

The Prevention and Management of HIV and Sexual and Gender-based Violence: Responding to the Needs of Survivors and Those-at-risk

Population Council, January 2011

A nine-year-old girl called Chisinsi woke up early in the morning to go to school in Lusaka, Zambia. She wondered, “Do I tell mummy or not?” Finally she decided to go to school without telling her mother.*

Throughout the day, Chisinsi felt pain as she walked and tried to urinate. After school, Chisinsi asked to accompany her mother to the market where she was going to buy relish. On the way to the market, she told her mother: “Last night after I went to bed, dad came to my bed and did stupid things to me.” The mother melted with fear and anger. In Zambia, many children, as well as adults, refer to sex as a “stupid thing.”

Chisinsi’s mother rushed to report the incident to the local police and hospital. At the hospital, both mother and child were counseled and the child was given HIV PEP among other medications and services. Friends of the family told her mother that PEP would damage Chisinsi’s health and that, because she was young and innocent, she could not catch HIV from this act of sexual violence. Chisinsi’s mother asked the nurse if this was true, and the nurse explained how the medicine works, what the side effects were, and how to cope with them. With this information, Chisinsi continued to take the medication.

Police investigations, combined with accounts from health care providers and Chisinsi herself, revealed that the father had also defiled Chisinsi at age five as well. He was sentenced to 25 years of imprisonment. Currently the family is under the capable supervision of a community based organization—Young Women’s Christian Association (YWCA) for continued emotional and social support until they are ready to move on.

**not real name*

Sexual and gender-based violence is a pervasive global health problem, rooted primarily in the context of women’s and girls’ subordinate status in society. Sexual violence in particular poses significant risks to women’s health, including physical injuries, psychological trauma, unwanted pregnancy, and sexually transmitted infections (STIs), including HIV.

The human rights framework holds that all people, including women and people living with HIV, have the right to live without stigma, discrimination, and violence, and with self-determination. In recent years, global health advocates have used this framework to bolster sup-

port for issues of sexual and gender-based violence and associated health consequences. At the U.N. Summit on Peacekeeping on September 23, 2010, the United States Secretary of State, Hilary Clinton, announced an increase in support by the US Government for the prevention of sexual violence, particularly in conflict settings such as the Democratic Republic of Congo. Reducing sexual and gender-based violence (SGBV) is one of the five gender strategies promoted through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), and it is crucial to meeting the global UN Millennium Development Goals, which call for lowering maternal mortality, improving child survival, combating HIV/AIDS and other STIs,

and reducing unintended pregnancies. Several international multilateral organizations, such as UNIFEM, UNICEF, WHO, many European Governments, and the African Union, have also spoken out against SGBV, particularly in the context of conflict settings. The UNAIDS “Agenda for Accelerated Country Action” specifically recommends that violence against women and girls is recognized within a human rights context, and, furthermore, addressed within the context of HIV [1].

The Double Burden of SGBV and HIV

Such high level interest in SGBV and in HIV has generated considerable research that has produced pivotal data demonstrating the link between SGBV and HIV. Forced or coercive sexual intercourse with an HIV infected partner is one of the routes of transmission for HIV and sexually transmitted infections (STI) to women. The trauma associated with forced vaginal or anal intercourse can result in both abrasions and tears, which facilitate the entry of the virus into the bloodstream. The risk of sero-conversion following forced sex is higher, especially among adolescent girls, whose vaginal mucous membrane does not have the density to serve as an effective barrier [2], and among women suffering forced anal sex. According to data from the DHS, the prevalence of STIs among women who have experienced violence is at least twice as high as in women who have not [3]. Population Council research found that married women in India who have experienced both physical and sexual violence were four times more likely to be infected with HIV than non-abused women [4, 5].

