand that the purpose of PEP was to prevent HIV infection More likely to have received the full 28-day course of PEP on their first visit and more than three times as likely to have taken a full 28-day course of PEP The time interval between assault and taking the first dose of PEP decreased from 28 hours to 18 hours Significantly more likely to report good quality of care (i.e. counselling was helpful, health worker's attitude towards them was good and examination was conducted in private) Limitations: For ethical reasons, no comparison group could be included. Therefore, changes could have anyway occurred over time. Generalizability may be limited due to selection bias (e.g. those who sought services may have been more empowered)	The results indicate that it is possible to improve quality of comprehensive post-rape care including HIV PEP and integrate this within a public sector hospital, using existing staff and resources. The results also highlight that with additional training, nurses can play an expanded role in providing quality post-rape care The study highlights the importance of a hospital policy to provide an institutional framework, the importance of improving hospital infrastructure and training to provide quality care and reduce delays in seeking and obtaining treatment. The study also highlights the need to strengthen referrals and linkages with other sectors – especially the legal and social services for adequate medico-legal care, and additional counselling and support for survivors

Annex 1.10. Examples, programming idea 12: Addressing HIV in services for survivors of violence

Intervention and location	Description of beneficiaries	Content of intervention	Evaluation design and outcomes	Results and limitations	Conclusions
Integrating HIV prevention into services for abused women South Africa *(150)*	97 women aged 18 years and over seeking abuse-related services at a Johannesburg NGO	Small group participatory intervention integrating HIV prevention strategies with issues of gender, power imbalance, and abuse The content of the sessions focused on: understanding abuse and trauma, its association with HIV risk and coping; knowledge about HIV and risk behaviours; condom use and strategies for overcoming barriers; communication, negotiation and problem solving skills; empowerment including economic independence and negotiating gender roles (e.g. position of women, gender norms and identities and their influence on women's lives)	Quasi-experimental: pre- and post- intervention comparison of the weekly six-session versus a one-day workshop of the group education that did not focus on skills building Outcomes: HIV knowledge; risk-reduction intentions and self-efficacy; trauma symptoms; intimate partner violence; sexual behaviour; HIV/STI testing and treatment Interviews at baseline, post-intervention, and two-month follow-up	Participants in the intervention and control arms showed significant improvements on all outcomes between pre-intervention and two-month follow-up with no differences between the two arms Women in the six session (intervention) group were less likely to be in a relationship immediately at post-intervention than women in the one-day format (control), but this difference was not maintained at two month follow-up Limitation: No randomization and loss to follow-up was high, with only 56% of six session and 62% of one-day participants retained at two months; follow up period too short after the intervention. Generalizability may be limited as women who seek services for violence may be different than those who do not	The findings from this small study support the feasibility of an approach to address HIV prevention among a group of abused women. Intervention trials are needed to ascertain the efficacy and longer term impact of multi-component interventions that address HIV risk and intimate partner violence HIV prevention interventions for women who are in violent relationships need to be mindful of their history of trauma and abuse. Women in violent relationships need to develop HIV prevention skills that can be safely applied in their current unequal relationships. They may need institutional options available to them to support leaving the relationship if they choose
Integrated risk-reduction intervention for HIV-positive women with child sexual abuse histories USA *(190)*	HIV-positive women with child sexual abuse histories, aged 18 years and over, sexually active in the past year; African-American, Latina, or European American from Los Angeles, California	A culturally sensitive, psycho-educational intervention called: Enhanced Sexual Health Intervention (ESHI) involving 11 sessions to reduce sexual risks, increase HIV medication adherence for HIV-positive women with childhood sexual abuse histories	Randomized controlled trial of ESHI versus attention matched control with 147 HIV-positive women Assessment at baseline, post-intervention, and for the intervention arm, three and six months follow-up Outcomes: Sexual risk-reduction; HIV medication adherence	There was improvement between pre- and post-intervention in the ESHI arm in sexual risk reduction in the unadjusted model However, in the multivariate (i.e. adjusted) model, participants in the ESHI arm showed nearly three fold greater sexual risk-reduction than women in the control (AOR = 2.96, p = .039) There were no differences between women in the ESHI and control groups on medication adherence post-intervention However, women in the ESHI arm who attended eight or more out of the 11 sessions reported greater HIV medication adherence at post-intervention than the control arm	The findings provide initial support for a culturally sensitive psycho-educational intervention with HIV-positive women with childhood sexual abuse. The study highlights the importance of addressing the effects of childhood sexual abuse on sexual risk-reduction in HIV preventive interventions for women

