Chapter 11. Strengthening the Enabling Environment

In order for HIV and/or AIDS interventions for women and girls to succeed, factors beyond the health services need to be addressed through multisectoral interventions. These environmental factors include gender norms that guide how girls and boys grow to be women and men, legal norms that confer or withhold rights for

"The choice between food or shelter and safer sex is not a free one, since almost everyone will choose daily survival over the comparatively abstract risk of HIV" (Pinkham et al., 2008: 169).

women and girls, access to education, income, levels of tolerance for violence against women, experience of HIV and/or AIDS-related and gender-related stigma and discrimination. Addressing these environmental factors through multisectoral interventions will determine whether any HIV intervention will truly help women and girls. "Bolstering control over resources – such as income, land and property, food security…and education – also helps to minimize HIV/AIDS risk" (Dworkin et al., 2011: 995). Creating a supportive and enabling environment for females and males to live in equity and for women and girls to be supported by equitable gender norms and legal rights is critical to reduce vulnerability to HIV infection and to ensure that interventions to prevent treat or care for those with HIV will have their intended effect. As the HIV epidemic proceeds into its third decade, "a key component of the shift from an emergency to a long-term response to AIDS is a change in focus from HIV prevention interventions focused on individuals to a comprehensive strategy in which social/structural approaches are core elements" (Auerbach et al., 2011).

Strengthening the enabling environment must be done at a structural or societal level (Gupta et al., 2008a; Piot et al., 2008). Structural interventions need a multi-pronged strategy, as well as political will and commitment at all levels, as evident, for example, in Uganda in the 1990s where "an array of preventive policies and strategies, mounted by different agencies, with strong partnerships between the media, government, NGOs, sex workers, people living with HIV/AIDS and international and local public health agencies, endorsed at the highest political level...the need for broader, integrated programmes in which all components are mutually reinforcing" (Wellings et al., 2006: 1721).

Yet, structural interventions are challenging to evaluate (McCoy et al., 2010). Given the discussion in the methodology section about determinants of HIV infection and the pathways through which interventions must work, it is clear that enhancing the enabling environment is important, but that structural interventions, as described in this chapter, are more difficult to correlate with HIV infection. Proving "what works," is challenging.

For example, the pathway from changing gender norms to women being able to refuse sex or insist on condom use is indirect and can be influenced by many other factors. In the case of the enabling environment, it would not be possible to conduct a study using randomized control trial methodology; therefore the level of evidence, as measured by the Gray Scale, tends to be lower. Studies tend to be cross-sectional, without control groups. Nevertheless, the environment in which women and girls live and work plays an enormous role in women's vulnerability to HIV and their ability to cope with the impact of HIV. Women are often "blamed" for bringing HIV into the family; women face stigma, are kicked out of their homes and denied property, leading to further vulnerability to infection. "Almost uniformly across the world, women have less access to and control of productive resources outside the home. Evidence for this imbalance in power includes the gender gaps in literacy levels, employment patterns, access to credit, land ownership and school enrollment fees. This imbalance in access to, and control of, productive forces and resources translates into an unequal balance in sexual relations in favor of men" (Abdool Karim et al., 2010a: S126). Women have provided most of the care in the epidemic. [*See Care and Support*] Strengthening a supportive environment for women and girls is integral to their ability to overcome the challenges women face in prevention, treatment and care of HIV. Social protection and impact mitigation are important for women living with HIV, as well as structural interventions which prevent women from acquiring HIV in the first place.

Building Social Capital is Central to Strengthening the Enabling Environment
Social capital refers to the connections and networks among individuals and the norms of reciprocity and trust that result from these networks (Ehrhardt et al., 2009; Ogden et al, 2012). "The basic idea of social capital is that one's connections, be it with family, kinsmen, friends, neighbors or associates, constitute an important asset that can be called upon in a crisis, leveraged to build mutually advantageous resources and tapped to maintain or improve well-being" (Thomas-Slayter and Fischer, 2011: S325). The central factors in social capital include trust, reciprocity, and cooperation among members of a social network that aims to achieve common goals. Social capital may affect health in a number of ways: By establishing social norms that promote and support healthy behaviors, by leading to the development of and fostering access to health care services and facilities; by fostering mutual trust and respect among members of communities, and by supporting egalitarian democratic political participation, thereby leading to the development of policies that protect all citizens (Holtgrave & Crosby, 2003). However, there is no universally accepted way to measure social capital (Pronyk et al., 2008 cited in Gregson et al., 2011b).

Many things contribute to building social capital for women including teaching women their legal rights so that they can be empowered to know and claim their rights, utilizing the community-building capacity of faith-based organizations (Frumence et al., 2010); or, as one adolescent girl who participated in Stepping Stones put it: (the benefits of) sitting with people and always chatting" (cited in Jewkes et al., 2010c: 1077). "Growing evidence also suggests that social capital approaches can positively influence health

policy…" (Ogden et al., 2012: 1). Many early HIV prevention programs built on social movements, such as TASO in Uganda, but other countries, such as Botswana, marginalized the community response (Low-Beer and Sempala, 2010). A survey study of 70 women in Zimbabwe from 1998 – 2003 found a correlation of greater female membership in community groups (excluding church membership) with women reporting adoption of lower risk sexual behaviors with a significant effect after controlling for confounding factors (Gregson et al., 2011b). Building social capital is central to strengthening the enabling environment because it enables allows women the opportunity to benefit from the resources and support within their communities and contributes to addressing the unequal balance in power between men and women.

Women in many countries often have weaker access to social capital than men, especially in countries where women's mobility and chance for interaction with others is limited. For example, in the Middle East and North Africa, women are expected to spend most of their lives at home and their networks are limited to close family (Ehrhardt et al., 2009). A review of the importance of NGO involvement in responding to the AIDS epidemic in Uganda concluded that "well-developed social capital leads to social inclusion, it helps in information flow, [and] reduces stress" (Jamil and Muriisa, 2004: 26). Through fostering support systems of groups of people living with HIV and AIDS, NGOs in Uganda and other countries have helped build social capital. In the United States, increased social capital has been found to be associated with lower HIV rates (Holtgrave and Crosby, 2003). Research in Namibia on the effect of involvement in social support on prevention behavior found "support for the link between social capital and greater HIV-related efficacies," or the notion that one could act to protect against HIV (Smith and Rimal, 2009: 142). The IMAGE program in South Africa combining microfinance and training on gender and HIV, which is discussed in more detail in this chapter, provides an example of an intervention to strengthen social capital by creating a support network among the women involved (Pronyk et al., 2006; Pronyk et al., 2008b).

The following interventions and supporting evidence demonstrate a number of ways to strengthen the enabling environment for women and girls and tackle the underlying roots of women's greater vulnerabilities to HIV and AIDS. Each topic is introduced in more detail in the sections outlined below. Although many of the interventions in this chapter are "promising;" a number could be scaled up to achieve greater impact.

> A. Transforming Gender Norms
> B. Addressing Violence Against Women
> C. Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights
> D. Promoting Women's Employment, Income and Livelihood Opportunities
> E. Advancing Education
> F. Reducing Stigma and Discrimination

G. Promoting Women's Leadership

What Works to Strengthen the Enabling Environment

11A. *Strengthening the Enabling Environment:* **Transforming Gender Norms**

Gender norms stand in the way of reducing HIV; indeed, a recent study states that, "The global HIV pandemic in its current form cannot be effectively arrested without fundamental transformation of gender norms" (Dunkle and Jewkes, 2007: 173). As U.S. Secretary of State Hilary Clinton stated: "Achieving our objectives for global development will demand accelerated efforts to achieve gender equality and women's empowerment" (USAID, 2012: i). The evidence is mounting that gender norms harm both women's and men's health (Barker, 2007b). Yet the social constraints women face that make them particularly vulnerable to HIV include gender norms that privilege men over women in most societies. Experts in development and gender increasingly agree that interventions to address gender norms and reduce HIV need to work with "men and women, boys and girls, in an intentionally and mutually reinforcing way that challenges gender norms, catalyzes the achievement of gender equality and improves health" (Greene and Levack, 2010: vi).

Programming that works to change the attitudes and practices of men and boys – the younger the better – is essential to reducing HIV risk in women (Abdool Karim et al., 2010a: S124). Yet as some have recently argued, HIV "….programs and policies [have] largely failed to include the prevention needs of men who have sex with women…" (Higgins et al., 2010: 435). Since it is in both men's and women's interest to avoid HIV infection, "men can and should play an active role in HIV prevention" (Higgins et al., 2010: 441). While many international agencies in the global HIV response have endorsed the importance of engaging men as the traditional sexual decision makers, most interventions involve men as instruments to improve women's or children's health.

Depending on how men are involved, interventions can potentially increase the disempowerment of women (Montgomery et al., 2011). Some interventions may similarly sideline attention to men, who also need to have their health needs met, beyond their support for women's health. Programs must work in overlapping and complimentary ways with men and boys as clients; involving men to improve women's health; and to promote a positive shift away from dominating gender attitudes and behaviors (Peacock et al., 2009; http://www.men-care.org). Research shows that there are HIV-positive men want to protect their wives from acquiring HIV. As one man living with HIV in Uganda put it:

"That thing that forced me to disclose to her where we stand, because I was thinking for her she might be negative. If she was negative, she would remain behind when I die to look after the children. But if she was positive, then we could see how we could protect ourselves and our children" (Ssali et al., 2010: 678).

A man living with HIV in Kenya stated, "I have changed. I am not like before, I have actually been using protection so that I do not infect my HIV-negative wife. I also avoid extra-marital affairs" (cited in Sarna et al., 2009: 786). Separate focus group discussions with men and women in Mozambique found that both sexes viewed men as "superior, dominant and decision-makers, while women are considered subservient, passive and obedient" (Bandali, 2011a: 578). Even some men who portrayed these dominant characteristics wanted to protect their families. As one man stated:

"I don't want to look for another woman who will bring diseases from outside and then it gets transmitted to my wife. If our child is born and has this disease, I would feel very much about this, so I cannot do it" (Man quoted in Bandali, 2011a: 583).

Many women and men are taking action to prevent HIV transmission but gender norms can sometimes impede communication between partners. HIV-positive men in the Kenya study above also described their struggles to negotiate condom use: "I explained to her we use condoms, I have the disease…and then she tells me, she does not believe it, lets do away with it" [the condom]" (cited in Sarna et al., 2009: 788). In contrast, a South African woman living with HIV described her efforts to persuade her cohabitating boyfriend to use condoms: "He doesn't take it seriously, he says I'm the one who has a problem, he doesn't" (Christofides and Jewkes, 2010: 282). Women in the Christofides and Jewkes (2010) study in South Africa wanted their partners to engage in the full range of behaviors to prevent HIV but found it difficult to influence them. Surveys from Chad, Ghana, Malawi, Nigeria, Tanzania, Uganda, Zambia and Zimbabwe found that higher levels of extramarital sexual risk-taking by men was more prevalent in communities characterized by less gender equity (Stephenson, 2010). Women face an imbalance of power in negotiating the terms of condom use. *[See also Prevention for Women: Male and Female Condom Use]*

Traditional Gender Norms Lead to Behaviors That Put Women – And Men – at Risk for HIV
For both women and men, gender norms are codified through public policy in a range of sectors/areas including health and employment (Barker et al., 2010a). Gender norms, including those that influence sexual and power relations, influence all program areas related to HIVAIDS, from prevention to treatment, care and support. Traditional gender norms lead to behaviors that put everyone at risk for acquiring HIV. Women are less

likely to have access to resources and are more likely to depend on men for financial survival for themselves and their children. For many women, having more than one partner is a central survival strategy for themselves and their children. Such dependence makes it difficult to negotiate safer sex with partners. A study in Mozambique, for example, found that men and women agreed that for women, the only way of getting money was to have sex. Poor women with children would have to have multiple partners. Regardless of the circumstances, women tend to be blamed for spreading HIV, not the men (Bandali, 2011a). A study in Haiti showed that to balance the multiple demands of family and economic survival and to obtain food and housing, single mothers enter into a series of sexual relationships (Fitzgerald et al., 2000). A study in Tanzania found that 70 percent of sexually active girls reported granting sexual favors to meet their basic daily needs (Maganja et al., 2007). Yet whatever puts women at lower risk of acquiring HIV will also ultimately affect the risk of HIV acquisition for men.

Women's dependence makes it difficult for them to negotiate the terms of sex with their partners. These norms may limit women's mobility. Relationship power inequity and intimate partner violence increased the risk of incident HIV infection among 128 South African women who acquired HIV in a 2002-2006 study of 2076 person-years of experience (Jewkes et al., 2010b). It may be that concurrency, rather than relationship power inequity is key to reducing HIV (Epstein 2010). Some contend that having multiple partners can engender violence (Castor et al., 2010) but others have presented data that do not show a relationship between concurrency and violence. (Jewkes and Dunkle 2010).

Nonetheless, in sexual relationships, women often lack the power to protect themselves, and there are close connections between gender inequality and violence against women (WHO and UNAIDS, 2010: 9). *[See Addressing Violence Against Women]*

Traditional Gender Norms Also Harm Men
Men are also affected by gender norms that define masculinity as including early, risky sex with multiple partners and limited communication (Barker et al., 2007b;

"...Reflections on men and HIV/AIDS are usually limited to their culpability as drivers of the epidemic. Addressing these issues effectively means moving beyond laying blame, and starting to develop interventions to encourage uptake of prevention, testing and treatment for men – for everyone's sake" (Mills et al., 2009: 276).

Pulerwitz et al. 2010). The 1,268 participants in a study in Botswana who held three or more gender discriminatory beliefs had nearly *three times* the odds of having had unprotected sex in the past year with a non-primary partner as those who held fewer such beliefs (PHR, 2007a). Homophobia makes men who have sex with men more likely to marry a woman to diminish stigma and legal or other consequences, where homosexuality is illegal (White and Carr, 2005. *[See also Prevention for Women: Partner Reduction]* In many settings, men also tend to seek out health services less than women.

And when men *do* seek health care, they may not be offered information on how to lead a healthy sex life, and the sexual health concerns of men living with HIV and AIDS are frequently neglected, (Esplen, 2007). A study in China with ten AIDS health professionals and 21 adults living with HIV found that "power differences between men and women, men's dominant role in sexual life and their ignorance about HIV/AIDS and its prevention contribute to the increasing HIV risk faced by women" (Zhou, 2008: 1119).

When masculinity is equated with sexual risk-taking and control over women, men are less likely to use condoms, more likely to have more partners, more casual partners, and to engage in more transactional sex (Greig et al., 2008). A qualitative study of six groups of 5 to 10 participants meeting once per week for three weeks in rural South Africa with sexually experienced young people ages 14 to 19 found that young men universally felt that female virginity was a desirable characteristic (Harrison, 2008).

> *"People say that cooking and child care are duties of the wife… But I don't see anything wrong in cooking and looking after the children…Doing such chores can help me, because, if my wife falls ill, I will be able to cook for her and the children…" -Male patient on antiretrovirals in Zimbabwe (cited in Skovdal et al., 2011)*

However, once in a relationship, boyfriends often insisted on sexual intercourse to establish that their girlfriend was a virgin. Young women acquiesced, as they believed that their virginity should be saved for the right partner – and that this partner was the one. Young women then lost their valued status as virgins in the process of proving virginity, with some young women claiming coercion: "…he forces you to have sex to prove to him that you are still a virgin" (Harrison, 2008: 185). Transforming attitudes towards gender equity have been successful in young adolescents and in men as well as women (IRH, 2011; Promundo et al., 2012).

Changing Gender Norms Requires Synchronized Programming for Both Men and Women
The role of gender norms in fueling the AIDS epidemic is clear but insufficiently addressed in programs (UNIFEM, 2008). For example, AIDS programs face a gender-related paradox that in most countries, women are more vulnerable to HIV transmission—in Africa, 61 percent of new HIV cases are in women—yet statistics on treatment show that more women than men access ARV services. Both statistics are related to gender norms that discourage women from obtaining knowledge about sex and protection and discourage men from seeking health care. Working to help people question gender norms, "the societal messages that dictate appropriate or expected behavior for males and females—is increasingly recognized as an important strategy to prevent the spread of HIV infection" (Pulerwitz et al., 2006: 1).

There seems to be some convergence on the idea that "gender relational programming" that works with both women and men – in the same or different ways – may be most

successful in shifting gender norms in a more equitable direction, with positive impacts on health (Greene and Levack, 2010). Meaningful or constructive male involvement has been defined as involving men in in three overlapping roles: as clients of reproductive health services; as supportive partners to women; and as agents of change in the family and community (Greene, 2006). Program and policy interventions can make positive changes in men's gender-related attitudes and behaviors (e.g., Barker et al., 2010c) and numerous programs have shown results in addressing gender norms with men to reduce HIV risks (Colvin, 2009; Pulerwitz et al., 2006), but these programs reach a tiny fraction of the population in need (Barker et al, 2010b). Additional programming and evaluations are needed for boys under the age of 15 and for longer than two-year time spans (Barker et al., 2010b). Some of the most effective interventions involve working with young boys to promote gender equitable attitudes and behaviors. At the same time, attention to public policies that reinforce or transform gender norms for both women and men is critical (Barker et al., 2010a). It's clear that additional programming and evaluations are needed in three key areas: 1) for boys under the age of 15; 2) for longer than two-year time span; and 3) to work at the policy level (Barker et al., 2010b).