Many risk behaviors are common to both HIV and sexual violence. Forced sex in childhood or adolescence increases the likelihood of later engaging in unprotected sex, having multiple partners, participating in sex work, and substance abuse, all behaviors likely to increase risk of HIV acquisition [6]. People who experience forced sex in intimate

relationships often find it difficult to negotiate condom use, which in turn makes these women more vulnerable to HIV infection. Experience of sexual coercion is also associated with low self-esteem and depression—factors that can themselves be associated with many of the risk behaviors for HIV infection. Moreover, being infected with HIV can also increase the risk of suffering sexual violence. A Population Council project in Tanzania showed that HIV-positive women (aged 18-29 years) were ten times more likely to report suffering partner violence than young HIV-negative women [7].

HIV and SGBV prevention programs should operate at several levels to prevent and respond to SGBV. These can include building condom negotiation skills (behavioral), increasing access to emergency HIV prophylaxis (biomedical), and developing laws and policies that positively impact gender norms (structural) [8, 9, 10]. At the provider level, services related to SGBV and HIV require similar psycho-social skills among service providers: discretion and confidentiality; recognizing and countering cultural norms that discriminate against women; and interacting objectively and compassionately with patients on issues related to sexuality and intimate relationships [11]. The medical skills required to provide HIV and SGBV services do differ, however; consequently, providers should be adequately trained in both HIV and SGBV care.

Several key recent publications highlight the importance of an integrated approach to combating HIV and SGBV, including the WHO manual *Integrating gender into HIV/AIDS programs in the health sector: tool to improve responsiveness to women's needs* (2009) and a study from the Harvard School of Public Health [12]. However, much of the available literature lacks evidence on how to forge essential linkages between HIV programs and services for preventing and responding to SGBV.

The Population Council seeks to understand the social, economic, political, and physical

context of risks to SGBV and HIV. Among the top priorities of Council research are supporting and evaluating efforts to prevent violence and HIV, including creating safe spaces for adolescent girls, and working with men and boys to change gender norms within the community; and comprehensively responding to the needs of survivors (including those who are HIV-infected) by strengthening health systems and integrating services.

Population Council Programs on HIV and SGBV Prevention

Population Council researchers are emphasizing the importance of developing programs to prevent HIV infection and decrease women's vulnerability to SGBV. Some of these prevention efforts include empowering and educating girls and women and changing social and cultural norms so that men are involved in family planning and household chores.

Preventing HIV and violence through girls' and women's empowerment

Girls' and women's empowerment is central to HIV and SGBV prevention and mitigation. The ability of a woman to ask a partner to use a condom, to avoid and leave violent relationships, to provide appropriate child care and support, and to seek health care and/or other services is dependent upon her sense of empowerment. Determinants of empowerment for girls and women include formal education, knowledge of legal rights and advocacy skills, representation in law-making and other decision-making bodies at all levels, and participation in the justice system.

The Population Council's intensified focus on female adolescents began in the 1990s. Since then, the Council's ground-breaking work has shifted the field of adolescent policy research to include broader social and economic issues that underpin women's empowerment in accessing HIV and SGBV prevention services. In order to understand, document, and address sexual coercion and intimate partner

violence, and to provide young people with sexuality education that focuses attention on gender and rights, the Council has designed and implemented projects to create "safe spaces" to protect the rights of girls vulnerable to violence and HIV infection. One such project in Ethiopia, *Biruh Tesfa*, promotes functional literacy, life skills, livelihood skills, and HIV/reproductive health education through girls' clubs led by adult female mentors. The project's evaluation included baseline and end-line assessments of variables reflecting social participation, as measured through friendship networks, making new friends, or participating in girls' groups. At endline, girls in the *Biruh Tesfa* site were significantly more likely to be considered 'socially participatory' compared to girls in the control site; furthermore, girls in the project site were significantly more likely to have undergone voluntary counseling and testing for HIV, compared to girls in the control site. Since its inception in 2007, over 10,000 out-of-school girls have participated in *Biruh Tesfa* groups in five cities in Ethiopia, and the project is being expanded to 12 additional cities [13].