Annex 1.11. Good practice examples, programming idea 13: Promoting laws to address violence against women and gender equality

1. *Advocacy and activism by women's organizations* in Latin and Central American countries have been instrumental in bringing about reforms on legislation related to violence against women in the past 15 years *(158)*. Organizations such as the Latin American Committee for the Defense of Women's Rights (CLADEM), as well as women's commissions in national legislative bodies, have engaged in legal analysis, lobbying and raising awareness of the weaknesses of existing legislation, as well as the need for reforms. These organizations have worked with women parliamentarians, political leaders, cabinet advisers and ministers of health to exchange experiences, define priority issues for actions and press for changes in laws. Some important achievements of the legal reforms have been:

- Establishing protective measures (Belize, Costa Rica, El Salvador, Guatemala and Nicaragua) including for psychological damage such as depression or post-traumatic stress disorder resulting from abuse as a criminal offense (Nicaragua).
- Establishing family ties as an aggravating circumstance in the case of injury, warranting the use of more severe penalties (Nicaragua).
- Changing the status of sex crimes and spousal violence to public offenses, and broadening the definitions and the sanctions for rape and incest (Belize, Costa Rica, Honduras, Nicaragua, and Panama).

2. *Decriminalizing sex work and implications for violence against sex workers:* In New Zealand, the 2003 *Prostitution reform act* decriminalized sex work and enabled sex workers to operate safely in public. The New Zealand Prostitutes' Collective, brothel operators and the labour inspectorate collaborated to develop workplace health and safety standards for sex work. Sex workers can bring employment discrimination complaints to the Human Rights Commission. The Mediation Service on Employment adjudicates disputes. The police support sex workers in reporting violence *(191)*.

3. *Working with community elders to change customary laws and practices:* The Kenya Legal and Ethical Issues Network on HIV and AIDS is educating community elders in alternative dispute resolution to property and inheritance disputes between widows and their in-laws. They are also training widows and local law enforcement officials to create awareness of human rights so that traditional legal systems can be adapted to facilitate promotion and protection of women's rights *(151)*.

4. *Resources for law reform on violence against women:*

- *Handbook for drafting legislation on violence against women* (2012) *(192)*
- *Global commission on HIV and the law: Risks, rights and health* (2012) *(151)*
- *Respect, protect and fulfill: Legislating for women's rights in the context of HIV and AIDS – Volume One: Sexual and Domestic Violence* (2009) *(193)*

Annex 1.12. Good practice examples, programming idea 14: Improving women's access to justice

1. *Training and fostering police accountability to increase sex workers' access to justice:* Tais Plus is an nongovernmental organization that promotes human rights of sex workers, including male and transgender sex workers in Bishkek, Kyrgyzstan. They work to improve sex worker access to direct legal assistance through multisectoral collaborations. The organization works with the police, municipal officials and members of the judiciary. It also provides education to sex workers about their human rights. Since 2003, Tais Plus and the AIDS Foundation East-West have been supporting police training to improve police and sex worker interactions, particularly as many sex workers face violence from the police, sex work managers, clients and criminal gangs. A pilot program, *Legal Support for People Involved in Sex Work,* which began in 2003, offered sex workers direct legal assistance, education about their legal rights, and peer training. The pilot also facilitated collaboration between sex workers and police and other members of the criminal justice system. In the first year of its operation, the project took on 76 legal cases involving sex workers. In 2008, the organization provided documentation of human rights abuses and violence against sex workers in the CEDAW shadow report. Evaluation of its police training is ongoing and results are forthcoming (194).