Some programming can reinforce traditional gender norms. PAHO analyzed gender roles in 200 HIV-related public service announcement TV spots from Latin America and found that TV spots tended to reinforce the traditional gender roles that contribute to the HIV epidemic, with women bearing sole responsibility for HIV prevention and men as more interested in sex than women (Parodi and Lyra, 2008). It is critical to change prevailing gender norms that dictate multiple sexual partners for men and sexual ignorance and submissiveness for women and girls.

While this section focuses on transforming gender norms, several other interventions that influence gender norms are featured in the rest of the chapter as they relate to violence against women, women's legal rights, employment, education, etc. Changing gender norms requires political will and leadership at every level, from national policymakers to public sector implementers to community leaders. A multi-pronged approach is needed to work with individual men to help them question harmful gender norms and support safer sexual behavior, as well as with the media, community, religious leaders and others who can influence gender norms.

11A. What Works—*Strengthening the Enabling Environment:* Transforming Gender Norms

1. Training, peer and partner discussions, and community-based education that questions harmful gender norms can improve HIV prevention, testing, treatment and care.

Promising Strategies:

2. Mass media campaigns that take up gender equality as part of comprehensive and

> integrated services can increase HIV protective behaviors.
>
> 3. Programs that persuade men to reduce their number of sexual partners could greatly reduce the risk of HIV acquisition for their female partners.

11A. Evidence

1. **Training, peer and partner discussions, and community-based education that questions harmful gender norms can improve HIV prevention, testing, treatment and care.**

   - An evaluation of the Stepping Stones program for young people in the Eastern Cape Province of **South Africa** found that the program was effective in reducing sexual risk-taking and violence perpetration among young, rural African men (Jewkes et al., 2006b). (Gray II) *(violence, condoms, sex behavior, South Africa)* [*See Addressing Violence Against Women*]

   - The Yaari Dosti program in **India** replicated aspects of Program H in Brazil. Nearly 1,150 young men in Mumbai and rural Uttar Pradesh were exposed under the Yaari Dosti program to either peer- led group education activities alone, or combined with a community-based behavior change communication or a delayed intervention which promoted gender equity. The study found that in all intervention sites there was a significant increase in report of condom use at last sex, decreased partner violence and increased support for gender equitable norms. The sample of young men included married and unmarried young men ages 16-29 in the urban areas and ages 15-24 in the rural settings. Logistic regression showed that men in the intervention sites in Mumbai were 1.9 times more likely and in rural Uttar Pradesh 2.8 times more likely to have used condoms with all types of partners than were young men in the comparison sites in each place. Furthermore, self-reported violence against partners declined in the intervention sites (Verma et al., 2008) (Gray IIIa) *(men, peer education, behavior change communication, condom use, sexual partners, violence, gender equity, India)*

   - In **Tanzania**, evaluation of Tuelimishane (Let's Educate One Another), a community-based HIV and violence program for young men in Dar es Salaam that combined community-based drama and peer education, found that the project resulted in significant changes in attitudes and norms related to gender roles and partner violence and some risk behaviors, including condom use. Changes in two of the six measures of HIV risk behaviors were found to be significant. Men in the intervention community were significantly more likely to have used condoms during their last sexual experience, and they were less likely to report using condoms less than half the time in the past six months. There were no significant differences regarding reported use of violence, but men in the intervention village were significantly less likely to report that violence against women is justified under various scenarios. The program was designed based on formative research among young men and women regarding the context of sexual relationships among youth at risk for HIV, including gender norms and roles, partner violence, and sexual behavior. The theme of transactional sex and the active roles of young men and women in the practice also emerged in the formative research (Maganja et al.., 2007). The interventions for young men were designed around three themes that emerged from the formative research, namely, infidelity, sexual communication and conflict (Maganja et al., 2007). (Gray IIIa) *(gender norms, peer education, violence, condoms, Tanzania)*

- A peer group HIV prevention intervention that compared matched workplaces between an intervention group that addressed issues of gender inequality with a delayed control group for 300 urban employed women in **Botswana** found that the intervention group significantly increased their HIV prevention behaviors including personal safer sex practices, positive attitudes toward condoms and confidence in condom use;, greater knowledge of HIV transmission, sexually transmitted diseases and more positive attitudes towards persons living with HIV/AIDS. After the intervention, 76% of the intervention group felt confident about using condoms correctly, compared to 44% in the delayed control group. Almost half of the intervention group reported practicing safer sex compared to 34% of the delayed intervention group. The intervention group also had increased community HIV-related activities, with a mean of 6.1 activities compared to 4.7 activities for the delayed control group. The intervention group had an 83% positive response towards persons living with HIV/AIDS compared to 68% in the delayed intervention group, with stigma being "an important aspect of prevention that needs direct attention" (Norr et al., 2004: 222). The intervention consisted of six ninety-minute weekly or bi-weekly sessions with hands-on condom skills and partner negotiation skills. The peer group leaders sustained the program for more than five years after the end of research funding. As a preliminary phase of the study, 56 in-depth interviews were conducted with urban women in Gaborone, Botswana regarding their HIV prevention needs. A concern that mixed-gender groups might expose women to partner violence led to a decision to have women-only groups. The peer group sessions occurred in workplaces during lunch or after work (Norr et al., 2004). (Gray IIIa) *(gender norms, condoms, workplace, Botswana)*

- A campaign in **South Africa,** *One Man Can*, by the Sonke Gender Justice Network, found that as a result of training workshops, 25% of the men and boys had accessed VCT, 61% increased condom use and 50% reported acts of gender-based violence that the men had witnessed so that appropriate action could be taken to protect women. Sonke provided training over the period of one year to engage men in gender awareness. The campaign implemented a range of communication strategies to shift social norms about men's roles and responsibility, engaged in advocacy and worked with local government, resulting in men's increased utilization of VCT and increased use of condoms. Phone surveys were conducted with 2000 randomly selected men and boys who had previously participated in the One Man Can Campaign workshops. Focus group discussions, in-depth interviews and key informant interviews were also conducted. Workshops included 20 to 30 participants and took place over four to five days, using interactive and experiential activities. The One Man Can Campaign used community events, workshops and peer education to create positive models of masculinity around PPT, VCT, HIV prevention, home-based care, violence, multiple concurrent partnerships and alcohol abuse. Pre- and post-test surveys showed positive changes toward gender equitable attitudes that would assist HIV prevention: prior to the workshop, all the men thought they as men had the right to decide when to have sex with their partners; after the workshop, this decreased to 75%. Prior to the workshop, 67% of the men thought they could get HIV from kissing that involved the exchange of saliva; after the workshop this decreased to none.. Prior to the workshop, 63% of the men believed that it is acceptable for men to beat their partners; after the workshop, 83% disagreed with the statement. Prior to the workshop, 96% of the men believed that they should not interfere in other people's relationships, even if there is violence; after the workshop, all believed they should interfere (Colvin, 2009). (Gray IIIb) *(men, gender norms, condom use, gender relations, violence, South Africa)*

- An impact evaluation of Program H, undertaken by PROMUNDO, was conducted in **Brazil** to test the hypothesis that young men in slum areas of Rio de Janeiro can change their

behavior and attitudes through participation in group education activities that encourage reflection on what it means to be a man. The program resulted in significantly smaller percentages of young men supporting inequitable gender norms over time. Improvements in gender norm scale scores were associated with changes in at least one key HIV/STI risk outcome. In two of the three intervention sites, positive changes in attitudes toward inequitable gender norms over one year were significantly associated with decreased reports of STI symptoms. In two of the three intervention sites young men were approximately four times and eight times less likely to report STI symptoms over time, respectively. No significant change was found in condom use. Those boys who reported that they had more equitable gender norms as measured by the GEM scale also reported a decrease in STI symptoms. Program H was developed on the premise that gender norms, which are passed on by families, peers, and institutions, among others, and are interpreted and internalized by individuals, can be changed. Furthermore, reinforcing these messages on the community level will have additional positive impacts. The quasi-experimental study, which followed three groups of young men ages over time, compared the impact of different combinations of program activities, including interactive education for young men led by adult male facilitators and a community-wide social marketing campaign to promote condom use as a lifestyle that used gender-equitable messages that reinforced the messages promoted in the education sessions (Pulerwitz et al. 2006). (Gray IIIb) *(gender norms, STIs, condoms, violence, Brazil)*

Promising Strategies:

2. **Mass media campaigns concerning gender equality as part of comprehensive and integrated interventions can increase HIV protective behaviors.** *[See also Prevention for Young People Encouraging Behavior Change – many of the media interventions promote equitable gender norms]*

- An evaluation of *Somos Differentes, Somos Iguales* (We're Different, We're Equal) that included a cohort of 4,800 young women and men ages randomly selected in three cities in **Nicaragua** who were interviewed at three times, 200 young women and men in focus group discussions and in-depth interviews with participants and non-participants of social action activities found that at baseline young women and men had good knowledge about HIV/AIDS and that AIDS-related stigma was prevalent and safer sex was not regularly practiced. The final survey found that exposure to the project, particularly the TV series *Sexto Sentido*, and greater exposure to project activities led to a significant reduction in stigmatizing and gender-inequitable attitudes, an increase in knowledge and use of HIV-related services, and a significant increase in interpersonal communication about HIV prevention and sexual behavior. Participants with greater exposure to the intervention had a 44 percent greater probability of having used a condom during last sex with a casual partner and men with greater exposure had a 56 percent greater probability of condom use with casual partners during the past six months.*Somos Differentes, Somos Iguales* project (2002-2005) used a communication for social change strategy aiming to promote the empowerment of young men and women and prevent HIV infection. The project considered *machismo* (dominant masculinity) as a risk factor for HIV/AIDS. *Somos Differentes, Somos Iguales* used the weekly drama TV series *Sexto Sentido* (Sixth Sense), which was also broadcast in Costa Rica, Guatemala, Honduras, Mexico and the US, and the call in radio program *Sexto Sentido* Radio to promote the gender transformative and HIV prevention messages and worked with more than 80 local service providers to increase access to SRH services for young women and men. The project also worked with about 200 collaborating organizations. Interventions included a

weekly national educational program (telenovela); a daily call-in radio show; community-based activities; visits by the case to schools; youth training camps and informational materials (Solarzano et al., 2008). (Gray IIIa) *(gender norms, youth, communication, condoms, self-perception, Nicaragua)*

- An impact evaluation of Program H, undertaken by PROMUNDO, was conducted in **Brazil** and followed three groups of young men ages over time, compared the impact of different combinations of program activities, including interactive education for young men led by adult male facilitators and a community-wide social marketing campaign to promote condom use as a lifestyle choice, using gender-equitable messages that reinforced the ideas promoted in the education sessions. The program resulted in significantly smaller percentages of young men supporting inequitable gender norms over time. Improvements in gender norm scale scores were associated with changes in at least one key HIV/STI risk outcome (Pulerwitz et al. 2006). (Gray IIIb) *(gender norms, STIs, condoms, violence, Brazil)*

3. **Programs that persuade men to reduce their number of sexual partners could greatly reduce the risk of HIV acquisition for their female partners. [***See Prevention for Women: Partner Reduction***]**

11A. Gaps in Programming—Transforming Gender Norms

1. Changing prevailing gender norms that can lead to increased HIV rates such as those dictating multiple sexual partners for men and sexual ignorance and submissiveness for women and girls is a current challenge. Further well-evaluated interventions are needed.

2. HIV programming must be more effective in creating meaningful involvement for both male and female partners and increase focus on gender.

3. Interventions are needed to reduce homophobia, which may lead MSM to have partnerships with women.

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1. **Changing the gender norms that can lead to increased risks of HIV such as those dictating multiple sexual partners, the use of violence, or drinking heavily for men and sexual ignorance, submissiveness and dependency for women and girls is a current challenge. Further well-evaluated interventions are needed and existing interventions need to be scaled up.** Studies found that women were aware of being at risk for HIV yet felt they had no power to negotiate the terms of sex or to demand condom use. Studies found that both men and women thought multiple sexual partners for men to be an accepted norm in many countries. Media reinforced these gender stereotypes.

   - Gap noted, for example, in **South Africa** (Kelvin et al., 2008; Harrison, 2008); **Chile** (Cianelli et al., 2008); **China** (Zhou, 2008); **Latin America** (Parodi and Lyra, 2008); and **Zimbabwe** (Feldman and Maposhere, 2003).

2. **HIV programming must be more effective in creating meaningful involvement for both male and female partners and increase focus on gender equality.** A review of 63 programs in developing countries found that only one-third had treated addressing gender norms as a strong central focus. In many programs, participants were asked only to bring their partners for HIV testing or other services, rather than supported to question harmful gender norms or to involve opposite sex participants in a meaningful way. "What is needed in the near future is more evidence of the synergies and sustainable outcomes that emerge when gender-transformative work with men and women becomes truly synchronized" (Levack and Greene, 2010: 21).

- Gap noted, for example, **globally** (Bruce et al., 2011).

3. **Interventions are needed to reduce homophobia, which may lead MSM to have partnerships with women.** *[See Prevention for Women: Partner Reduction]*

11B. Strengthening *the Enabling Environment:* Addressing Violence Against Women

Violence, in addition to being a human rights violation, has been clearly demonstrated as a risk factor for HIV (WHO and UNAIDS, 2010; Stephenson, 2007; Jewkes et al., 2006a; Manfrin-Ledet and Porche, 2003; Dunkle et al., 2004; Quigley

> *"Men never allow us to use condoms. If we suggest they beat us."* — Ugandan woman (cited in Karamagi et al., 2006: 7)

et al., 2000b; Silverman et al., 2008). Analysis of DHS data in Rwanda showed that currently married women with few, if any, sexual risk factors for HIV but who have experienced sexual, physical or emotional abuse within their marriages were between 1.61 and 3.46 times more likely to test HIV-positive (Dude, 2009). DHS analysis in Zimbabwe similarly found that currently married women who had experienced physical violence only, or both physical and sexual violence, were significantly more likely to be HIV-positive than those who had not experienced any physical or sexual violence. "Among currently married and formerly married women, husbands are the main perpetrators of violence" (Nyamayemombe et al., 2010: 7). In Brazil, suffering repeated and severe violence was more closely associated with confirmed HIV infection for women (Barros et al., 2011). Another study found that abusive husbands demonstrated increased odds of HIV acquisition outside the marriage and that husbands who were abusive were more likely to transmit HIV to their wives (Decker et al., 2009). Interestingly, a recent analysis of DHS data from the Dominican Republic, Haiti, India, Kenya, Liberia, Malawi, Mali, Rwanda, Zambia and Zimbabwe, however, did not find that intimate partner violence was consistently associated with HIV prevalence among ever-married women in all of the countries (Harling et al., 2010).

Acts that would be punished if directed at an employer, a neighbor, or an acquaintance often go unchallenged when men direct them at women, especially within the family (Heise et al., 2002: S5). "Male violence against women, an extreme manifestation of gender inequality, is the direct result of gender norms that accept violence as a way to control an intimate partner" (Pulerwitz et al., 2010b: 283). Violence against women (VAW), is a more specific form of the category of gender-based violence (GBV), and is considered acceptable behavior in many countries (Andersson et al., 2008).

Violence Against Women is Widespread
A report that analyzed DHS Surveys in Bangladesh, Bolivia, the Dominican Republic, Haiti, Kenya, Malawi, Moldova, Rwanda, Zambia and Zimbabwe found that women experienced a wide variation across countries in the prevalence of physical or sexual violence by their current husband or partner, from 16% in the Dominican Republic to 75% in Bangladesh (USAID, 2008a). Levels of violence are also high for Papua New Guinea, Fiji and East Timor (AusAID, 2007). Inequitable gender norms are related to increased violence: in five of the 10 countries studied (listed above), women who believe that wife beating is justified were more likely to report experiencing physical or sexual violence (USAID, 2008a). A study between 2000 and 2003 with 24,097 women ages 15 to 49 in Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and Tanzania found that of the 19,568 women who had ever had a partner, 15–71% reported they had experienced physical or sexual violence or both at some point in their lives by a current or former partner (Ellsberg et al., 2008). A survey in Vietnam with 465 women found that 37% said they had been beaten by their husbands (Luke et al., 2007). A study in India with 459 women, 216 of whom were living with HIV, found that 40% of HIV-positive women and 30% of HIV-negative women reported being forced to have unwanted sex with their husbands and one in three of all 459 women reported being hit by their in-laws (Gupta et al., 2008b). According to UNICEF, 5–21% of adolescent girls ages 15 to 19 reported that they have ever experienced sexual violence (UNICEF, 2011b).