In India, a similar prevention program called *Sakhi Saheli* was adapted from Instituto Promundo's "Program M" (working with young women). *Sakhi Saheli*, implemented by CORO for Literacy and Population Council, had the aim to reduce HIV risk among young men and women by addressing gender norms. The program undertook qualitative research to explore the construction of gender roles in two urban slums in Mumbai, which produced a training manual for use by peer leaders in teaching group educational sessions on gender, sexuality, reproductive health and contraception, violence, STI/HIV risk and prevention [14].

An ongoing project in India is developing an intervention exclusively for married women to build their negotiation skills with husbands who practice high-risk behaviors. The *RHANI Wives Project* was created in response to the lack of HIV prevention programs in India that directly address married women (*rhani* means "queen" in Sanskrit). The project involves the

development, implementation, and assessment of the acceptability of an HIV prevention intervention for at-risk wives living in slums in Mumbai. A three-pronged approach is used for intervening at the community level (community education), family level (financial management training and reducing stress within households), and individual level (building women's skills in negotiating with their husbands on reducing high-risk behaviors). The success of the study will be measured by the feasibility and acceptability of the intervention with respect to safety; marital communication and condom use; and intimate partner violence and perceptions of safety within the relationship.

Due to high rates of sexual violence and HIV infection among married girls in Kenya, findings from an operations research study in Nyanza Province show that there is an urgent need to expand married adolescent girls' access to comprehensive reproductive health (including family planning) and HIV information and services, while identifying culturally-acceptable ways to address spousal violence in Nyanza. Results indicate 41 percent of married girls in Nyanza aged 14 to 19 had been physically forced to have sexual intercourse with their spouses; 45 percent had been slapped or had a dangerous object thrown at them by their spouses; and the HIV prevalence rate among married adolescent girls is almost twice that of girls aged 15 to 19 nationwide.

The Population Council's AIDS, Population, and Health Integrated Assistance II Operations Research (APHIA II OR) Project, in collaboration with a local agency, Well Told Story, is implementing a media campaign to raise the profile of the health needs confronting married adolescent girls in Nyanza Province. The campaign includes a radio drama aired twice a week. APHIA II OR is also working with the Ministry of Health and community health workers to identify married adolescent girls in their communities, convey health information to them, refer them for health services, and follow up with them through periodic home visits [15].

Changing social and cultural norms to prevent HIV and gender-based violence

While HIV programs frequently recognize the role of men's risk-taking behavior in transmission of HIV, little is known about men's sexual and reproductive health and few HIV prevention programs address the social and cultural norms, which perpetuate men's risky and harmful behavior—such as alcohol abuse, multiple sex partners, and violence. Council research on sexual violence has shown that an effective approach to addressing SGBV is through multiple points of entry to change community norms. While it is essential to work with girls and women to empower them and to build their assets, it is not sufficient if the community is not also engaged [16, 17].

For example, the Council seeks to promote HIV prevention by promoting gender-equitable relationships through educating and engaging husbands. The project, entitled *Addis Birhan* or “New Light” in Amharic, assists men as they support their families in more than 100 villages in Ethiopia. In the program, men discuss a new topic each week, including reproductive and sexual health, HIV/AIDS prevention, alcohol and drug abuse, domestic responsibilities, and gender violence. The sessions also include HIV voluntary testing and counsel-

Before, I used to spend a lot of time drinking alcohol, but now I decided to limit the amount I drink...I used to visit sex workers before. Now I do not do that. This education has helped me.

—Male participant from Addis Birhan program

ing. Participants and families have described changes resulting from participation in the project, such as increased communication among couples and dialogue that is two-way, rather than directive. Qualitative research shows that men have started to change how they think about distribution of labor in the home and have changed risky behavior, such as drinking, and their perceptions of gender norms. Since the program began in 2008, over 30,000 men have taken part [18].

In India, recognition of the inter-relatedness of gender norms, partner violence and HIV risk led to the development, pilot-testing, and scale-up of a behavior-change intervention for young men, called *Yaari-Dosti*. This intervention was based on “Program H” (for *homens* or men) in Brazil and initiated by the Population Council’s Horizons Program, CORO for Literacy, MAMTA, and Instituto Promundo [19]. The project consisted of operations research on how young men construct gen-

As far as the sexual act is concerned, if my wife is uncomfortable I do not force her now, earlier I used to.... Because of the participation in YD program I have started respecting the feelings of my wife.