2. *The Women's Legal Rights Initiative* has implemented several projects to strengthen enforcement of laws related to violence against women and women's rights. For example, in Guatemala, the Initiative trained 50 community women as certified paralegals. The paralegals developed and used a manual on intra-family violence to facilitate better access to legal services for survivors of violence by educating the public about the law, legal mechanisms and available resources to help survivors of violence *(195)*.

3. *Resources for improving women's access to justice:* The United Nations Office of Drug and Crimes (UNODC) has developed a handbook of effective police responses to violence against women that serves as practical guidance for first responders, particularly the police in how to sensitively respond to and investigate cases of violence against women. The handbook provides a number of good practice examples from countries on investigating reports of violence, collecting evidence, responding to offenders, and providing services to victims of violence against women *(196)*.

Annex 1.13. Good practice examples, programming idea 15: Develop and implement national plans, policies and protocols to address violence against women including in HIV responses

1. *Developing national plans on violence against women:* A number of country-specific good practices in establishing national plans and policies on violence against women have been described in a *Handbook for developing national action plans on violence against women* by UN Women (*156*). Costa Rica's national plan for the care and prevention of intra-family violence (PLANOVI) was adopted in 1998 to address intra-family violence against women. The plan was a result of strong advocacy by women's organizations, and is coordinated by the National Institute of Women (INAMU). It includes governmental and nongovernmental organizations, and stipulates the health sector to provide services and support to women affected by gender-based violence. The goals of PLANOVI are: to implement an integrated system for detecting intra-family violence and extra-family sexual abuse; prevent aggression against women; provide care and services to survivors so that they may recuperate and begin living healthier lives free of violence; and promote actions to change sociocultural patterns that encourage and justify violent behaviours and instil non-violent lifestyles that are based on respect for individual differences *(156, 158)*.

2. *Integrating gender-based violence in national HIV plans:* Papua New Guinea's *National HIV and AIDS strategy (2011–2015)* recognizes the empowerment of women and girls as a key principal. It specifies reducing gender-related vulnerability, including gender-based and sexual violence, as a strategic priority to reduce HIV vulnerability. It stipulates that interventions to reduce physical and sexual violence against women and girls and support survivors of violence will be urgently scaled up. Its objectives for reducing violence against women include: implementation of multisectoral responses to reduce gender-based and sexual violence; strengthening access to comprehensive services to reduce HIV-related vulnerability among survivors of gender-based and sexual violence; working with men and boys to promote gender equality and prevent gender-based violence; and implementing advocacy interventions to address cultural practices and factors such as polygamy, bride-price, divorce, and customary laws on inheritance *(197)*.

Annex 1.14. Good practice examples, programming idea 16: Addressing the intersections of violence against women, harmful alcohol use and HIV risk

Policies to reduce availability of alcohol: In Australia, the population of Halls Creek, a small town in the remote Kimberley region of Western Australia, is predominantly Aboriginal. After many years of high alcohol consumption, a number of measures were taken in an effort to redress its negative influence on the community. Key among these was a restriction on the trading hours when 'take-away' alcohol was available. The effects of this intervention were monitored by examining longitudinal patterns of alcohol consumption, incidence of crime, and outpatient data at the local hospital. The data were compared with equivalent periods prior to the restricted trading hours. A decrease in alcohol consumption was observed for each of the two years following the intervention. Overall, incidence of crime declined. Alcohol-related presentations to the hospital and presentations resulting from domestic violence decreased relative to the equivalent quarterly period prior to the intervention. There were short-term fluctuations observed, particularly with domestic violence, where presentations (of less severity) became more frequent during several quarters. Emergency evacuations as a result of injury showed a marked decrease. The consistency of trends across a variety of health and social data showed a positive effect after the implementation of restricted trading hours. While a direct effect is likely, a multitude of concurrent programmes promoting health in the community place limitations on this conclusion. The process in achieving change, supported by statutory measures, has however, been successful in curbing the morbidity and mortality experienced by the community *(198)*.

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