Both males and females often justify violence as acceptable. For example, a study in Ghana found that 56% of boys and 60% of girls argued that it was acceptable for a boy to beat his girlfriend in some circumstances (Glover et al., 2003 cited in Jejeebhoy and Bott, 2003). Studies in Nigeria and Uganda found that rape was accepted as inevitable among victims because males were uncontrollable, that rape was accepted as a "way to teach a haughty girl a lesson" and the misperception that women enjoy coercive sex (Ajuwon et al., 2001; Hulton et al., 2000 cited in Jejeebhoy and Bott, 2003). Other studies also report the misperception that men's sexual needs are beyond their control (Sodhi and Verma, 2003 cited in Jejeebhoy and Bott, 2003). Gender-based violence is sometimes condoned for supposed religious reasons. A recent study found that of 1,803 women in Tanzania who agreed that "HIV is punishment for sinning" were more likely to have experienced intimate partner violence in the last year (Amuri et al., 2011). A recent review of 65 studies, most in the resource rich settings, found that there is substantial evidence of

effectiveness of interventions to improve boys and young men's attitudes toward rape and other forms of violence against women; however, there is little evidence of effectiveness of interventions to actually decrease violent behaviors in the long term (Ricardo et al., 2011). Recent literature indicates that abusive men are more likely to have other sexual partners unknown to their wives (Campbell et al., 2008a). *[See also Prevention for Women: Partner Reduction]*

Violence Can Increase Women's HIV Risk
"There are three mechanisms through which violence is hypothesized to increase women's risk for HIV infection: (1) through forced or coercive sexual intercourse with an infected partner, (2) by limiting women's ability to negotiate safe sexual behaviors, and (3) by establishing a pattern of sexual risk taking among individuals assaulted in childhood and adolescence" (Maman et al., 2000: 466). For example, a study in Uganda with 3,422 women ages 15 to 24 found that women who always used condoms were less likely than those who never used condoms or used them inconsistently to report physical violence and sexual coercion (Zablotska et al., 2006). A study in the Central African Republic found that among both men and women ages 15–50, those whose sexual initiation was forced were between 1.77 and 2.47 times more likely to report multiple partners in adulthood, compared to those whose first sex was consensual (Sonse et al., 1993 cited in Jejeebhoy and Bott, 2003). A study in Chile found that women who had suffered intimate partner violence were highly likely to have sexual relations with a partner whose HIV status was unknown, as well as having sex without condoms (Miner et al., 2011). Intimate partner violence tends to be consistently associated with inconsistent condom use, having an unplanned pregnancy or induced abortion, and having an STI, including HIV (Coker, 2007).

Violence is both a risk factor for HIV and a consequence of being identified as having HIV (WHO and UNAIDS, 2010). A review for the U.S. Institute of Medicine based on studies between 1998 and 2007 found that "violence or fear of violence from an intimate partner is an impediment (to) or a consequence of HIV testing" (Campbell et al., 2008b: 2). Many women do not disclose status based of fear of violence and abandonment. While some studies have shown that only a small percentage of women experienced negative responses after disclosure of their HIV status, there is some evidence that women are subjected to violence from their sexual partners as a consequence of HIV testing and disclosure of results (Maman, 2001b). Women who do disclose are more likely to be in secure relationships. In-depth interviews with both HIV-positive men and women in Kenya found that both reported that "disclosure was associated with a sense of relief, a lifting of a burden of guilt" (Sarna et al., 2009: 787). [*See also HIV Testing and Counseling for Women*] Violence can also be a barrier to adherence to treatment as spouses may demand that women share treatment if the spouse does not want to be tested. In cases where women face intimate partner violence, they may take HAART in secret. [*See also Treatment]*

Women threatened by violence and rape, including married women and adolescents, cannot negotiate condom use. A study with 428 South African men with multiple partners found high rates of intimate partner violence, with 36% reporting perpetrating physical intimate partner violence and 19% reporting sexual intimate partner violence. Inconsistent condom use was significantly related to reporting any kind of intimate partner violence (Townsend et al., 2011). A repeat survey from 2002 in Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe found that 40% of women said they would have sex if their partner refused to use a condom, and 40% said that they did not think women have the right to refuse sex with their partner (Andersson et al., 2008). A sample of 575 sexually experienced young women ages 15–19 interviewed in 2001-2002 in Rakai, Uganda, found that 14% reported that their first sexual intercourse had been coerced. Coercion at first intercourse was negatively correlated with subsequent condom use: 24% of unmarried women who reported coerced first sex had used a condom at last sex, compared with 62% of those who reported no coercion at first sex. Respondents who reported coerced first intercourse were less likely than those who did not to say they had used a condom at last intercourse (13% as compared to 33%) (Koenig et al., 2004).

Sexual Abuse of Children Increases Their Risk for HIV
Children who are sexually abused are more at risk as adults of acquiring HIV (Slonim-Nevo and Mukuka, 2007). The first national study on violence against children in Africa was conducted in Tanzania as part of the Together for Girls Initiative and used a nationally representative survey of 3,739 females and males between 13 and 24 years of age to find that nearly 3 in 10 females and approximately one in 7 males experienced violence prior to the age of 18. Of those who had their first sexual experience prior to age 18, 29.1% of female and 17.5% of males reported that their first sexual intercourse was unwilling. The prevalence of engaging in sex with two or more partners in the previous 12 months was significantly higher among both females and males who had experienced childhood sexual violence compared to those who had not experienced childhood sexual violence (UNICEF, Tanzania et al., 2011). Men report experiencing violence as children in countries such as Brazil, Chile, Croatia, India, Mexico and Rwanda. Childhood experiences of violence are associated with later adoption of inequitable gender attitudes including violence against women (Contreras et al., 2012). *[See Transforming Gender Norms]*

Pilot programs are beginning to successfully address the needs for post-exposure prophylaxis by children who suffer from rape (Speight et al., 2006). "There is a growing recognition that children in sub-Saharan Africa are vulnerable to HIV transmission through sexual abuse and exploitation including incest, child rape, early (coerced) coitus, 'sugar daddies' and transactional sex" (Lalor, 2008). In the Tanzanian study above, only 1 in 5 females and 1 in 10 males who experienced sexual violence prior to age 18 sought services although 1 in 6 females and males who experienced sexual violence said they would have liked counseling and support from police (UNICEF, Tanzania et al., 2011). A

survey of 613 men in Botswana and of 876 men in Swaziland conducted from 2004 to 2005 found a history of forced sex victimization was strongly correlated with past year perpetration of forced sex by men in both countries (Tsai et al., 2011).

Interventions are needed to reduce the incidence of sexual abuse, as well as to address the consequences of abuse. Furthermore, education-related exposure to violence needs to be addressed. Research conducted by Human Rights Watch in Zambia in 2002 found that long commute times to and from school was a significant factor associated with sexual assault among young girls. Approximately 100 girls under the age of 18 were interviewed in a largely open-ended format that covered a variety of topics and 36 NGOs and a number of government officials were contacted and visited. "The length of the girls' commute to school is an important factor here, since they risk sexual abuse by minibus drivers or conductors, if they take transportation, or abuse by others along the road, if they walk, can be significant" (Chimuka, 2002 cited in Fleischman, 2002: 49).

Evidence for Interventions is Scant
Some evidence exists that violence prevention interventions are effective, particularly by developing nurturing relationships between parents and children, by developing life skills in children and adolescents and by changing gender norms (WHO, 2009d). A study in South Africa found that integrating HIV prevention services into services for women who suffered abuse – through workshops about negotiation skills and economic independence – resulted in women reporting a decrease in unprotected sex from 20% to 14% (Sikkema et al., 2010). However, "…much of the available literature lacks evidence on how to forge essential linkages between HIV programs and services for preventing and responding to sexual and gender-based violence" (Raifman et al., 2011: 11). Programs and evaluations to work with men to reduce violence have been limited (Ricardo and Barker, 2008).

Eliminating Violence Against Women Requires a Comprehensive Approach
Eliminating violence against women requires primary prevention of violence, responding to survivors of violence and responding to violence against positive women. A comprehensive response, based on principles of human rights and ensuring survivor-centered and empowering approaches, is needed to address violence against women; including political commitment and resource mobilization, legal, and judicial and security sector reform, health sector responses, response from the education sector, use of mass media and community mobilization (UNIFEM, 2010; Jina et al., 2010).

How best to provide services that address both violence and HIV in various settings has been an ongoing challenge. "Research is urgently needed to build the evidence base and address the current lack of information on effective programmes for primary prevention" (i.e. approaches that prevent violence before it occurs) (WHO, 2010d: 76). Programs that integrate violence screening with VCT programs can be helpful, but only if they are ongoing. A study in South Africa found that women who went for HIV voluntary testing

and counseling found screening for violence at VCT centers acceptable; however, one year after training for lay staff who conducted the VCT and violence screening, violence screening did not continue. Women also had unrealistic expectations that lay VCT counselors could stop their partners' violence, believing that their counselors could talk to the partner of the woman and convince him to stop (Christofides and Jewkes, 2010).

Campaigns and public education can challenge the acceptance of violence against women and raise awareness of the adverse impact of violence on women's health. Comprehensive gender-based violence policies are needed that "include primary prevention targeting men and boys; policies to engage men and boys in making public spaces free of violence for women and girls; programs for male perpetrators that are integrated with [the] judicial sector; implementation of gun control; control over alcohol sales; and legal, financial and psychological supports for survivors of violence, both women and men" (Barker et al., 2010a). Efforts to stop violence against women will not succeed unless male attitudes and behavior are addressed. *[See Transforming Gender Norms]* Since exposure to violence in childhood has also been correlated with violence perpetration against women (Clark et al., 2010), violence prevention efforts that start with children may be warranted. Innovative programs such as *One Man Can* in South Africa are good examples of working with men to reduce violence (Colvin, 2009). Political, religious and community leaders, along with the media can play a significant role in changing social norms. Improved awareness and attitudes need to be supported by the enforcement of laws that prohibit violence against women and punish the perpetrators. Women's advocacy organizations have been key in raising awareness and working with governments to strengthen legal solutions. Women who experience violence, including from intimate partners, need counseling, health services and support. "To date, there have been few initiatives worldwide designed to respond to violence against positive women; consequently, evidence regarding promising practices ….is limited" (Hale and Vazquez, 2011).

Health Services Can Play a Critical Role to Respond to Survivors of Violence
A baseline survey of nine sexual violence services in Uganda and eight in Rwanda found that in practice, much also needs to be done to meet the needs of survivors, including provision of adequate equipment and supplies; adherence to legal requirements that physicians be present when services were provided; client follow-up; awareness by providers of community services; privacy for clients; reduction in stigmatizing attitudes of providers; and community outreach so that survivors know where to go (Elson and Keesbury, 2010). Changes are needed in health care organizations to address violence using a systems approach, which includes awareness of laws, ongoing training and support for staff, referral networks, protocols and education for clients. *[See also Structuring Health Services to Meet Women's Needs]* A study in the Dominican Republic conducted in 2006 with 31 women living with HIV who were victims of violence and 39 providers for either HIV or violence services, including HIV physicians, counselors, social workers, etc. found that few HIV providers had training on services for women

who suffered from violence; and few providers for violence services had training on HIV. Almost all the providers did not know the pertinent legislation related to violence and more than a third believed that women provoke violence. Protocols are needed for to establish linkages between HIV and violence services (Betances and Alba, 2009). A randomized survey among 100 obstetricians-gynecologists in Pakistan in 2002 found that "the significant mismatch between perceptions of prevalence of domestic violence in Pakistani society (>30%) and in clinical practice (<10%) suggests that obstetricians are socially aware of the enormous public health burden but cannot associate an equivalent magnitude among their clientele..." (Fikree et al., 2004: 64). Only 8% of the survey participants had ever received domestic violence training related to case identification and management, however, 83% reported that it was important to receive such training (Fikree et al., 2004).

It is vital that health providers do not further compound the suffering of a woman or girl who has been raped by blaming her for the rape (Carretta, 2008). Health care providers must remain objective in the case of a sexual assault. Based on a review of the evidence, the International Federation of Obstetricians and Gynecologists notes: "Except in survivors who are unable to give consent, it is impossible for a health professional to know whether a rape has occurred. Indeed it is the task of the judge to determine whether a rape occurred" (Jina et al., 2010: 89). Providers should support a woman who comes to services in cases of rape. Services are also needed for young girls and adolescents (Keesbury and Askew, 2010).

Ensuring Rape Victims Have Access to PEP and Emergency Contraception Is Essential
In many countries, there are few services for women who are subjected to violence – and fewer for girls. In some countries, women fear rape most because of the fear of acquiring HIV (Gharoro et al., 2011). Rape victims need timely access to post-exposure prophylaxis (PEP) and the International Federation of Obstetricians and Gynecologists note that rape survivors also need access to and counseling concerning emergency contraception within five days of rape (Jina et al., 2010). "The risk of HIV transmission after rape is estimated to be very low, yet is of grave concern to survivors" (Jina et al., 2010). A review of barriers to PEP in 13 PEPFAR countries found that requiring HIV testing to access PEP, reporting rape to police to access PEP and the need for no-cost services and quality counseling were gender-related barriers to accessing PEP (Herstad, 2009). A record review of 390 clients of a rape crisis center in South Africa that saw, on average, 26 women per month over 15 months from 2003 to 2004 found that up to 36% of women were HIV-positive at the time of presentation. Acceptance of HIV testing and provision of PEP was high; however, adherence to antiretroviral therapy and return for testing were low. Only 57% of clients filled the four weekly PEP prescriptions, possibly because of travel costs and distance. Making services more user-friendly may increase uptake of completion of PEP (Carries et al., 2007). Children also need access to PEP. A qualitative study was conducted in Kenya to better understand the reasons for the low uptake of post-rape care services in health facilities and to establish perceptions of sexual

violence in Kenya. Thirty-four key informants were interviewed and 16 focus group discussions with women and men were held in three districts in Kenya. Important implications for the delivery of HIV post exposure prophylaxis (PEP) after sexual violence include the need for gender-aware patient-centered training for health providers and for HIV PEP interventions to strengthen on-going HIV prevention counseling efforts (Kilonzo et al., 2008a).

The need to address post-conflict violence in relationship to HIV has been the subject of some controversy, but few evaluated interventions were found.

Stronger Links Are Needed Between The Health and Justice Systems
Linkages between the justice system and the health system in many sub-Saharan countries is weak, making women more reluctant to seek judicial justice for crimes of rape (Kilonzo et al., 2009b). "Laws need to be reformed and implemented to sanction all forms of gender-based violence and to provide survivors with access to justice" (Ellsberg and Betron, 2010). *[See also Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights]*

Guidelines for the management of female survivors of sexual assault from the International Federation of Gynecology and Obstetrics are available (Jina et al., 2010). Additional evidence and resources for working with all sectors – health, legal, police, justice, education, and in conflict settings are available at www.endvawnow.org (UNIFEM, 2010). Guidance for integrating gender-based violence into PEPFAR programming is available: (http://www.aidstar-one.com/focus_areas/gender/resources/pepfar_gbv_program_guide). (USAID/AIDSTAR-One, 2011a) as is USAID guidance for child abuse and violence USAID, 2011b).

11B. What Works—*Strengthening the Enabling Environment:* Addressing Violence Against Women

1. Community-based participatory learning approaches involving men and women can create more gender-equitable relationships, thereby decreasing violence.

Promising Strategies:

2. Establishing comprehensive post-rape care protocols, which include PEP and emergency contraception, can improve services for women.

3. Microfinance programs can lead to reduction in gender-based violence when integrated with participatory training on HIV, gender, and violence.

4. Training teachers about gender-based violence can change norms about acceptance of gender-based violence.

> 5. Public health promotion can increase awareness of violence against women.

11B. Evidence

1. **Community-based participatory learning approaches involving men and women can create more gender-equitable relationships, thereby decreasing violence.** *[See also Transforming Gender Norms]*

   - An evaluation of the Stepping Stones program for young people in the Eastern Cape Province of **South Africa** found that the program was effective in reducing sexual risk taking and violence perpetuation among young, rural African men. The evaluation was designed using the gold standard of evaluation, a random controlled trial. Women in the intervention arm had 15% fewer new HIV infections than those in the control arm and 31% fewer HSV 2 infections, although neither was significant at the 5% level (Jewkes et al., 2008). Findings also showed that men reported fewer partners, higher condom use, and less transactional sex, perpetration of intimate partner violence, and substance use. Among the women, there was an increase in transactional sex. Stepping Stones, originally designed for use in Uganda in the mid-1990s, is among the most widely used prevention interventions around the world, having been used in over 40 countries (Jewkes et al. 2007). Stepping Stones is a gender transformative approach designed to improve sexual health through building stronger and more gender-equitable relationships among partners, including better communication. Stepping Stones uses participatory learning approaches to increase knowledge of sexual health, and build awareness of risks and the consequences of risk taking. The evaluated program included a 50-hour program (with a comparison group receiving a 3-hour intervention on HIV and safer sex) (Jewkes et al., 2006b). (Gray II) *(violence, condoms, sex behavior, South Africa)*

   - A quasi-experimental study in 2008 with 645 young men in **Ethiopia** results in significantly less perpetration of violence by men against women over time. Measured against a comparison group of 159 men, 251 men received training on gender equitable norms and 235 men received training on gender equitable norms in addition to community engagement activities such as community workshops, drama skits, monthly newsletter and condom distribution. Interviews were also conducted with primary female partners of 25 of the men who received the intervention. At baseline, 62% of the men reported having been violent towards a primary partner at some point in their lives. The percentage of men who reported being physically violent toward a female partner over the past six months significantly decreased in both intervention arms but not in the comparison arm. Qualitative reports from female partners confirmed these changes. Young men from both intervention groups were more likely to report increased communication about condoms with their partners. However, due to small sample size, quantitative changed in sexual risk was not measured (Pulerwitz et al., 2010a) (Gray IIIa) *(men, gender norms, violence, Ethiopia)*

   - A campaign in **South Africa,** One Man Can, by Sonke Gender Justice Network, which provided training over the period of one year to engage men in gender awareness, implemented a range of communication strategies to shift social norms about men's roles and responsibility, engaged in advocacy and worked with local government, and resulted in men's positive attitude shifts regarding gender based violence. Phone surveys with a randomly selected pool of previous One Man Can Campaign workshop participants were conducted

with 2,000 men and boys. Focus group discussion, in-depth interviews and key informant interviews were also conducted. Following the training workshops, 50% reported acts of gender-based violence that the men had witnessed so that appropriate action could be taken to protect women. Workshops included 20 to 30 participants and took place over four to five days, using interactive and experiential activities. The One Man Can Campaign used community events, workshops and peer education to create positive models of masculinity around PPT, VCT, HIV prevention, home-based care, violence, multiple concurrent partnerships and alcohol abuse. Pre- and post-test surveys showed positive changes toward gender equitable attitudes that would assist HIV prevention: prior to the workshop, 63% of the men believed that it is acceptable for men to beat their partners; after the workshop, 83% disagreed with the statement; prior to the workshop, 96% of the men believed that they should not interfere in other people's relationships, even if there is violence; after the workshop, all believed they should interfere (Colvin, 2009). (Gray IIIb) *(men, gender norms, condom use, gender relations, violence, South Africa)*