—Male participant in Yaari Dosti program

der identities, and aimed to change negative aspects of masculinity and reduce risky sexual behavior among young men. To assess program impact, the researchers developed and used the Gender-equitable Men (GEM) Scale, which measures attitudes toward gender norms related to topics such as HIV/AIDS prevention, partner violence, and sexual relationships, as well as information on HIV-related risk prevention factors.

Results demonstrated improvements in partner communication, gender norms, and partner violence. The proportion of men in the urban intervention sites who reported violence against a partner in the last three months was more than halved to less than 20 percent. There was a significant decrease from 50 percent to 37 percent of rural respondents in the intervention arm who reported partner violence at follow up. In both urban and rural comparison groups, partner violence actually increased. Given the study’s successful results, collaborators proceeded to adapt and scale up the *Yaari-Dosti* program and the GEM Scale for younger age groups in India’s public education sector. In yet another adaptation of the program, implementers have worked with teachers of 600 schools in an attempt to scale up the gender equality programs in the in-service training programs [20].

At the policy level, the Council has participated in international expert review meetings convened by the WHO and PEPFAR’s Gender Technical Working Group, which contributes to changing norms to prevent SGBV and HIV. Supported by background evidence from Program H, *Addis Birhan* and *Yaari-Dosti*, collaborative efforts have led to PEPFAR-supported interventions to address and evaluate gender dynamics in HIV/AIDS and violence prevention through the Male Norms Initiative (MNI) in Ethiopia, Namibia, and Tanzania, which is implemented by EngenderHealth, PATH, and local partners [21, 22].

Population Council Programs on HIV and SGBV Response

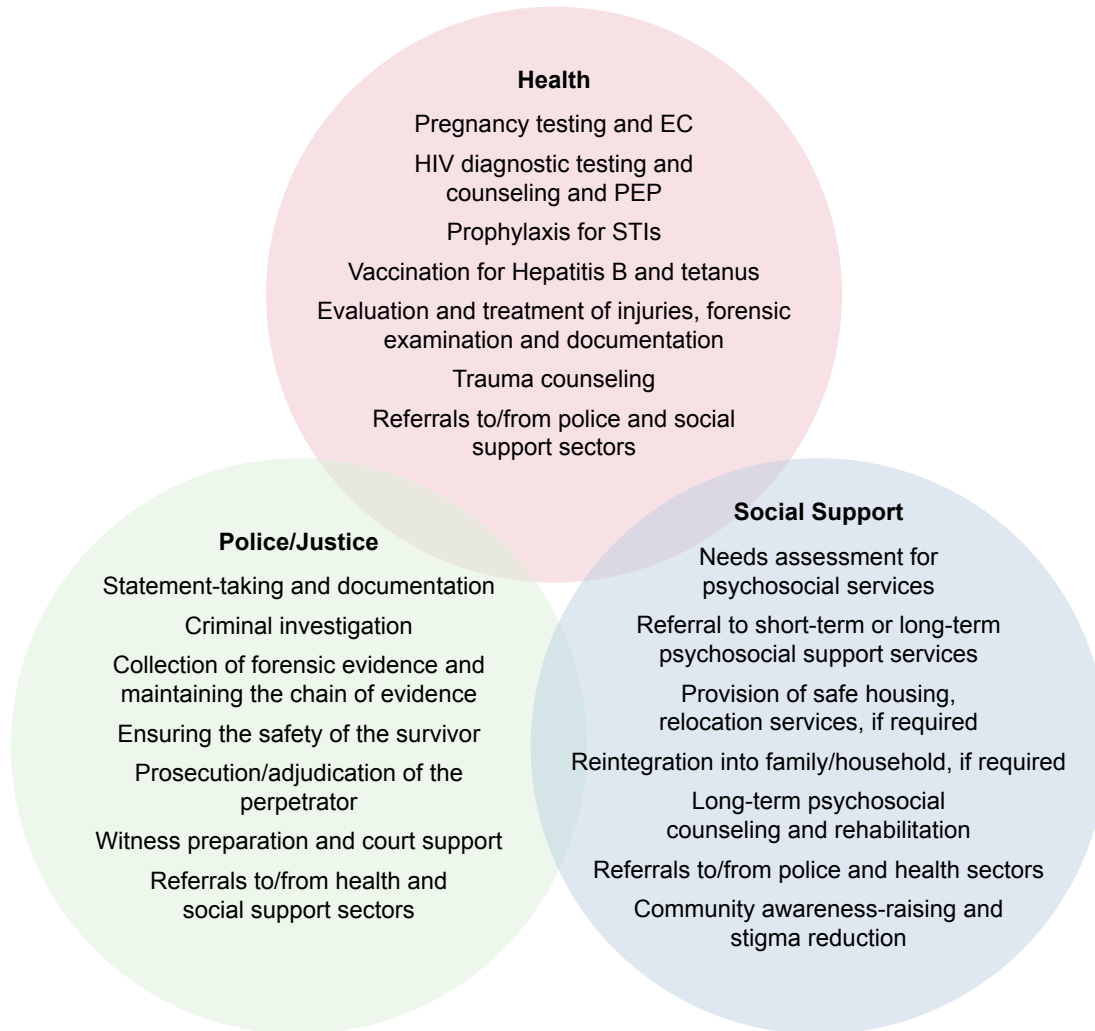
In addition to efforts to prevent SGBV from occurring in countries around the world, the Population Council has also worked to respond to the immediate and long term needs of victims and survivors of violence.