- A follow-up study of a Stepping Stones program in **South Africa** using in-depth interviews with ten men and eleven women before the intervention and then again at one year, along with 18 follow-up interviews with 18 people and four focus groups found that Stepping Stones men sought to be less violent and more likely to avoid HIV risk behavior; but only some women could challenge their male partners to engage in HIV risk reduction. Some women said that as a result of Stepping Stones they aspired for a more respectful and non-violent relationship (Jewkes et al., 2010c). (Gray IV) *(violence, sex behavior, South Africa)*

Promising Strategies:

2. **Establishing comprehensive post-rape care protocols, which include PEP and emergency contraception, can improve services for women.**

- Implementation of an intervention between 2003 and 2006 consisting of establishing a sexual violence advisory committee, instituting a hospital rape management policy, training for providers, centralizing and coordinating post-rape care in a designated room and community awareness campaigns in **South Africa** resulted in utilization of services from 8 to 13 cases per month. Rape survivors who reported seeing six or more providers on the first visit decreased from 86% to 54%. Chart reviews and patient interviews suggested improved quality of history, exam, provision of pregnancy testing, emergency contraception, STI treatment, VCT, PEP, follow-up counseling and referrals. Following the intervention, patients were more likely to report having received PEP, to have received a full 28 day course on their first visit and to have completed the full 28 day regimen. Providing anti-emetics for control of nausea, a common side effect of PEP, may have increased completion of PEP as well. There was a reduction from 28 hours to 18 hours between the assault and receiving the first dose of PEP and 49% of survivors knew that PEP was given to prevent HIV infection, as compared to 13% prior to the intervention. Post-intervention, survivors were 27% more likely to have been given a pregnancy test and 37% more likely to have received any VCT. Project nurses worked with women's groups, radio and others to distribute information pamphlets to over 14,000 and trained nurses at 15 primary health care clinics to include information on sexual violence and services during health talks for patients waiting for services. The project took place in a rural hospital with a 450-bed district hospital that functions as a referral site for post-rape care. Interviews were conducted with 109 rape survivors, 50 providers and 334 hospital charts were reviewed. Two-day training for healthcare workers and other service providers was

implemented. A designated room for treating patients who have been sexually assaulted can reduce delays and increase privacy. The per case costs for the Refentse services, once systems were established were deemed cost-effective at $58 (Kim et al., 2007a; Kim et al., 2009a). (Gray IIIb) *(violence, rape, pregnancy, counseling, providers, South Africa)*

- Between 2002 and 2007, a standard of care and a simple post-rape care system was developed in **Kenya,** resulting in 784 survivors of rape accessing services. Client exit interviews conducted with survivors or their guardians in 2005 indicated a high level of satisfaction with post-rape services. In 2002, a situation analysis was conducted. In 2003, there was no policy, no coordination, no confidential spaces for treatment, no service delivery mechanisms for post-rape services in Kenya and PEP was not offered. Formal counseling for sexual trauma did not include HIV testing. Starting in 2003, a standard of care, post-rape algorithms and counseling protocols were developed. Training that included knowledge, skills and values clarification was conducted with clinicians, lab personnel and trauma counselors. Post-rape kits were developed to facilitate the collection of evidence. Services were provided through VCT and casualty department. Services were advertised within public health services. A universal data form became acceptable for legal presentation in Kenyan courts. Since 2006, indicators for post-rape care have been incorporated into national planning. By June 2007, 13 post-rape facilities in Kenya delivered services to over 2,000 adults and children with 96% of those eligible initiating PEP at presentation. The cost of providing post-rape care was estimated at US$27 per patient, similar to costs for VCT (Kilonzo et al., 2009a). (Gray IIIb) *(violence, rape, pregnancy, counseling, providers, Kenya)*

- A project in **Kenya** with AMPATH instituted provision of occupational PEP and nonoccupational PEP between 2001 and 2006, during which 446 patients sought PEP. Of these 446 patients, 91 sought PEP for occupational exposure. Of the 72 patients who presented for occupational exposure and tested HIV-negative, 69 completed PEP. Of the 296 patients who presented for non-occupational exposure and tested HIV-negative, only 104 completed PEP. Numerous reasons were advanced as contributing to high loss to follow-up in non-occupational cases, such as multiple stops, fees, and confidentiality concerns (Siika et al., 2009). (Gray IIIb) *(post-exposure prophylaxis, Kenya)*

- Following on the Refentse model from South Africa (see Kim et al., 2009a), programs in **Malawi and Zambia** conducted similar programs and built on existing infrastructure which resulted in services in those two countries being self-sustaining for at least two years after project funding ended (Keesbury and Askew, 2010). (Gray V) *(violence, rape, pregnancy, counseling, providers, South Africa)*

3. **Microfinance programs can lead to reduction in gender-based violence when integrated with participatory training on HIV, gender, and violence.**

- Using a cluster-randomized trial in rural **South Africa**, the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) intervention combined a microfinance program with participatory training on understanding HIV infection, gender norms, domestic violence, and sexuality, which resulted in a reduction in experience of physical or sexual violence by an intimate partner. After 2 years, the risk of past-year physical or sexual violence by an intimate partner was reduced by more than half. Women in the intervention group experienced a substantial reduction in intimate partner violence in the previous 12 months and experienced less controlling behaviors by their partners. At baseline, 11% of the intervention group – 22

out of 193 experienced intimate partner violence; at follow-up, only 6% - 17 out of 290 participants experienced intimate partner violence. In the comparison group, 9% or 16 out of 177 experienced intimate partner violence in the last twelve months; at follow up, 12% or 30 out of 248 participants experienced intimate partner violence, for an adjusted risk ratio of 0.45. Fewer individuals in the intervention group reported more than one partner in the past year than did individuals in the comparison group; however, there was no difference in HIV incidence between intervention and comparison groups and there was little evidence that unprotected sexual intercourse at last occurrence with a non-spousal partner in the past 12 months was less common in the intervention group than it was in the comparison groups. The study could not demonstrate in the short term an impact on HIV risk (Pronyk et al., 2006). However, the findings indicate that economic and social empowerment of women can contribute to reductions in intimate partner violence. The study also showed that it is possible to target, even in the short term, the structural determinants of HIV and intimate partner violence in Africa. (Kim et al., 2007b; Croce-Galis, 2008). Data from attendance registers, financial records, observations, 378 structured questionnaires and 128 focus group discussions and interviews with clients and staff had a delivery system that was feasible in the short term, but with questions on sustainability in the long term, with other models being assessed. The IMAGE trial enrolled 430 female clients in ten loan centers in four villages. In the scale-up phase, more than 3,000 clients were recruited from 115 villages. IMAGE did not undermine microfinance delivery or repayment (Hargreaves et al., 2010). An analysis of the IMAGE data showed that only IMAGE group, which had both microfinance services and health training improved health outcomes. Those participants who received the microfinance services only did see improvements in economic well-being, but not in violence or HIV related variables. However, the microfinance only intervention did not exacerbate the risk of intimate partner violence over the last year (Kim et al., 2009c). (Gray II) *(gender norms, microfinance, violence, self-perception, South Africa*)

4. **Training teachers about gender-based violence can change norms about acceptance of gender-based violence.**

- A project in **South Africa** found that training teachers resulted in less teacher acceptance   of gender-based violence and more confidence to raise the issue of gender-based violence in the classroom. Of the teachers who received the training, 47% were women who had previously experienced physical abuse from a partner, while 25% were male teachers who previously reported that they had been physically abusive to a partner. The project trained two representatives from each selected school who in turn trained others. The project also trained all school employees, including administration and the cleaning staff, leading to significant changes in teachers' perceptions about the roles of school in addressing gender-based violence and greater commitment from school management (Dreyer, 2001 cited in James-Traore et al., 2004). (Gray IIIb) *(violence, teachers, training programs, South Africa)*

- A Safe Schools project that trained 185 supervisors in **Ghana** and 221 in **Malawi**, along with 359 teachers and 80 students, to recognize, prevent and respond to school-related gender-based violence increased recognition by teachers of sexual harassment from 30% to 80%. In Malawi, at baseline, 70% of girls disagreed with the statement that it was okay for a teacher to get a girl pregnant as long as he married her; post-intervention, 90% disagreed with the statement (USAID, 2008a). (Gray IIIb) *(teachers, pregnancy, violence, training programs, Ghana, Malawi)*

5. **Public health promotion can increase awareness of violence against women.**

- An evaluation of gender-based programming in Zambia found that providing direct services at the same time as conducting public outreach and sensitization campaigns and activities, from community to national levels, increased within three years awareness of gender-based violence from 67% to 82%. The number of individuals able to identify spouse battery as a form of gender-based violence increased from 37% to 67%. Services were provided in as a coordinated community response (Morel-Seytoux et al., 2010). (Gray IIIb) *(violence, Zambia)*

- In **South Africa**, a multi-media health promotion project working with the National Network on Violence against Women, showed an impact on attitudes, help-seeking behaviors, and participation in community action, but not incidence of GBV (possibly because reporting of violence increased as a result of the intervention). The project, Soul City, used edutainment, integrating social issues into entertainment formats such as television or radio. Shows in domestic violence were coupled with advocacy for implementation of the 1998 Domestic Violence Act. Evaluation includes national level pre-post surveys and 29 focus group discussions and 32 in-depth interviews. There was a shift in knowledge regarding domestic violence, including 41% of respondents hearing about the project's helpline. Attitudinal shifts following the intervention include a 10% increase in respondents disagreeing that GBV is a private affair and a 22% shift in perceptions of social norms regarding GBV (Usdin et al., 2005, cited in Rottach et al., 2009). (Gray IV) *(violence, mass media, South Africa)*

- Pre- and post- surveys with 2,722 men in **India** who had viewed scripted street theater which discouraged violence against women and increased gender equity found a significant reduction in reported spousal violence (Pelto and Singh, 2010). (Gray IIIb) *(violence, gender equity, India)*

11B. Gaps in Programming—Addressing Violence Against Women

1. Interventions that reduce commute times and/or ensure easy and safe access to safe public transportation may lessen the risk of sexual violence among adolescent girls.

2. Strategies are needed to ensure that women are able to complete their PEP regimen.

3. Programs are needed that link interventions addressing HIV/AIDS and child abuse.

4. Programs are needed to reduce violence against women who test HIV-positive and/or are already living with HIV.

5. Effective interventions are needed to reduce sexual coercion among youth.

6. Interventions are needed to combat gender-based violence of sex workers and women who inject drugs.

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1. **Interventions that reduce commute times and/or ensure easy and safe access to safe public transportation may lessen the risk of sexual violence among adolescent girls.** A study found that long commutes for girls increased the risk of sexual violence.

- Gap noted, for example, in **Zambia** (Chimuka, 2002).

2. **Strategies are needed to ensure that women are able to complete their PEP regimen.** One study found that travel costs and distance were factors in women not completing their PEP regimen. A meta-analysis found that adherence to PEP is poor in all settings (Chacko et al., 2012).

    - Gap noted, for example, globally (Chackdo et al., 2012) and in **South Africa** (Carries et al., 2007).

3. **Programs are needed that link interventions addressing HIV/AIDS and child abuse.** One report found that no PEP access guidelines exist for children who were raped and were under the age of 14. Other studies found high risk behavior among those who had been sexually abused as children.

    - Gap noted, for example, in **Ethiopia, Kenya, Malawi, Zambia and South Africa** (Keesbury and Askew, 2010); **Philippines** (Ramiro et al., 2010); **South Africa** (HRW, 2003a).

4. **Programs are needed to reduce violence against women who test HIV-positive and/or are already living with HIV.** A study found that HIV-positive women report that they were subjected to violence upon disclosure of their serostatus. Women living with HIV continue to experience violence (Hale and Vazquez, 2011). A study of serodiscordant couples found that intimate partner violence was more frequent in those who were HIV positive (2.7% as compared to 2.2%). Those women who suffered from violence prior to couples testing continued to experience violence (Were et al., 2011).

    - Gap noted, for example, in numerous African countries (Were et al., 2011); **Kenya** (Machera, 2009).

5. **Effective interventions are needed to reduce sexual coercion among youth.** A study among youth both found high rates of sexual coercion for both males and females which was correlated with early sexual debut and a greater likelihood of multiple sexual partners. *[See also Prevention for Young People]*

- Gap noted, for example, in **Uganda** (Agardh et al., 2011).

6. **Interventions are needed to combat gender-based violence of sex workers and women who inject drugs.** *[See Prevention for Key Affected Populations: Female Sex Workers and Women Who Use Drugs and Female Partners of Men Who Use Drugs]*

PLEASE SEE THE JULY 2014 UPDATE FOR A MORE RECENT VERSION OF THIS SECTION (11C), NOW CALLED *ADVANCING HUMAN RIGHTS AND ACCESS TO JUSTICE FOR WOMEN AND GIRLS*

11C. *Strengthening the Enabling Environment:* **Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights[1]**

In many of the countries where women are most at risk for acquiring HIV, laws to protect women are weak (Mukasa and Gathumbi, 2008; Ezer et al., 2006; Ezer et al., 2007). Laws which deny women the right to divorce, the right to own property, the ability to enter into contracts**,** to sue and testify in court**,** to consent to medical treatment and to open a bank account reinforce the subordinate status of women. These are critical legal rights for women. For example, in Swaziland, fathers are

> *"Without legal rights, a woman can do little to prevent her husband's relatives from seizing property and land" (Swaminathan et al., 2007).*
>
> *"Like any other human being, we take legal resort to stop the abuse and to protect our right" -Ethiopian woman living with HIV (cited in IPPF et al., 2011)*

automatically granted custody of children (Ezer et al., 2007), which may make a woman less likely to leave an abusive situation that may place her at risk of HIV acquisition. In Tanzania, the legal age of marriage is 15 years of age for girls, which can contribute to an increased risk for HIV acquisition, as both age and marital status tend to affect condom negotiation (Ezer et al., 2006). Women also need the basic right to mobility, i.e., women are not prohibited from accessing transport to services or need permission of male relatives in order to do so.

These legal norms directly affect women's risk for HIV. For example, if a woman has no right to divorce, she must stay with a man who may put her at risk for HIV. If a woman cannot own property, she is more likely to have to engage in transactional sex to survive (HRW, 2002). While being a female alone denies women their rights in certain countries, these limited rights can be restricted even further if a woman is living with HIV. In some countries, people living with HIV have little access to the formal legal system (Kalla and Cohen, 2007). "Fundamental means of empowering 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" (Gardsbane, 2010: 6). The implementation of the laws matter just as much as the laws

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[1]As noted in *Methodology*, the topic of legal reform related to HIV/AIDS did not receive the same systematic review of the legal literature that health-related topics received in the public health and HIV/AIDS literature. Stakeholders wishing to work on legal reform should consult with legal experts. Some references to groups working on legal issues are provided in this section.

themselves. Thus, the capacity of the government and its institutions to implement the laws, the political will to implement them to their fullest, addressing the potential contradictions and intersections with customary law, and the translation of laws from "legalese" into popular discourse are also important to ensure that women realize and can act on their rights (Jacobs et al., 2011).

Laws often reflect unequal gender norms that discriminate against women. Legal rights and gender norms must be addressed together; because in order to change gender norms, laws must be transformed to empower women with basic legal rights and in order to transform laws in countries where women are disempowered, gender norms must be addressed. Women need knowledge of the legal rights that are in place and women living with HIV particularly need knowledge of their rights. Protecting the legal rights of people living with HIV as well as others at high risk of HIV acquisition, such as same sex partners, sex workers and IDUs, is also critical to addressing the AIDS pandemic. *[See also Prevention for Key Affected Populations]*

Understanding Legal Systems is Necessary to Determine Entry Points
Legal frameworks can empower women—for example through laws that ensure nondiscrimination on the basis of sex—but unfortunately laws often do not support women. "In many countries, national laws restrict women's ability to own, inherit, or dispose of property. Women suffer inequality in access to education, credit, employment and divorce. Legal and social inequality renders women economically dependent on their husbands, leaving them little choice but to remain in relationships where they cannot refuse sex or insist on condom use. Women often sink into poverty upon the death of their husband or the dissolution of their marriage, finding their choices and possibilities so diminished that they have to trade sex for survival or rely on situations of lodging or work that expose them to sexual abuse or violence. Each of these factors places women at a heightened risk of HIV infection" (Jurgens and Cohen, 2007: 2).

It is important to understand the range of legal systems operating around the world when considering promoting legal changes to protect women. Countries, or "political entities," which can include political subdivisions of countries, operate under a range of legal systems, categorized in various ways, but broadly as Civil Law, Common Law, Customary Law, Religious Law, and Socialist Law (JuriGlobe, 2009). Among these, civil law is the most prevalent system of law in the world, and relies on written law that is codified in statutes or a constitution. Common law, also widely used worldwide and particularly in countries previously under British colonial rule, gives precedence to case-law, or decisions made by judges, over legislation (JuriGlobe, 2009).

Many countries use mixed systems in which customary and religious laws often exist as components of legal civil or common legal systems. These mixed domains can incorporate discriminatory views against women. Nigeria, for example, has three legal systems with three rivaling jurisdictions: common law, customary law, and Sharia

(Muslim) law (JuriGlobe, 2009). A study by UNIFEM found that the three systems make it difficult to protect women's rights. Customary courts were found particularly problematic because they "administer 'justice' based on local social norms, beliefs and practices, resulting in significant variation in customary law and its implementation from one locality to another… to the disadvantage of women" (UNIFEM, 2006). These nuances should be taken into account in any legal reform process.

Legal Protections Against HIV-Based Discrimination Are Essential
Studies have documented discrimination based on HIV status; violations of medical privacy; forced HIV testing; HIV status as a barrier to employment and/or education and/or housing (Mukasa and Gathumbi, 2008); and discrimination in health care settings. *[See also Reducing Stigma and Discrimination]* Between 2006 and 2010, the number of countries reporting the existence of laws, regulations or policies protecting people living with HIV from discrimination increased from 56% to 73% among 85 countries – but one third of countries still do not have such legislation (UNAIDS, 2010e).

"Laws can protect people living with HIV from discrimination or can increase discrimination against them" (NIDA and IAS, 2010: 66). "However, when the activities of such groups [e.g., IDUs or sex workers] are criminalized, the law and its enforcement can become a major barrier to access and uptake of HIV prevention, treatment, care and support" (NIDA and IAS, 2010: 66). "HIV has always been an epidemic of the vulnerable and legally disenfranchised" (Cameron, 2011: 103). Legal reform to ensure proper support for vulnerable groups is necessary (Gruskin and Ferguson, 2007b). Applying criminal law to HIV exposure or transmission does not reduce the spread of HIV and undermines HIV prevention efforts (Jurgens et al., 2009c). AIDS2031 Consortium recommended minimum legal standards to combat the AIDS pandemic:
- Decriminalize HIV status, transmission and exposure;
- Decriminalize same-sex relationships and practices;
- Guarantee equal rights of people living with HIV;
- Guarantee equal rights to men and women;
- Eliminate laws that limit access to health services for marginalized populations, including sex workers, people in same sex relationships and drug users; and
- Decriminalize harm reduction approaches for prevention of AIDS among those injecting drugs (AIDS2031, 2010).

Criminalization of HIV Can Hinder Prevention, Treatment and Care Efforts
No evidence exists that HIV-specific criminal laws are effective in preventing transmission and in fact, may be harmful. Criminalizing HIV transmission creates a huge disincentive for HIV testing, since ignorance of one's HIV status may be the safest way to avoid being accused of deliberately trying to transmit the virus (Forbes, 2010). "Many countries [criminalize] HIV transmission itself, possibly as a surrogate for persecuting the groups to whom they attribute such transmission" (Forbes, 2010: 23). The threat of criminal liability for HIV transmission has been used by providers, for example in

Ukraine, to ask for bribes to not report two HIV-positive partners who were both open to each other about their serostatus. When the patients could not afford the bribe, the male partner was imprisoned, where he died (Finnerty et al., 2010). "It is evident that criminalizing transmission means criminalizing the behavior of people living with HIV, thus stigmatizing and discriminating against all individuals living with HIV." (IPPF et al., 2011: 9).

With women more likely to be tested in the context of antenatal care, women can be disproportionally impacted by criminalization of HIV (IPPF et al., 2011). In addition, some countries, such as Zimbabwe, have legislation that criminalizes transmission of HIV from mother to fetus, even for women who are not able to access PMTCT or antiretroviral therapy. "This is in a context where medicines that can reduce or prevent transmission are not always made available and where many people do not have control over all aspects of their sexual life" (Cameron, 2009: 64).

Marriage and Divorce Laws Need to Protect Women
Marriage and divorce laws and inheritance and property rights are areas of particular importance for women and require specific action to change the legal norms that keep women unequal to men in the eyes of the law. Marriage is not a protective factor for reducing risk of HIV transmission. [*See Prevention for Women*] Marriage laws, including those related to forced marriages, child marriages, polygamy, and divorce, are needed to protect women. Laws protecting wives from violence and non-consensual sex, for example, can help protect women from HIV transmission. "Spousal sexual violence including marital rape, where permissible by law, amount to legal sanctioning of violence against women in one of the most intimate spaces of their lives" (Archampong, 2010: 2). For example, in Sierra Leone, "only rape of a virgin is seen as a serious crime. Rape of a married woman or a non-virgin is often not considered a crime at all…" (HRW, 2003a: 65). In Kenya, marital rape is excluded from recent legislation in the "Sexual Offenses Act" as well as customary law, which "results in presumed and perpetual consent to sex" (Sampson, 2010: 23). Ghana also still has no direct prohibition of marital rape (Archampong, 2010; HRW, 2003a). The 1999 Federal Constitution of Nigeria discriminates against women in that "it encourages child marriage when it proclaims 'every woman who is married shall be regarded as an adult,' while it also encourages spousal abuse when it says that 'wives may be corrected provided grievous harm is not committed'" (UNIFEM 2006: 11). Women's inability or difficulty in obtaining divorce, often coupled with men's ease with divorce, has serious implications for protection of women from HIV transmission. Women's lack of legal rights within marriage is often compounded with custody and maintenance arrangements and lack of property rights upon divorce.

Some countries have made progress. Ethiopia has reformed its laws to make child marriage under age 18 illegal and established 18 years of age as the legal minimum (Ezer et al., 2006); now the challenge is to enforce this new legal minimum (CHANGE, 2009).

In Lesotho, the Parliament enacted a bill providing married women—who up to then were considered minors—with status equal to their spouses, with rights to own land, right to inheritance, the right to have a bank account or to take out a loan without their husband's permission. These laws only protect married women, however, and depend on implementation and enforcement of new laws (Braun and Dreiling, 2010).

Women's Inheritance and Property Rights Must Be Secured
"Strengthening women's property and inheritance rights is critical to reversing ….new HIV infections across the globe" (USAID, 2010c: 1). "Research and intervention strategies are just beginning to consider the role that women's property ownership and inheritance rights might play in potentially breaking the cycle of AIDS and poverty. There is growing evidence to suggest that where women's property rights are upheld, women acting as heads and/or primary caregivers of HIV/AIDS-affected households are better able to manage the impact of AIDS. Additionally, preliminary evidence indicates that such rights may help prevent further spread of HIV/AIDS by promoting women's economic security and empowerment, thereby reducing their vulnerability to domestic violence, unsafe sex, and other AIDS-related risk factors" (Strickland, 2004: 1).

When women are denied their rights to property, whether in widowhood or desertion by their husbands, they experience deepened poverty and lower social status as a result. This is tragically compounded when they themselves become ill, and they are left destitute without shelter or care (Steinzor, 2003). Women in polygamous marriages have additional concerns in accessing property where only one wife is entitled to property (Knox et al., 2007).

Rights-based training for women is underway in a number of countries in sub-Saharan Africa and training is also underway for police and the judiciary to uphold women's property rights (Oja, 2008). Women's access to pro bono legal assistance is critical (COHRE, 2004). Small grants provided through ICRW to grass roots organizations [in Kenya, Malawi, Rwanda, South Africa, Zambia, and Zimbabwe] resulted in these groups "addressing the links between women's property rights and HIV…. Though small in scales, these efforts are educating communities about how property rights affect women and girls in the context of HIV, and mobilizing stakeholders at all levels to take action" (Welch et al, 2007: 1).

Yet international treaties, laws, and other instruments that protect women's inheritance and property rights, like other laws that protect women's rights, may exist but are not consistently applied. Similarly, existing national laws that protect women's property rights are often poorly enforced. A random sample of 219 households in rural Uganda with 74 enrolled in focus group discussions from seven villages found that many women are ignorant about the laws that protect them from widow inheritance and protect their property rights (Mabumba et al., 2007).

A 2007 review found that "more data is needed to guide the design and implementation of interventions that will effectively address women's property rights within the HIV/AIDS context" (Swaminathan et al., 2007: 17). Others have recommended that legal frameworks recognize women's property rights and secure adequate access to justice for women living with or affected by HIV (COHRE, 2009; Welch et al., 2007).

Moving Forward Requires Access For Women and Transformation of Legal Frameworks
Women's access to legal services is critical. Few women have access to legal advice and current provision of services is often dependent on volunteers or paralegals with limited knowledge of women's rights. These networks train paralegals in the fundamentals of property law and dispute resolution. If legal services are available through health services accessed by women and people living with HIV, more of those in need will have access to legal services (Kalla and Cohen, 2007). The tremendous need for HIV-related legal services in some countries has been well documented (Mukasa and Gathumbi, 2008).

In many countries, reform of constitutional, statutory, and customary laws is needed to guarantee equal rights for women. Constitutional reform has been underway in many countries such as Kenya and Tanzania, providing an opportunity to change women's rights. Ensuring that laws are consistent with constitutional change is critical. Protective legal frameworks should encompass inheritance, marriage, division of property upon divorce, custody, land use and ownership, and access to housing. Many organizations are working to change written codes using the Committee on the Elimination of Discrimination against Women (CEDAW) as a guide. In Nepal, for example, women's groups pressured leading political parties to protect the right of women to own and inherit property, and this led to a new law, passed in 2002, which gives a wife equal right to her husband's property immediately after marriage. While some customary laws support the equal rights of women, others are discriminatory. Changing customary laws requires efforts to change community attitudes and practices. Furthermore, the constitutions in some countries are progressive and the issue is to challenge statutes that no longer comply with the constitutions.

Efforts to promote women's legal rights should ensure gender-transformative legislation, the promotion of judicial capacity and effective litigation and advance public awareness (Kim et al., 2008; ARASA, 2009). Partnerships, such as that between the Namibia Women's Health Network and the Legal Assistance Centre which have worked together to seek redress for women living with HIV who suffered coerced sterilization, are a model for meaningful community involvement at the heart of strengthening the enabling environment (Gatsi et al., 2010). While numerous countries have constitutions that recognize women's equality and have ratified international and regional human rights treaties, national legislation is not enforced or is superseded by customary law.

Governments need to establish a gender-sensitive legal framework as a key element of HIV/AIDS policy and programming; one that upholds the human rights of women,

including reform of laws and policies that place women at a disadvantage to men. A model legal framework for women's rights in the context of HIV/AIDS has been recently developed by the Canadian HIV/AIDS Legal Network (http://www.aidslaw.ca/EN/womensrights/english.htm), and includes four modules related to strengthening the enabling environment: (1) sexual violence, (2) domestic violence, (3), family issues, and (4) property issues. Current efforts to share gender equitable laws are also available through the International Association of Women Judges (http://www.iawj.org/) – an association of women judges to ensure promotion and sharing of gender equal laws. In addition, legal obligations on women's equality in relation to HIV and AIDS is available at (Gerntholtz and Grant, 2010). Advocay and training for women to know their rights is critical (ICASO, 2010; IDLO and UNAIDS, 2010). Additional tools and information about property rights are available at (Mumma, 2010) and COHRE et al., 2012).

11C. What Works—*Strengthening the Enabling Environment:* Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights

1. Enforcing laws that allow widows to take control of remaining property can increase their ability to cope with HIV.

Promising Strategies:

2. Community organizing can help women pursue their legal rights.

3. Integrating legal services into health care can help ensure that women retain their property.

11C. Evidence

1. **Enforcing laws that allow widows to take control of remaining property can increase their ability to cope with HIV.**

   - An overview of 40 organizations working at a national level on property and inheritance rights, based on a survey of 60 community- based organizations in **East and Southern Africa** suggests that where women's property and inheritance rights are upheld, women acting as heads and/or primary caregivers of HIV/AIDS-affected households are better able to mitigate the negative economic and social consequences of AIDS. Conversely, the denial of property and inheritance rights drastically reduces the capacity for households to mitigate the consequences should a member be infected with HIV. Recommended interventions can be categorized as legislation, litigation and education: activities promoting gender sensitive legislation and a legislative framework that protects women's human rights; activities enhancing the judicial sector's capacity to uphold women's rights and provide for effective litigation; and activities that advance public awareness, understanding, and application of

women's rights (Strickland, 2004). (Gray V) *(property rights, inheritance, East Africa, Southern Africa)*

- A study in **Zambia** using a nationally representative survey from 5,342 rural households, found that women rarely own or have control over land. Under customary law, a wife cannot inherit land or other property from her husband. Under statutory law, women have the right to own land, but titles tend to be passed through male relatives, despite the Zambian Constitution which states that discrimination on the basis of sex is forbidden by law. Survey results showed that widowed households became worse off compared to nonafflicted households and suffered a decline between 35.6% and 36% of total landholding size among households suffering a prime-age male head death. If another adult household member died, there was no statistically significant effect on land holding (Chapoto et al., 2011) (Gray IIIb) *(property rights, inheritance, Zambia)*

Promising Strategies:

2. **Community organizing can enable women pursue their legal rights.**

- An evaluation of GROOTS (Grassroots Organizations Operating Together in Sisterhood) **Kenya**, self-help and community organizations for women in Kenya which formed to strengthen the visibility of women in development and decision-making, found that the intervention resulted in both increased awareness and an increase in the number of women and girls receiving legal support (186 as a result of the intervention compared to 15 in the six months prior to the start of the intervention). The intervention was successful in raising women's participation in their communities around the issue of HIV/AIDS and property and inheritance rights for women and girls. GROOTS Kenya focuses on: property rights, community responses to HIV/AIDS, women's leadership and governance and community resources and livelihoods. The intervention was evaluated through discussion questions administered pre- and post- radio listening group discussion and community discussions, focus group discussions with project beneficiaries and records of paralegals (GROOTS Kenya, 2007). (Gray IV) *(community organizing, legal rights, Kenya)*

- A project in **Kenya** in 2004 to improve the ability of widows to reclaim their property led to 20 widows reclaiming their property. The project mobilized and educated widows; provided training for customary leaders, NGOs, faith based organizations and community groups and held public meetings with media coverage to raise awareness of the issue (Nyong'o and Ongalo, 2005). (Gray IV) *(training programs, property rights, Kenya)*

- Ntengwe for Community Development, a non-profit organization trained women and girls on comprehensive legal rights, resulting in 600 women regaining their property in **Zimbabwe,** where property rights are legally protected. Paralegals and peer educators interacted with community elders in the training to show support from the elders (Welch et al., 2007). (Gray V) *(property rights, peer education, Zimbabwe)*

3. **Integrating legal services into health care can help ensure that women retain their property.**

Gay, J., Croce-Galis, M., Hardee, K. 2012. What Works for Women and Girls: Evidence for HIV/AIDS Interventions. 2nd edition. Washington DC: Futures Group, Health Policy Project. www.whatworksforwomen.org

- A study in **Zambia** examined the impact of a video-based motivational intervention promoting future planning in 1,504 HIV-positive couples in Lusaka, Zambia and found that motivational messaging integrated into HIV VCT services encouraged future planning. Following a group video session, couples randomized to the motivational arm could choose to write a will, identify a guardian for their children and make financial plans. Desirable behaviors modeled in the motivational video were measured at quarterly intervals for a year and compared in intervention and control arms. Demographic measures including age, income and educational status were not associated with planning behaviors. Participation in the intervention was associated with will writing (23% versus 5%) and naming a guardian (32% versus 17%) but not with other planning behaviors. The intervention was noted if a male, a female or both wrote wills. The study points to the need to expand existing HIV and VCT services to meet other non-health needs of those living with HIV (Stephenson et al., 2008). (Gray IIIa) *(property rights, wills, Zambia)*

11C. Gaps in Programming—Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights

1. Interventions are needed to increase the knowledge of HIV-positive people—especially women—regarding their rights and provide resources to fight for these rights.

2. Legislation that allows women the right to refuse forced marriage and penalizes marital and non-marital rape may reduce coercive sex and the risk of HIV transmission.

3. Laws prohibiting young age at marriage need to be enacted and enforced.

4. Laws prohibiting discrimination against those who are HIV-positive in employment, housing, access to services and education are urgently needed.

5. Interventions are needed to assist parents dying of AIDS with planning for the future well-being of their children.

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1. **Interventions are needed to increase the knowledge of HIV-positive people—especially women—regarding their rights and provide resources to fight for these rights.** Studies found that women had insufficient knowledge of their legal rights and no resources to fight for their legal rights.

   - Gap noted, for example, in **DRC** (Solhjell, 2009); **India** (Devasahayam et al., 2008); **Uganda** (Mabumba et al., 2007); **Kenya** (Machera, 2009); and **Zambia, Namibia** and **Uganda** (Steinzor, 2003; Manchester, 2004).

2. **Legislation that allows women the right to refuse forced marriage and penalizes marital and non-marital rape may reduce coercive sex and the risk of HIV transmission**. Studies found that in some countries, legislation penalizing marital rape does not exist.

- Gap noted, for example, in **sub-Saharan Africa** (Kilonzo et al., 2009b; HRW, 2003a).

3. **Laws prohibiting young age at marriage need to be enacted and enforced.** Field reports and studies found that child marriage for girls is still common in some countries, including in some countries where child marriage has been made illegal.

- Gap noted globally (Malhotra et al., 2011; CHANGE, 2009; Ezer et al., 2006).

4. **Laws prohibiting discrimination against those who are HIV-positive in employment, housing, access to services and education are urgently needed.**   A study found that women feared losing their homes if found to be HIV-positive.

- Gap noted for example, in **Burkina Faso** (Obermeyer et al., 2009) and **Uganda** (Twinomugisha et al., 2011).