Providing stronger evidence for a comprehensive response to SGBV in Africa

In 2006, SGBV specialists at the Population Council initiated a multi-country SGBV network, with support from the Swedish-Norwegian Regional HIV and AIDS Team for Africa, with the explicit aim of providing stronger evidence around issues related to SGBV, including data to demonstrate links between SGBV, health, human rights and national development. This network includes eight partner agencies in East and Southern Africa who are implementing SGBV projects that address the determinants and consequences of SGBV in an integrated manner using a conceptual framework for a comprehensive response to SGBV [23]. This project has already significantly increased the evidence base on program responses to sexual violence in Africa and highlighted the need for more work in particular areas (see Figure 1).

Evidence from projects implemented by the SGBV network and its partners demonstrate

Figure 1: Framework for a comprehensive response to SGBV



that the overall quality of care improved in intervention sites following the introduction of a comprehensive model of care for SGBV. Pre- and post-intervention data from hospitals in Malawi and South Africa indicate significant improvements in core indicators of care, including the proportion of survivors who received PEP, EC and STI prophylaxis. Rates of VCT/HIV testing among survivors of sexual assault increased from 18 percent to 63 percent in Malawi, and from 41 percent to 73 percent in South Africa, and those who received PEP increased from 43 percent to 95 percent in Malawi and from 15 percent to 68 percent in South Africa [23].

PEPFAR has built on the strengths of the Council's SGBV network, by collaborating to

start its own Initiative on Sexual and Gender-based Violence. Under this program, Council staff provided technical assistance to help network members exchange information and ideas to support PEPFAR's pilot projects on SGBV in Rwanda and Uganda. Results reflect the start-up phase of efforts to improve GBV services and demonstrate most notably that conducting community outreach activities and creating linkages with other stakeholders are highly effective activities that increase timely presentation of survivors and increase referral rates and follow-up care seeking [24]. In March 2008, partners and organizations involved in broader South-to-South collaboration—including nine new partners—met at the Africa Regional Meeting on Sexual and Gender-based Violence to strengthen broad

based responses to SGBV and discuss lessons learned [25].