5. **Interventions are needed to assist parents dying of AIDS with planning for the future well-being of their children.** *[See Care and Support: Orphans and Vulnerable Children]*

11D. *Strengthening the Enabling Environment:* Promoting Women's Employment, Income and Livelihood Opportunities

Women's economic dependence on men and unequal access to resources, including land and income-generating opportunities, increases the likelihood of women and girls engaging in a variety of unsafe sexual behaviors including transactional sex, coerced sex, earlier sexual debut, and multiple sexual partners, and thus increases their risk of becoming infected with HIV (Gillespie and Kadiyala, 2005).

A Woman's Economic Stability Can Enhance Her Ability to Insist on Safer Sex
Married women and women in partnerships often accept risky behavior by their partners due to the need for economic security. A study in Vietnam in 2004 and 2005, consisting of interviews with 23 husbands and 23 wives, along with 15 key informant interviews found that because women needed the economic benefits of marriage, women acquiesced to their husband's multiple partnerships or purchasing sex with sex workers. Independent sources of income and employment for women may allow women to insist on safe sex (Phinney, 2008). Similarly, a qualitative study in Brazil among women with children enrolled in a day care center found that financial dependence is the factor that most contributes to accepting a man's multiple sexual partnerships. As one woman put it: "She accepts his infidelity because ...she's thinking...How will I care for the children? How will I find a job?" (Hebling and Guimaraes, 2004: 1215). The authors point out: "The

results show that although women know how they should prevent...AIDS – by using condoms – they feel powerless to do so, since they feel that this depends on the man's wishes. They admitted that they don't have the real decision power...where 'the man always has the final word.' Fear of separation was associated with loss of financial...stability" (Hebling and Guimaraes, 2004: 1216). A study in South Africa found that the women interviewed claimed that if they had jobs, they would be able to refuse sex to men who refused to wear condoms. The women said, "Poverty makes prostitutes of us" (Susser and Stein, 2000: 1044). A study consisting of group discussions with 160 men and women and in-depth interviews with 29 men and women found that financially dependent women feel they have no choice but to accept risk or try to leave a risky marriage to seek financial security whereas financially autonomous women will negotiate condom use with their husband. Gender norms require that married women are responsible for ensuring protection against their husband's infidelity, despite the fact that men decide on condom use (Bandali, 2011b).

Economic independence may not always have a clear-cut role in HIV acquisition, however. One study found that both wealth and poverty may have associated risks and protective effects for HIV acquisition, depending on the different contexts. "Being poor or being wealthy may be associated with sets of behaviors that are either protective or risky for HIV infection" (Parkhurst, 2010: 524). For example, a woman who has no resources may have sex with multiple partners to feed her children; men who are wealthy may have multiple partners as a sign of status. A review of 41 studies found that context specific factors influence whether financial autonomy is protective or associated with increased risk of intimate partner violence in low and middle-income countries (Vyas and Watts, 2009). Another more recent study found that women who gained employment in India following unemployment were at increased risk of violence (Krishnan et al., 2010).

In certain circumstances, providing microfinance for women can reduce unsafe sex (Pronyk et al., 2008a). Although there is a need for better indicators to measure the HIV/AIDS-related impact of economic empowerment on women and girls, studies have consistently shown that increasing women's access to information, skills, technologies, services, social support, and income increased their ability to protect themselves from HIV (Weiss et al., 1996 cited in Weiss and Gupta, 1998; Kaufman et al., 2002).

"The owners of the fish nets are men. The woman comes to this man who says 'You want some fish, give me sex.' The woman has to feed her family, so she can't say no."

—Malawian man (Kathewera-Banda et al., 2006: 655)

Condom use is an example of this. Women's "inability to negotiate [condom use] is closely linked with women's inferior economic situation: women's frequent dependency on men renders them more likely to fear abandonment and the destitution that might

ensue as a result of confronting or leaving their partners" (Mane et al., 2001: 10). With financial independence, women are better able to negotiate protective behaviors. Women around the world describe economic dependence on men. In the words of a sex worker in India, "I used to think why I should live such a horrible life with him. But I know how difficult it is to survive without any support" (Panchanadeswaran et al., 2008).

Conditional cash transfers (CCT) are being introduced to address risk factors for HIV, including a CCT program in Malawi to encourage girls to stay in school (Baird et al., 2012), and the ongoing RESPECT ("Rewarding STI Prevention and Control in Tanzania") study. Cash transfer programs are not without controversy. For example: Should they be conditional or unconditional? What are appropriate conditions or behaviors to target through a cash transfer program? What is the appropriate length of a cash transfer intervention? What happens when the intervention ends? A randomized trial found evidence of effectiveness (Baird et al., 2012) but clarification is needed on the "mechanism by which the intervention worked" (Pettitfor et al., 2012: 1). A literature review by Concern and Oxfam GB on conditional cash transfers found that in some cases, cash transfers worsened relations in the community by displacing sharing strategies which could result in increased long-term food insecurity. They can also reinforce, rather than challenge, women's traditional household roles. On the other hand, transfers may increase women's self-efficacy to handle money and increase male acceptance of women handling money. An additional issue is that "men are often negatively stereotyped as self-serving…. and irresponsible…Some men may… feel excused from responsibilities or disempowered…" (Brady, 2011: 12, 17 and 18). "Women's empowerment is not an automatic by-product of a cash transfer program" (Brady, 2011: 26).

Economic Empowerment Can Greatly Enhance Women's Lives
The International Community of Women (ICW) network has found that "the most commonly expressed need from women in sub-Saharan Africa is support and training on establishing income-generating projects in the hope that they can earn income which will alleviate the difficulties they face in their day to day lives" (Manchester, 2004: 95). As one woman living with HIV from Cameroon put it: "We have to look for ways and means to get out of this abyss. Rather than seek alms we must look for an honest livelihood" (ICW, 2000: 11, cited in Manchester, 2004).

Access to treatment can be beneficial in increasing employment access for people living with HIV. In India, access to HAART resulted in a rapid increase in employment and income for 1,238 HIV-positive patients (including those not eligible for HAART) followed between 2005 and 2007. At six months after initiation of treatment, patients were 10 percentage points more likely to be economically active and at 24 percent the employment increases remained large and significant, although the effects were nearly twice as high for men as for women. One possible explanation for this is that employment outcomes in the study did not include domestic work such as cook or housekeeper, jobs of relevance to women (Thirumurthy et al., 2011).

Economic empowerment of women and girls requires that they have access to vocational training, and opportunities to develop practical and business skills. Women also need access to financial resources to support the establishment of small businesses. The loans through microfinance programs are often very small "…and would more accurately be viewed as increasing the ability of households to survive rather than as 'economic empowerment'…." (Dworkin and Blakenship, 2009: 465). But skill sets taught by microfinance programs, such as assertiveness, recognition of gender norms, etc. may help women negotiate safer sex (Dworkin and Blakenship, 2009).

Finally, in some countries, women (and men) living with HIV face employment discrimination because of their HIV status. For example, some employers require HIV testing as a condition of employment, while others have abused the employment rights of workers who test positive (Human Rights Watch, 2004a; CHANGE, 2009). Laws to protect people living with HIV and AIDS, especially women, from employment and other forms of discrimination must also be enacted and enforced. *[See also Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights]*

11D. What Works—*Strengthening the Enabling Environment:* Promoting Women's Employment, Income and Livelihood Opportunities

1. Increased employment opportunities, microfinance, or small-scale income-generating activities can reduce behavior that increases HIV risk, particularly among young people.

11D. Evidence

1. **Increased employment opportunities, microfinance, or small-scale income-generating activities can reduce behavior that increases HIV risk, particularly among young people.[2]**

   - Secondary analysis of quantitative and qualitative data in **South Africa** from IMAGE (*see Pronyk et al., 2006)* found that after two years of follow-up, young women ages 14 to 35 who had received microfinance loans to establish small businesses, along with training on gender and HIV, were more likely to have accessed VCT and less likely to have had unprotected sex at last intercourse, as well as being more likely to have had more communication concerning HIV with sexual partners and others. "…Data from focus group discussions and key informant interviews indicated a sense of enhanced bargaining power among intervention participants" (p. 1663). Qualitative data from non-participant observation of 160 women attending microfinance loan meetings during one year, focus group discussions, key informant interviews and diaries of training facilitators were used along with quantitative data. One

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hundred and twelve women in the intervention group and 108 in the control group were followed and interviewed. (Pronyk et al., 2008a). (Gray II) *(microfinance, employment, risk behavior, South Africa)*

- In **Haiti**, access to microfinance loans improved the well-being of women who received the loans between 2005 and 2007. Through the program, 420 women (of whom 57% were HIV-positive) who were screened for HIV infection at GHESKIO received a loan from a microfinance institution following evaluation and training on business development. Of the women, 85% reported that the loans had improved their life conditions. The women were followed for a median of 12 months from the time of the first loan until the most recent clinic visit. Loan repayment was high: 95% for HIV-negative women and 93% for women living with HIV. An impact evaluation among the first 66 women receiving loans found significant differences in women's ability to feed, clothe, and house themselves compared to women in a control group. Although not statistically significant, among the group receiving the loans, 6% said that they received money for sex, compared to 16% in the control group (Longuet et al., 2009). (Gray IIIb) *(HIV testing, microfinance, Haiti)*

- A time-usage study in 1999 that analyzed data on education, work, and organized activities among 2,992 youths ages 14-22 in two **South African** districts found that employment opportunities decreased the odds of sexual activity among girls and higher wages for both boys and girls were associated with increased condom use. For example, girls were about one-third less likely to have had sex in the last year in communities where youth generally made more money from working and were almost two and a half times more likely to report having used a condom. Boys living in communities with higher employment and wage rates were 50% more likely to report having used a condom. Overall, "for most groups, the number of hours spent hanging out is positively associated with having had sex in the last year and negatively associated with condom use" (Kaufman et al., 2002: 16). (Gray IV) *(employment, youth, sex behavior, condoms, South Africa)*

- Four years after an income-generating HIV prevention project for youth was initiated in Ewo, **Republic of Congo**, a follow up inquiry found that 24.2% of the youth were still involved in income generating activities. The follow up visit in 2006 used focus groups and a cross sectional survey of 372 young people ages 15-24, selected from four zones through cluster sampling to explore practices associated with risk of HIV in young people. Youth reported that, for those who continued with the income-generating activities, these activities provided them with money and, for some, skills training, which for the girls especially, reduced their dependency on others. Few (5%) reported having sexual intercourse with a new sexual partner without using a condom and this was significantly lower in those currently involved in income generating activities. Young people involved in agriculture, however, reported higher levels of sexual intercourse with a new sexual partner without using a condom. The focus group discussions pointed out that farm activities were carried out in neighboring villages and some on a seasonal basis. This may imply an increase on other risk factors such as insecure income, exposure to non-familiar adults and mobility. Further assessment is needed, however, to understand the factors driving the behavior of the young people involved in agriculture. Researchers found that for the youth in Ewo, there are four dimensions of income generating activities that are reported to be important for reducing susceptibility to HIV: the revenue they earned, the control/autonomy it brings to their lives, the training and new skills and the occupation of time in useful activity. Mobility and exposure to non-familiar adults in insecure forms of activity may counter some of these beneficial effects (Boungou, 2007). (Gray V) *(employment, youth, risk behavior, training programs, Republic of Congo)*

11D. Gaps in Programming—Promoting Women's Employment, Income and Livelihood Opportunities

1. Expansion and scaling up of interventions promoting economic opportunities for women are needed to increase their ability to refuse unsafe sex and reduce stigma for women living with HIV.

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1. **Expansion and scaling up of interventions promoting economic opportunities for women are needed to increase their ability to refuse unsafe sex and reduce stigma for women living with HIV.** Studies found that lack of income, food and jobs forced women to sell sex to survive, placing them at risk of HIV acquisition.

   - Gap noted, for example, in **Uganda** (Miller et al., 2011b); **Haiti** (Fawzi et al., 2010); **Vietnam** (Phinney, 2008); **Brazil** (Hebling and Guimaraes, 2004); **Serbia** (Bernays et al., 2010) and **South Africa** (Susser and Stein, 2000).

11E. *Strengthening the Enabling Environment:* Advancing Education

Increasing girls' access to education is critical to combating the AIDS pandemic. "There is a well-established protective effect of schooling on HIV risk" (Pettitfor et al., 2008; Hargreaves et al., 2008 and Jukes et al., 2008 cited in Pettitfor et al., 2012: 1). Education of girls is associated with delayed marriage and childbearing, lower fertility, healthier babies, and increased earning potential. Analysis by the Global Campaign for Education estimates that seven million HIV infections in young people could be averted in a decade, if all children completed primary school (Global Campaign for Education, 2004, cited in UNAIDS et al., 2004b). In 2009, 56% of the world's children who are at primary school age live in countries that have achieved gender parity at the primary level but this drops to 29% at the secondary level and to 15% at the upper secondary level (UNESCO, 2012a).

The 2009 report of the Millennium Development Goals (UN, 2009) shows that in the developing world, enrollment coverage was 88 percent in 2007, up from 83 percent in 2000, but still not on track to reach the MDG Goal 2 of achieving universal primary education. Many regions have reached gender parity where males and females are equally likely to attend primary school education, although girls remain disadvantaged in some countries in Africa and Asia, such as Afghanistan, Cote d'Ivoire, Pakistan, Mali, Benin, Lesotho, India, and Tanzania. Furthermore, there can be significant disparities by region or within countries. In India, for example, in some states, one-third to nearly one-half of

school age female children are not in school (UN, 2009). In most countries, girls and boys are equally likely to transition to secondary school. However, once girls get to secondary education, they do not stay in school at the same rate as boys due to the fact that young women are significantly more likely to be married as child, have sex before the age of 15 and become pregnant (UNICEF, 2011a). Secondary school attendance and completion are strongly influenced by poverty, location and gender. Young people aged 23 to 27 in Cambodia from the wealthiest 20 per cent of households have secondary completion rates of 28 per cent, compared with 0.2 per cent for the same age group from the poorest households (UNESCO, 2012b: 54). In 2007, only 53 of the 171 countries with data had achieved the target of gender parity in education. An estimated "72 million children worldwide were denied the right to education in 2007. Almost half of these children live in sub-Saharan Africa, followed by Southern Asia, home to 18 million out-of-school children" (UN, 2009). It is estimated that half or more of those children might never have any schooling. A recently released report from UNESCO found that "girls and women remain deprived of full and equal opportunities for education" (Bokova, 2012: 1).

In addition, recent data from the International Men and Gender Equality Survey (IMAGES) finds that boys' education may also be a key to HIV and gender equality. Across middle- and low-income countries where the household survey was carried out, men with some secondary education consistently showed less use of violence against women, more gender-equitable norms and were more involved in caregiving/domestic activities in their households. This suggests that while we must work to reduce gender disparity gaps in education and to promote girls' education, the education of boys also brings multiple benefits for women and men (Contreras et al., 2012)

Education: The "Window of Hope" in HIV Prevention
The effectiveness of education as an HIV prevention strategy, which the World Bank calls the "window of hope," rests upon two key components: (1) greater access to schooling and (2) using schools as a natural place to reach young people with AIDS education and life skills training – practical tools that help them stay safe (World Bank, 2002). "Data compared across countries and regions and disaggregated by education levels show that young women and men with higher levels of education are more likely to have increased knowledge about HIV/AIDS, a better understanding of ways to avoid infection, and an increased likelihood of changing behaviour that puts them at risk of contracting the disease. Thus, it is clear that ensuring quality education for all children is one of the best ways to protect both the rights and the lives of young people threatened by HIV/AIDS" (UNICEF, 2004a). Comprehensive sex education, covered in *Prevention for Young People*, is also an important component of HIV prevention planning.

DHS surveys from 11 countries found that women with some schooling were nearly five times as likely as uneducated women to have used a condom the last time they had sexual intercourse (Global Campaign for Education, 2004). Literate women are three times more likely than illiterate women to know that a healthy-looking person can be HIV-positive

and four times more likely to know preventive behaviors (Vanandemoortele and Delamonica, 2000 cited in Global Campaign for Education, 2004). While universal primary education is not a substitute for HIV/AIDS treatment and prevention, young people with little or no education may 2.2 times more likely to become HIV-positive as those who have completed primary education (De Walque, 2004 cited in Global Campaign for Education, 2004). Even controlling for income, education's impact on HIV/AIDS is robust. In the five years before the publication, better-educated young people have increased condom use and reduced the number of casual partners at a much steeper rate than those with little or no education (Hargreaves and Glynn, 2002; World Bank, 2002 cited in Global Campaign for Education, 2004).

Yet girls face barriers to staying in school. A study of primary school in Uganda in 2001 found that 51 percent of girls dropped out of primary school due to money needed for school funds, uniforms, textbooks and supplies, among other items, including uniforms and shoes. Some girls receive pressure from their parents to marry (Kasente, 2003). Other barriers can include the need to provide income for the family, long distances to school, safety issues traveling to school, sanitary facilities for girls at school, and the preference to send boys, among other barriers. One study found that since 2003 when school fees were abolished in Kenya, girls in schools with free uniforms had a 10 percent decrease in childbearing and a 12 percent decrease in teen marriage (Duflo et al., 2007). Furthermore, lack of sanitary facilities means that girls and female teachers cannot attend school during menstruation" (Adams et al. 2009). An estimated 1 in 10 African girls of school age do not attend school during menstruation or drop out at puberty due to lack of appropriate sanitation facilities in schools (UNICEF, 2005). Further interventions are needed to eliminate these barriers and enable girls to stay in school, for example "school fee abolition strategies to be embedded within country-wide poverty alleviation and growth strategies" (World Bank and UNICEF, 2009: 11), or improving sanitary facilities so girls can attend school when they are menstruating (Adams et al., 2009).

Schools Can Be a Source of Support for Children Affected by HIV

With significant numbers of the world's HIV-positive youth living longer, even in resource-poor settings, more schools will be attended by students living with HIV. Schools can be a source of support and protection for children affected by HIV/AIDS. Education beginning in primary school for all children about routes of HIV transmission is important to reduce HIV

"I think we should not tease a student with AIDS."

—Girl in grade 4, Thailand, who received education on how HIV is transmitted (cited in Ishikawa et al., 2011a: 242)

stigma against the students living with HIV (Ishikawa et al., 2011a). *[See also Prevention for Young People and Reducing Stigma and Discrimination]* Programs on behavior change and gender norms can also be conducted in schools. See http://ippf.org/resources/publications/healthy-happy-hot, prepared by IPPF in 2010.

11E. What Works—*Strengthening the Enabling Environment:* Advancing Education

1. Increasing educational attainment can help reduce HIV risk among girls.

2. Abolishing school fees helps enable girls to attend (or stay in) school.

3. Providing life skills-based education can complement formal education in building knowledge and skills to prevent HIV.

Promising strategies

4. Conditional cash transfer for school attendance can enable girls to stay in school and may result in reduced incidence of HIV.

11E. Evidence

1. Increasing educational attainment can help reduce HIV risk among girls.

- A systematic review of published peer-reviewed articles explored the time trends in the association between educational attainment and risk of HIV infection in **sub-Saharan Africa** and found that HIV infections appear to be shifting towards higher prevalence among the least educated in sub-Saharan Africa, reversing previous patterns. Articles were identified that reported original data comparing individually measured educational attainment and HIV status among at least 300 individuals representative of the general population of countries or regions of sub-Saharan Africa. Statistical analyses were required to adjust for potential confounders but not over-adjust for variables on the causal pathway. Approximately 4000 abstracts and 1200 full papers were reviewed. Thirty-six articles were included in the study, containing data on 72 discrete populations from 11 countries between 1987 and 2003, representing over 200,000 individuals. Studies on data collected prior to 1996 generally found either no association or the highest risk of HIV infection among the most educated. Studies conducted from 1996 onwards were more likely to find a lower risk of HIV infection among the most educated. Where data over time were available, HIV prevalence fell more consistently among highly educated groups than among less educated groups, in whom HIV prevalence sometimes rose while overall population prevalence was falling. In several populations, associations suggesting greater HIV risk in the more educated at earlier time points were replaced by weaker associations later (Hargreaves et al., 2008a). (Gray I) *(education, sub-Saharan Africa)*

- A 2001 cluster-randomized study evaluated the impact of school attendance on the sexual risk behaviors and HIV prevalence of 916 males and 1,003 females between the ages of 14 and 25 in rural Limpopo Province, **South Africa**, where HIV prevalence in antenatal clinics was 13.2 percent. The study found that school attendance correlates with lower HIV prevalence among males, fewer sexual partners for both sexes, and among females, a lower likelihood of having partners who are more than three years older, more frequent condom use, and less frequent sex within relationships. Because students did not have greater access to HIV prevention materials than non-students, the study suggests that school attendance may have a protective effect on HIV risk by affecting the sexual network structure of young people. "School

attendance might affect communication within sexual networks, in turn helping to improve confidence, self-efficacy and the adoption of safer sexual behaviors. It might also increase group negotiation of positive attitudes toward positive behaviors, by putting young people in regular contact with each other in a structural environment," (Hargreaves et al., 2008b: 118). Women from very poor households were less likely to be students. Among study participants, HIV prevalence rates were 3.4% for men and 9.8% for women, increasing over the age range (Hargreaves et al., 2008b). (Gray II) *(youth, education, sex behavior, risk behavior, South Africa)*

- A study in **Ethiopia** of 35,512 VCT clients of Family Guidance Association of Ethiopia found that male and female VCT clients with more than secondary level education are 58% and 66% (respectively) less likely to be HIV-positive than those with no education (Bradley et al., 2007). (Gray IIIb) *(education, counseling, HIV testing, Ethiopia)*

- Evidence from population-based surveys in **Zambia** (1995-2003) shows a marked decline in HIV prevalence among higher educated young people. Data are from serial population-based HIV surveys conducted in selected urban and rural communities in 1995 (n = 2989), 1999 (n = 3506) and 2003 (n = 4442). Analyses were stratified by residence, sex and age group. Logistic regression was used to estimate age-adjusted odds ratio of HIV between low (< or = 4 school years) and higher education (> or = 8 years) for the rural population and between low (< or = 7 school years) and higher education (> or = 11 years) for the urban population. Results show there was a universal shift towards reduced risk of HIV infection in groups with higher than lower education in both sexes among urban young people in men and in women. A similar pattern was observed in rural young men but was less prominent and not statistically significant in rural women. In age 25-49 years, higher educated urban men had reduced risk in 2003 but this was less prominent in women. The findings suggested a shift in the association between educational attainment and HIV infection between 1995 and 2003. The most convincing sign was the risk reduction among more educated younger groups where most infections can be assumed to be recent. The changes in older groups are probably largely influenced by differential mortality rates. The stable risk among groups with lower education might also indicate limitations in past preventive efforts (Michelo et al., 2006). (Gray IIIb) *(education, Zambia)*

- A survey of 1,087 **Malawian** youth, of whom 722 were young women, with 133 in-depth interviews found that being enrolled in school was strongly negatively associated with having had sex for young women (Clark et al., 2009). (Gray IIIb) *(education, sexual behavior, Malawi)*

- A review of demographic data and HIV prevalence found that in **India**, women with less than five years of education had the highest HIV prevalence. In **Cambodia**, the highest HIV prevalence was among uneducated women; however, conversely, men with higher levels of education had higher HIV prevalence than men with lower levels of education (Greener and Sarkar, 2010). (Gray IV) *(education, India, Cambodia)*

- A survey of 669 boys and 699 girls ages 14 to 19 in **Lao PDR** found that "having some education and attending school are protective factors for both sexes…" (Sychareun et al., 2011: 8) for age at first sex before 15 years of age; two or more partners during the last six months and not using condoms during the last sexual intercourse. By contrast, out of school adolescents of both sexes were more likely to have these risk factors (Sychareun et al., 2011). (Gray IV) *(education, condom use, sexual behavior, Lao PDR)*

- Data from a longitudinal HIV surveillance and a linked demographic surveillance in a poor rural community in KwaZulu-Natal, **South Africa,** showed that in multivariable survival analysis, one additional year of education reduced the hazard of acquiring HIV by 7% net of sex, age, wealth, household expenditure, rural vs. urban/periurban residence, migration status and partnership status. The purpose of the study was to investigate the effect of three measures of socioeconomic status on HIV incidence: educational attainment, household wealth categories (based on a ranking of households on an assets index scale) and per capita household expenditure, the sample comprised of 3325 individuals who tested HIV-negative at baseline and either HIV-negative or -positive on a second test (on average 1.3 years later). Holding other factors equal, members of households that fell into the middle 40% of relative wealth had a 72% higher hazard of HIV acquisition than members of the 40% poorest households. Per capita household expenditure did not significantly affect HIV incidence. The results suggest that increasing educational attainment in the general population may lower HIV incidence (Bärnighausen et al., 2007). (Gray IV) *(education, income, South Africa)*

- A 2003 household survey of 1,708 15-24 year-old women in **South Africa** who were sexually experienced but only had one lifetime partner (typically considered "low risk" for HIV) found that women who had not completed high school were more likely to be HIV-positive by odds of 3.75 than those who had completed high school. Fifteen percent of the women surveyed were HIV-positive, and 77.5 percent had not completed high school (Pettifor et al., 2008a). (Gray IV) *(sexual partners, education, South Africa)*

- A study of key findings from nationally representative surveys conducted in 2004 of 5,950 young people ages 12 to 19 in **Burkina Faso;** 4,252 in **Ghana;** 4,012 in **Malawi** and 5,065 in **Uganda** found that formal education was positively associated with protective behaviors such as delaying first sex, abstaining from sex and using condoms. Surveys were supplemented with 16 focus groups each in Burkina Faso and Ghana, 11 focus groups in Malawi and 12 focus groups in Uganda. The research team also conducted 406 in-depth interviews with adolescents and 240 in-depth interviews with key adults in the lives of the adolescents (Biddlecom et al., 2007). (Gray IV) *(education, sex behavior, condoms, abstinence, Burkina Faso, Ghana, Malawi, Uganda)*

- Cross sectional data from a population-based survey with 9,843 adults (80% of those eligible) including 2,268 young women large-scale, conducted between 1998 and 2000 in rural **Zimbabwe** found that young women's chances of having avoided HIV were strongly associated with experience of secondary education. "Young women with higher levels of school education...had better knowledge about HIV...(and) young women with greater knowledge about HIV" were more likely not to have started sex and to have avoided HIV (Gregson et al., 2004, p. 2126). Greater education was positively associated with self-efficacy in both married and unmarried young women (Gregson et al., 2004). (Gray V) *(education, self-perception, Zimbabwe)*

- DHS surveys from **11 countries** found that women with some schooling were nearly five times as likely as uneducated women to have used a condom the last time they had sexual intercourse (Global Campaign for Education, 2004). Literate women are three times more likely than illiterate women to know that a healthy-looking person can be HIV-positive and four times more likely to know preventive behaviors (Vanandemoortele and Delamonica, 2000 cited in Global Campaign for Education, 2004). While universal primary education is not a substitute for HIV/AIDS treatment and prevention, young people with little or no education may 2.2 times more likely to become HIV-positive as those who have completed

primary education (De Walque, 2004 cited in Global Campaign for Education, 2004). Even controlling for income, education's impact on HIV/AIDS is robust. In the five years before the publication, better-educated young people have increased condom use and reduced the number of casual partners at a much steeper rate than those with little or no education (Hargreaves and Glynn, 2002; World Bank, 2002 cited in Global Campaign for Education, 2004). (Gray V) *(education, condoms, protective behavior)*

2. **Abolishing school fees can enable girls to attend (or stay in) school and staying in school is linked with better HIV outcomes.**

- A 2009 World Bank and UNICEF study evaluated the impact of primary school fee abolition in five African countries. **Ethiopia** abolished primary school fees in 1994, **Ghana** in 1995, **Kenya** in 2003, **Malawi** in 1994, and **Mozambique** began implementation in 2004. Fees were abolished in all countries for grades 1 through 7, with several countries extending the fee abolition to higher grades. Fee abolition resulted in a 23% increase in total enrollment from 1994/95 to 1995/1996 in Ethiopia, a 14% increase in total enrolment from 2004/2005 in Ghana, an 18% increase from 2002/03 to 2003/04 in Kenya, a 51% increase from 1993/94 to 1994/95 in Malawi, and a 12% increase from 2003/04 to 2004/2005 in Mozambique. The ratio of girls to boys enrolled in primary school increased in Ethiopia from 0.61 girls to 1 boy in 1994/95 to a ratio of 0.79 girls to 1 boy in 2004/2005. The increase in the ratio of girls to boys was insignificant in the other countries (The World Bank and UNICEF, 2009). (Gray IIIa) *(education, school fees, Ethiopia, Ghana, Kenya, Malawi, Mozambique)*

- A successful strategy for increasing access to education has been the elimination of school fees, which otherwise put education out of reach for many families. Because staying in school is linked with better HIV outcomes, abolishing school fees, particularly for girls, should lower HIV vulnerability. In **Tanzania**, the removal of school fees more than doubled primary school enrollment. **Kenya** saw enrollment jump by 22% in the first week alone with their abolition. In **Uganda**, girls' school enrollment leapt by over 30% when school fees were dropped, including a near doubling for the poorest economic fifth of girls (Bruns et al., 2003; UNICEF, 2005; Deininger, 2003; Bundy and Kattan, 2005, cited in Global Coalition on Women and AIDS, year not specified). (Gray V) *(education, school fees, Tanzania, Kenya, Uganda)*

3. **Providing life skills-based education can complement formal education in building knowledge and skills to prevent HIV.** *[See Prevention for Young People]*

Promising Strategies

4. **Conditional cash transfers can enable girls to stay in school and may result in reduced incidence of HIV.** *[See also Promoting Women's Employment, Income, and Livelihood Opportunities]*

- A randomized control trial during two school years of a conditional cash transfer program for girls to remain in school in **Malawi** resulted in higher percentages of school attendance for girls who received the cash (95%, compared to 89% of girls in the control group). School girls who received monthly cash payments of various amounts were significantly less likely than girls who did not receive payments to be HIV positive (1.2% or seven of 490 young women) as compared to 3% or 17 of 799 young women). Self-reported behavior change was

correlated with lower rates of HIV in those who received cash transfers. Girls and their parents were given up to $10 per month conditional on satisfactory school attendance, that is, if the girl attended school for at least 75% of the days her school was in session. School fees for the girls were also paid through the intervention. The analysis was conducted on a panel sample consisting of 396 treatment and 408 control girls who had dropped out of school as of baseline, and 480 treatment and 1,408 control girls in school, for a total sample size of 2,692 girls. The percentage of initial dropouts who returned to school (and were in school at the end of the 2008 school year) was 17.2% among the control group compared with 61.4% among the treatment group. Program beneficiaries were 3-4 times more likely to be in school at the end of the 2008 school year than the control group. The program led to significant declines in early marriage, teenage pregnancy, and self-reported sexual activity among program beneficiaries after one year of program implementation. For program beneficiaries who were out of school at baseline, the probability of getting married and becoming pregnant declined by more than 40% and 30%, respectively. In addition, the incidence of the onset of sexual activity was 38 percent lower among all program beneficiaries than the control group (Baird et al. 2010). Subsequent analysis of biomarker data 18 months after the program was initiated showed an HIV infection rate of 1.2% among the girls who received the CCT, compared to 3% among the control group. However, HIV incidence was not measured nor was HIV testing conducted until after the program was initiated, rather than at baseline. Costs for a scaled up cash transfer program was estimated at $5,000 per HIV infection averted (Baird et al., 2012). (Gray II) *(education, cash transfers, sexual behavior, Malawi)*

11E. Gaps in Programming—Education

1. Successful efforts to increase educational attainment for girls, particularly to secondary school, must be scaled up.

2. Interventions are needed for school children that suffer from violence on the way or at school.

1. **Successful efforts to increase educational attainment for girls, particularly to secondary school, must be scaled up.** *[See also Care and Support: Orphans and Vulnerable Children]* Studies and surveys found that in some regions girls lag behind boys in educational attainment.

   • Gap noted, for example, in 11 DHS countries (Hargreaves and Glenn, 2002; World Bank, 2002 cited in Global Campaign for Education, 2004).

2. **Interventions are needed for school children that suffer from violence on the way to or at school.** *[See also Addressing Violence Against Women]* Studies found that girls suffer from violence both on the way and at school.

   • Gap noted, for example, generally (WHO, 2006 cited in USAID, 2008a; USAID, 2008a). Increased recognition of sexual harassment by students was found in Ghana, but no HIV related outcomes were studied (USAID, 2008a).

11F. Strengthening *the Enabling Environment:* **Reducing Stigma and Discrimination**

"…Three decades into the epidemic, stigmatization remains a core feature of the patient experience of HIV/AIDS" (Gilbert and Walker, 2010: 144). Or as one woman living with HIV in Thailand put it: "It does not matter how many thousand people have HIV/AIDS …I would say that only zero percent will accept people living with HIV/AIDS" (quoted in Liamputtong et al., 2009:865). Stigma and discrimination have been identified as tremendous barriers to addressing HIV/AIDS (Carr et al., 2010; ICRW and LSHTM, 2010; Stangl et al., 2010; MacQuerrie et al., 2009; Mann, 1999; Paxton et al., 2004a and b). Stigma was defined by Goffman (1963) as a discrediting attribute about an individual or group that serves to devalue that person or group in the eyes of society. Regarding HIV and AIDS, Jain and Nyblade (2012) describe a number of types of stigma, including anticipated stigma, experienced stigma, secondary stigma, internalized stigma, compound/layered stigma, and observed stigma. Deacon (2005: ix) suggests "that it is vital to distinguish between what we call HIV/AIDS stigma (negative things people believe about HIV/AIDS and people living with HIV/AIDS), and what we call discrimination (what people do to unfairly disadvantage people living with HIV/AIDS)." Deacon (2005, ix) adds that "Stigma does not always have to result in discrimination to have a negative impact [and that] discrimination can result from stigma but could also stem from [other factors]." Parker and Aggleton (2002) suggest that stigmatization and discrimination are manifest in a number of contexts, including within families, communities, schools, employment, travel/migration opportunities, health care settings, and HIV/AIDS programs. Hardee et al. (2009b) found remarkably consistent views related to people living with HIV and AIDS in a national survey in China, suggesting that stigma and discrimination can be pervasive in societies.

Stigma Affects Prevention, Treatment and Care Behaviors

In a review of interventions to reduce HIV/AIDS stigma, Brown et al., (2003) noted that stigma affects prevention behaviors, test-seeking, care-seeking, quality of care provided to HIV-positive clients, and perceptions and treatment of people living with HIV and AIDS by communities and families.