Strengthening sexual violence services in public health facilities: a step-by-step guide

One result of the collaborative work between the Population Council and PEPFAR's Initiative on Sexual and Gender-based Violence in Rwanda and Uganda is a step-by-step guide that provides practical guidance on the steps necessary to establish and strengthen sexual violence services within existing public health facilities, improve linkages to other sectors, and engage local communities around issues of sexual violence. The step-by-step guide [25] includes tips, resources and tools that will help partners and stakeholders design, implement and evaluate sexual violence programs (see sidebar on page 8). The promotion of country ownership, sustainability, and scale-up are essential for programmatic success.

Increasing access to SGBV-related services through one-stop centers in Rwanda and Zambia

Council staff recently began reviewing and evaluating one-stop center facilities in Rwanda and Zambia, with respect to factors such as feasibility, effectiveness, acceptability and user-friendliness. The results from this review will be compared with traditional service delivery approaches, to provide an evidence-informed basis on which to determine whether the one stop center is a viable alternative model for quality and cost effective SGBV service delivery in the broader region.

Integrating post-rape care into existing reproductive health and HIV services in South Africa

HIV post-exposure prophylaxis (PEP) can be used following sexual assault to reduce the risk of HIV acquisition, especially in settings such as South Africa, where both sexual violence and HIV are endemic. A study led by the

Council and the University of Witwatersrand developed a nurse-driven, post-rape care model, known as the Refentse model (meaning "we shall overcome" in Venda), that can be integrated into existing reproductive health/HIV services within a public sector hospital. Evaluation of the impact of this model on quality of care showed that initially the services were fragmented and of poor quality; however, following the intervention, there were improvements in quality of clinical history and examination, and the provision of pregnancy testing, emergency contraception, STI treatment, HIV counseling and testing, PEP, trauma counseling, and referrals. PEP completion rates increased from 20 percent to 58 percent [26].

Improving national support for access and sustainability of immediate post rape care in South Africa

In February 2010 the Council, in collaboration with the Government of South Africa (Departments of Health, Police and Correctional Services), began implementing a national program aimed at improving access and delivery of post rape care for survivors of sexual assault with special attention to vulnerable groups such as children, migrants, incarcerated populations and men who have sex with men.

For example, child victims of sexual assault require special attention because of the high exposure rates in this vulnerable group and lack of available and appropriate services. An initial assessment completed in 53 public hospitals in two provinces showed that 45 percent of clients in need of PEP were aged below 17 years, the majority of whom were female (93 percent). Care for children is generally restricted to specialized centers and providers outside of these centers lack training in the immediate needs of child survivors and pediatric treatment. There is also confusion among providers about when to issue emergency contraception for a female child sexual assault survivor, as well as inconsistencies about dosage.

A Step-By-Step Guide to Strengthening Sexual Violence Services in Public Health Facilities

The purpose of the guide is to provide practical guidance on the steps necessary to establish and strengthen SV services within existing public health facilities, improve linkages to other sectors, and engage local communities around issues of sexual violence. It includes tips, resources and tools that will help partners and stakeholders design, implement and evaluate SV programs. The steps contained in the guide are summarized below.

1. Collect information needed to inform service strengthening and integration.
Strengthen SV services by learning as much as possible about how SV services are currently provided in health facilities, the attitudes, awareness and concerns of the community and service providers, other SV services and resources in the community and the linkages that exist between the health facility and other service providers, especially the police.
2. Establish the regulatory and infrastructural framework for services.
Based on the findings of the assessment, program managers can begin to ensure that the regulatory and infrastructure frameworks are in place for delivering quality SV services.
3. Train health care providers.
Provider training is essential for ensuring access to quality SV services. As a multi-sectoral effort, some degree of training or sensitization is essential for all service providers, including health care workers, counsellors, police, paralegals, and prosecutors.
4. Increase PEP adherence and follow-up care.
Once SV and PEP services are introduced and routinely provided in the facility by trained providers, it is important to ensure ongoing care. Follow-up appointments are recommended to monitor the survivor's condition and treatment, assess her/his mental and emotional state, provide counseling and support for PEP adherence, and conduct follow-up tests for HIV. Nonetheless, many survivors do not access this care.
5. Develop referral linkages to other service providers.
In most cases—even in “one-stop” settings—providing comprehensive care to SV survivors will require one or more referrals from the primary care provider to other service providers located outside of (or inside) the health facility. Ensuring strong referral linkages to and from these providers is a critical, yet often underdeveloped element of clinical SV services.
6. Strengthen linkages between the health facility and communities to increase timely utilization of services.
To ensure the timely utilization of the services available within the health facility, it is critical that communities are aware that the services exist and how to access them. Essential messaging includes the need for survivors to seek SV health services as soon as possible, no later than 72 hours of the assault.
7. Monitor and evaluate (M&E).
Routine and systematic M&E of SV services is essential for ensuring the quality and accessibility to all survivors of SV. A good M&E system also enables the identification of good practices and lessons that other health programs can learn from.
8. Ensure adequate resources.
Planning for integrated SV services entails budgeting appropriately for start-up costs, developing a sustainability strategy for recurrent costs through establishing routine line items in annual budgets, and planning for scale-up from inception.

Summary of “A step-by-step guide to strengthening sexual violence services in public health facilities: Lessons and tools from sexual violence services in Africa.” Jill Keesbury and Jill Thompson, 2010, Lusaka: Population Council (available at www.popcouncil.org).

To improve access and delivery of post rape care for survivors of sexual assault, the Council is collaborating with a variety of stakeholders, including government agencies, traditional leaders, police, correctional services, and NGO partners. To ensure that vulnerable populations receive adequate access to services, intervention efforts must focus on both the demand and provision of quality services. The Council is currently improving uptake and knowledge by creating community awareness of comprehensive PEP. In addition, the program is building capacity for service providers through training, as well as standardizing forensic kits, processes, and reporting procedures for health workers and police. The program is also promoting program monitoring and evaluation by developing tools that capture statistics on relevant PEP indicators, including follow up.

Enhancing provider knowledge in Vietnam

In Vietnam, evidence from projects implemented by the Population Council to introduce a comprehensive model for SGBV care showed that changing service delivery procedures on their own were not effective without simultaneously increasing health providers' knowledge about existing legislation on domestic violence and changing their perceptions of SGBV norms. Similarly, survivors of SGBV were often disappointed when reporting violence events to police because the officers possessed little or no knowledge about how to apply the Law on Domestic Violence.

While many Asian countries have ratified policies in support of a comprehensive model of SGBV care, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), there is a lack of funding allocated to training police, court personnel, and community/civil society organizations in an integrated way along with health care providers, law makers, counselors, and teachers [27].

Challenges to an Integrated Approach for the Prevention of SGBV and HIV

While recent research over the past 10 years has led to heightened awareness and international support for the prevention of both HIV and SGBV, many challenges exist around integrating activities to mitigate SGBV within the context of HIV prevention and treatment, and vice versa. These include poor adherence to the PEP regimen; stigma; insufficient provider capacity and services available for child survivors; and limited support at national government levels.

One of the central challenges in providing quality clinical services for comprehensive SGBV management is ensuring adherence with the full 28-day course of PEP drugs. While PEP has become more accessible for eligible clients, ensuring compliance with the full regimen remains difficult. In South Africa, limited follow-up, due to cost and availability of transportation, as well as limitations in record-keeping, has undermined attempts to encourage and monitor PEP adherence. One South African partner, Thohoyandou Victim Empowerment Programme (TVEP), addresses these issues through intensive counseling and household-level follow-up, through which clients are given pills for all 28 days at the initial visit, and receive initial counseling from a Victim Advocate. TVEP has recorded an overall PEP adherence rate of at least 55 percent for the 765 clients who were given PEP between 2007 and 2009 [28]; this is higher compared to other studies conducted in South Africa, which recorded 35 percent adherence rate in Durban's Ghandi Memorial Hospital Crisis Center [29] and 20 percent in Tintswalo Hospital [30]. However, these adherence rates are still sub-optimal. Given that survivors must take the entire 28-day course to ensure protection against HIV transmission.

Integrating SGBV and HIV services can be particularly challenging due to the threat of additional stigma and discrimination resulting from HIV/STI testing and disclosure, which

may increase the risk of further violence. Fear of further abuse from partners, family, friends, and others can significantly decrease the likelihood that at-risk patients would visit a health facility for testing and treatment, particularly if SGBV prevention and response services are not integrated in to other medical and SRH care.

Provider capacity, knowledge and attitudes are often barriers to quality comprehensive care due to the high level of stigma and fear around SGBV and HIV. Research in Rwanda and Uganda highlight capacity constraints that are common across the continent, including a lack of trained medical staff; negative attitudes toward survivors of sexual violence; and growing reluctance to provide emergency prophylaxis, such as emergency contraception (EC) and pre-exposure prophylaxis (PrEP), for fear that it is being abused. Perceptions about client abuse of PEP are particularly widespread in Uganda and are becoming more common across Africa, including in Kenya and Zambia [31].

These same concerns were addressed in a Population Council program in Vietnam to improve the quality of care for SGBV victims: health care providers were trained on gender sensitivity, types of domestic violence and sexual violence, country and international context, how to provide sensitive, non-judgmental and non-punitive support, and counseling skills [32]. In South Africa, Population Council assessments have demonstrated insufficient services available for children survivors. Providers outside of specialized centers have no knowledge about how to respond to the immediate needs of children post-violence and there continues to be a lack of or inconsistencies within existing SGBV provider guidelines for children. Across regions, there is a need for thorough measurement frameworks and the use of monitoring and evaluation tools and job aides for providers in order to ensure access to and quality of SGBV and HIV prevention and treatment services for adults and children.

Lastly, at the international level, there is limited political will or commitment to gender issues,

particularly compared to what is needed to adequately fund and implement many of the strategic plans that already exist. Furthermore, governments in developing countries often lack support at the national level for programs that focus on gender and violence. This is primarily due to social and political barriers, as well as financial constraints and decreased interest in changing social and cultural traditions. For programs that do exist, gender analysis of the impact of program activities before or during program implementation is still relatively rare. This limited political support undoubtedly has an indirect effect on available funding and legislation that supports programs specifically aimed at the prevention of HIV within the context of sexual and gender-based violence.

Next Steps

With an increasingly large foundation of evidence around the intersection of SGBV and HIV, what is needed now is further attention to capacity building, infrastructure development, expansion of services and training on services for adults and children, and more effective monitoring and evaluation for integrated SGBV-HIV prevention programs. As is highlighted in this document, emphasis on prevention, including a range of activities around girls' and women's empowerment and awareness-building for boys and men, is also essential. The WHO called for action that addresses both long-term and short-term needs related to violence and HIV, due to the potential to impact MDG 6 (HIV), as well as other health-related MDGs, including reduction of maternal mortality and achievement of universal access to reproductive health and rights [33]. Efforts are needed to design and implement laws, policies and procedures for national, regional and local levels that set minimum standards and impose penalties. In order to enforce policies on SGBV, training should also be provided to equip health care providers, police, and key community leaders with knowledge and skills to transform gender norms and attitudes that contribute to stigma

and discrimination. Continued efforts to raise awareness of the rights of women and other marginalized groups, as well as policy advocacy and support for those navigating complicated judicial systems, will further educate those at risk of violence about options for prevention and management. And finally, ensuring funding mechanisms and sufficient budgets to support the implementation and evaluation of integrated SGBV and HIV care, through service-delivery programs and legislation, is also required.

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Suggested citation: Raifman, Sarah, Ian Askew, Sajeda Amin, Jill Keesbury, Saiqa Mullick, Judy Diers, Meiwita Budiharsana, Chi-Chi Undie, Mary Zama, Mantshi Menziwa, Sherry Hutchinson, and Naomi Rutenberg. 2011. "The prevention and management of HIV and sexual and gender-based violence: Responding to the needs of survivors and those-at-risk." Washington, DC: Population Council.

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