> *"No matter where I go, there's always someone who will reject me."*
>
> —HIV-positive woman, Cuba (cited in Castro et al., 2007: S52)

Externalized and internalized stigma deters people from accessing needed HIV services (Brouard and Willis, 2006) or engaging in protective behavior, as well as delaying treatment, impeding adherence to medication, reducing survival and other HIV outcomes (ICRW and LSHTM, 2010). HIV-related stigma negatively impacts the quality of life of

people living with HIV (MacQuarrie et al., 2009). A study in India found stigma correlated with disclosure avoidance and depression (Steward et al., 2011). In addition to decreasing the ability to implement effective HIV/AIDS responses, stigma leads to violations "of human rights. People living with HIV are often turned away by their partners, family members and relatives, community members; are rejected by health care workers; are discriminated against in employment; are evicted from their homes, are subjected to physical abuse" (Hossain and Kippax, 2011: 172). A study of 460 youth in Ghana found that higher stigmatizing attitudes were associated with reduced safety in intended sexual behavior through reduced perceptions of vulnerability to HIV acquisition (believing that HIV only happens to other stigmatized populations). Girls were more likely than boys to blame others (Riley and Baah-Odoom, 2010).

Layered Stigma Compounds the Effects on People Living with HIV and AIDS
Layered stigma makes it even more difficult for individuals who are most at risk for HIV to access services etc. Parker et al. (2002), contend that HIV/AIDS-related stigma is often layered upon other stigma, for example, that HIV is associated with engaging in illegal behavior such as sex work and drug use. A study in China with 10 AIDS health professionals and 21 adults living with HIV found that the Chinese public assumes that any woman who has HIV is a sex worker (Zhou, 2008). A study of Japanese managers in Thailand found that they only believed that workers, sex workers and those they defined as "others" were at risk for acquiring HIV (Michinobu, 2009).

Women Face Double Stigma
Women face multiple stigmas - stigma and discrimination associated with HIV and their inferior status to men in society (Peters et al., 2010b). *[See also Transforming Gender Norms]* Yet, many studies of stigma and discrimination do not collect sex-disaggregated data, making it difficult to determine differential experiences that men and women face.

For some, though, the gender differences in stigma are clear. A 2010 study in Ethiopia with 3,353 people living with HIV found that women were more heavily stigmatized. In addition, women were more likely to drastically change their goals upon learning their HIV status to include not having sex, not getting married and not having children (IPPF et al., 2011).

Findings from a qualitative research study conducted in 2003 in Vietnam found that "women living with HIV and AIDS tend to be more highly stigmatized than men...While women tend to be 'blamed' for acquiring HIV and AIDS, men are often forgiven by family and society. The consequences of stigma are also more severe for women, who are more frequently sent away from their families and separated from their children than men are" (Hong et al., 2004: 2). A qualitative study conducted from 2001 to 2003 in rural and urban Ethiopia, Tanzania, and Zambia with structured text analysis of more than 650 interviews, and 80 focus group discussions, and a quantitative analysis of 400 survey respondents found that "constraints are particularly acute for young, married women with

HIV who try to balance the stigma of being HIV-positive with the reality that childbearing is often their only route to social status and economic support" (Nyblade et al., 2003: 51).

In the words of an HIV-positive man who is an injecting drug user, "Men are forgiven. Women would not be forgiven. Women are blamed even if they are unlucky and sleep with a husband who used to sleep with many girlfriends or is an injecting drug user and brought the disease to his wife" (Nguyen et al., 2009: 146). An HIV-positive woman tested in a PMTCT program in Malawi explained that, "In the community, few people accept HIV-positive mothers. They think you are HIV-positive because you were just moving around and sleeping with a lot of men. They keep gossiping about you. Some even do witchcraft against you so you die faster. It is thus better that you keep your HIV status for yourself without telling others" (Bwirire et al., 2008: 1197).

Misconceptions About HIV Continue to Drive Stigma and Discrimination
Inadequate information about how HIV is transmitted contribute to stigmatization and discrimination faced by people living with HIV. For example, findings from a qualitative research study conducted in 2003 in Vietnam found that lack of detailed understanding of the routes of HIV transmission led to isolation and rejection of people living with HIV and AIDS, avoidance of their goods and services, and secondary stigma against their family members and children. Further, many families of people who live with HIV or AIDS take unnecessary 'preventive' measures, such as eating separately, adding needlessly to the already significant emotional, economic and time-related burdens of care-giving (Hong et al., 2004). In Mali, "...the fact that social transmission (through sharing of food, bowls, latrines, blankets and clothes) was widely thought to be feasible is probably related to the perceived need to quarantine suspected AIDS cases..." (Castle, 2004: 6). It's critical to educate parents and teachers so they can accurately educate young people as well. Interviews and focus groups in Mali found that three-fourths of the teachers in the study held mistaken beliefs about methods of HIV transmission that they then communicated to their students (Castle, 2004). *[See also Advancing Education and Prevention for Young People]*

Stigma Affects Access To and Use of Treatment
With the introduction and expansion of antiretroviral treatment, there was hope that stigma and discrimination would decline, however, "despite ongoing research, there is not yet conclusive evidence to support this hope" (Gruskin et al., 2007b: 12). What is clear is that reducing stigma improves quality of life for women living with HIV, especially in the realms of employment and schooling, in addition to improving quality of life within families and communities. In-depth interviews with 30 women living with HIV in Uganda found that women who publicly disclosed their HIV status acted as advocates for people living with HIV and viewed themselves as important sources of support for those newly diagnosed as HIV-positive (Medley et al., 2009b). As one Indian woman living with HIV pointed out: "…I met many men who were infected by women,

but I didn't see them blaming the women. I also saw many women who were infected by their husbands, but they never blamed them! ...Then I started to see that, okay, the infection can come from anyone…if you know that the infection can come from anyone, then no one can blame or shame anyone else" (HIV-positive woman cited in de Souza, 2010: 248).

A study in South Africa found that some would travel 1,200 kilometers to access antiretroviral therapy instead of in nearby communities in order to reduce stigma both for the patient and her family: "…I travel from Port Elizabeth to Johannesburg to receive my medication to spare my mother the shame in the community…." (female patient cited in Gilbert and Walker, 2010: 143). A study in Russia found that in a sample of 492 people living with HIV (252 male and 238 female), greater perceived discrimination predicted lower condom use (Amirkhanian et al., 2011).

A survey of 14,203 participants in Tanzania, Zimbabwe, South Africa and Thailand found that negative attitudes towards people living with HIV was related to lack of knowledge of antiretroviral therapy. Insufficient ARV coverage in a high prevalence setting may contribute to persistent discrimination towards people living with HIV (Genberg et al., 2009; Maughan-Brown, 2010).

A study of 800 people living with HIV in Zambia found that stigma was the single strongest predictor of not accessing antiretroviral therapy, fearing that if they went to the clinic, people would not like them (Fox et al., 2010a). Data from 1,457 people living with HIV taking antiretroviral therapy in Lesotho, Malawi, South Africa, Swaziland and Tanzania found that a significant relationship between perceived HIV stigma and self-report of missed medications over time (Dlamini et al., 2009). A study in Uganda found that females and those who had been on antiretroviral therapy longer experienced higher levels of stigma (Nattabi et al., 2011). However, a study of 277 Mozambican patients found no change in stigma one year after initiating antiretroviral therapy (Pearson et al., 2009).

Religious Institutions Can Combat or Perpetuate Stigma
A review found that religious institutions have played both a supportive and detrimental role towards people living with HIV (Mbonu et al., 2009). Another study found that religious leaders promoted stigma against those living with HIV (Rios et al., 2011) and may need training so as not to perpetuate stigma (Ansari and Gaestel, 2010). A recent review of 36 studies of the role of church groups in stigma found that "in many settings church teaching are actively contributing to the perpetuation of gendered inequalities…through emphasizing heterosexual marriage [and] limiting people's (especially women's) knowledge of HIV/AIDS" (Campbell et al., 2011a: 1212). At the same time, churches provide care and support for those who are HIV-positive and emphasize the care of orphans as a religious responsibility. In some settings, people

living with HIV "derived great comfort from their ability to confide in God…a level of social support they were not getting elsewhere" (Campbell et al., 2011a: 1214).

A study in Mozambique with 522 unmarried youth between the ages of 12 and 28, with 352 young men, found that young men who were religiously affiliated were less likely to have stigmatizing attitudes, offering to buy food from someone HIV-positive, be friends with someone HIV-positive and/or agree that HIV-positive teachers should be allowed to continue teaching. However, the link between religious affiliation and stigma reduction was not observed for female youth. This may be explained by the increased opportunities for male youth to go to school past grade 5, with educational opportunities of this age mostly available in religious schools (Noden et al., 2010).

Interventions to Address Stigma and Discrimination are Needed at Multiple Levels
Interventions to combat stigma should include interventions for *individuals*, which create awareness of what is stigma, address fears and attitudes for the individual, and the benefits of reducing stigma, *environmental* interventions, i.e., meeting the need for information, supplies and training; and *structural* interventions, i.e., addressing policies and laws (Nyblade, 2009). Interventions should address three actionable drivers of stigma and discrimination, namely, 1) creating awareness; 2) deepening understanding of HIV transmission to address fears of casual transmission; and, 3) addressing socially driven stigma and discrimination. "Understanding the association of HIV and AIDS with assumed immoral and improper behaviors is essential to confronting perceptions that promote stigmatizing attitudes towards individuals living with HIV" (Nyblade et al., 2009: 4).

Evidence for Successful Interventions to Reduce Stigma Are Desperately Needed
A 2008 review of published literature on stigma in the HIV/AIDS epidemic that included 390 articles, of which 176 were either global in scope or were in a developing country context, found that "there are only a small number of published studies on interventions and programmes designed to reduce HIV/AIDS stigma" (Mahajan et al., 2008: S74). An earlier review in 2003 found that among 22 relevant studies, "No study looked at different messages that could be tailored to men and women, nor were there any efforts to compare differential impact of male versus female contacts for different gendered audiences" (Brown et al., 2003: 66). The authors of a systematic review conducted in 2009 remarked that "the paucity of good quality studies within the last 20 years identified in this review reveals the current gap in evidence-based interventions to reduce HIV/AIDS stigma" (Sengupta et al., 2011: 1084). International AIDS conferences over the years have offered tantalizing glimpses into potentially successful, yet unpublished interventions, for example, programs to reduce stigma and discrimination in the workplace (Singh, 2008; Pramualratana, 2008) and health care settings (James et al. 2004).

The Commission on AIDS in Asia reviewed more than 5,000 papers; commissioned 30 papers; surveyed 600 members of civil society; conducted five country missions and held two sub-regional workshops and concluded that it is crucial to "avoid programmes that accentuate AIDS-related sigma...Such programs may include 'crack-downs' on red-light areas and arrest sex workers, large-scale arrests of young drug users under the 'war on drugs' programs and mandatory testing for HIV" (Report of the Commission on AIDS in Asia, 2008: 17).

Improvements in stigma can be generated from legal protections against discrimination, and advocacy can foster positive changes in laws and policies (ICRW and LSHTM, 2010; Carr et al., 2010). *[See Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights]*

[See also *Meeting the Sexual and Reproductive Health Needs of Women Living with HIV, Safe Motherhood and Prevention of Vertical Transmission, and Structuring Health Services to Meet Women's Needs* for further discussion of stigma as it relates to those topics.]

11F. What Works—*Strengthening the Enabling Environment:* Reducing Stigma and Discrimination

1. Community-based interventions (including media) that provide accurate information about HIV transmission can significantly reduce HIV stigma and discrimination.

2. Training for providers, along with access to the means of universal precautions, can reduce provider discrimination against people with HIV/AIDS.

Promising Strategies:

3. Recruiting and training opinion leaders can reduce stigmatizing behaviors in the community.

4. Support to voluntarily disclose positive serostatus, along with ongoing support, increases HIV-positive women's ability to cope and reduces perceived stigma in the community.

11F. Evidence

1. **Community-based interventions (including media) that provide accurate information about HIV transmission can significantly reduce HIV stigma and discrimination.**

- A community-based intervention to increase HIV/AIDS knowledge and reduce HIV/AIDS stigma with surveys conducted of 32 people in implementation and 34 people control villages in **Thailand** found a substantial increase in both the HIV/AIDS knowledge score and the HIV/AIDS stigma score in the implementation village but very little change in the control village. Focus group discussions also found that increased knowledge reduced stigma (Apinundecha et al., 2007). (Gray IIIa) *(knowledge, stigma, Thailand)*

- A study and intervention in two communities in **Vietnam** found that project interventions led to a significant increase in awareness of stigma, reduction in fear of becoming infected with HIV through casual contact with HIV-positive people and stigma and intentions concerning stigmatizing behavior. Better, more complete knowledge of how HIV was not transmitted translated into a greater degree of acceptance of people living with HIV and their family members. Stigma was so strong in these communities that no one was open about their HIV-positive serostatus. The intervention consisted of a workshop with community leaders to sensitize leaders on the impact of stigma and to provide knowledge on HIV and to meet people living with HIV. A sub-set of these community leaders then Each community participated in a facilitated design workshop to develop designed activities to reduce stigma in their communities.   This included selecting influential people in each ward, who were then trained and personally delivered: distributing an HIV and stigma fact sheet to each household; follow-up meetings held by the trained community members; posters; drama; a program in primary schools that included participatory development of 8 ½ hour sessions delivered by trained teachers sessions for students and teacher; and support groups for people living with HIV. 35 focus group discussions and 97 in-depth interviews were conducted with people living with HIV, family members and community members. 700 in each community were sampled at prior to the intervention and at the end of the project, fourteen months later. Prior to the project, people living with HIV reported not accessing health services due to fear of disclosure of their serostatus. A dose-response effect was seen, that is, self-reported exposure to multiple activities led to lower stigma scores at endline. greater increases in stigma reduction. The intervention was most successful in increasing awareness of stigma and reducing fear-driven stigma.   Some reductions were seen in socially-driven stigma (e.g. blame and shaming of people living with HIV), though these were less marked. However, the intervention was less effective in reducing blame toward HIV-positive people (Nyblade et al., 2008). (Gray IIIb) *(knowledge, stigma, Vietnam)*

- An intervention in 2002 to 2003 in Shanxi Province, **China** to reduce community apprehension about AIDS and subsequent discrimination against PLWA resulted in improved knowledge about HIV, improved attitudes and behavior towards PLWA. For example, before the intervention, 70% said PLWA should be segregated from the public, compared to 37% after the intervention. While knowledge about condom use improved, actual condom use increased only slightly. The study included an intervention and control area and collected focus group and in-depth interview data and pre- and post- intervention surveys.   The intervention included an activity center for PLWA; training and BCC material; care and support; and free condoms (Yang and Zhang, 2004). (Gray IIIb) *(knowledge, stigma, China)*

- Between 2004 and 2006, a project in **Thailand** that paired HIV-positive with an HIV-negative partner to receive loans to create a small business found that HIV-negative partners reported greater willingness to participate in activities with HIV-positive people. Within a few months, the percent of people involved in the project who said they would be comfortable visiting a house of an HIV-positive person increased from 20% to 90%. HIV-positive partners reported they no longer felt they had to accept discrimination. People living with HIV who

participated in the project reported improvements in quality of life, as well as in their economic, social, physical and mental well-being between 2004 and 2006. In addition, 91% of the loans have been repaid on time. Both partners needed training in basic business skills. More than 62% of members were female. More than 42% of all participants paired two women and 39% were composed of one man and one woman. HIV-positive participants had the final decision on accepting their HIV-negative partner, providing those living with HIV more security and control. Disclosure of HIV was voluntary and not required for program participation (UNAIDS, 2007b; Viravaidya et al., 2008). (Gray IIIb) *(knowledge, stigma, microfinance, Thailand)*

- A study in **Nigeria** between 2003 and 2007 found a significant and positive trend between exposure to mass media on the levels of accepting attitudes towards people living with HIV and that exposure to mass media communications on HIV and AIDS issues were significantly related to reduced stigma and discrimination against people living with HIV/AIDS. Data was obtained from 31,692 respondents of the National HIV and AIDS and Reproductive Health Survey, a nationally representative sample of female aged 15 to 49 and males aged 15 to 64 years of age. Mass media exposure was measured based on viewership, listenership and frequency of being exposed to HIV/AIDS messages. The level of accepting attitudes towards people living with HIV/AIDS increased from 3.5% in 2003 to 9% in 2007. However, this also meant that those who still stigmatize people living with HIV decreased from 96.5% to 91% in 2007. Exposure to mass media on HIV was significantly related to reduced stigma and discrimination against people living with HIV/AIDS. Another analysis of the same data using a nationally representative sample of 4,685 females and 5,396 males ages 15 to 49 found that personal exposure to HIV messages through the media was correlated with increased accepting attitudes toward people living with HIV among both men and women. However, accepting attitudes were significantly more prevalent among men than among women. For women, communication exposure was correlated with higher levels of knowledge about HIV (Fakolade et al., 2010; Babalola et al., 2009). (Gray IIIb) *(stigma, discrimination, education, mass media, Nigeria)*

- A study with two separate cross-sectional surveys in **Malawi**, one at baseline in 2004 with 891 people and another follow-up survey in 2005, found that a national mass media campaign including radio diaries featuring the lives of a man and a woman living with HIV; radio programming educating youth about HIV; and community mobilization using trained community facilitators concerning HIV prevention found a significant positive association between program exposure and being less likely to show stigmatizing attitudes to people living with HIV, even after adjusting for potential demographic confounders. This, in turn, was associated with an uptake of HIV testing. "...Reduction in stigma, as an intervention goal, is important not only to promote the respectful treatment of people living with HIV, but also to promote uptake of HIV testing" (Berendes and Rimal, 2011:224). (Gray IIIb) *(stigma, discrimination, HIV testing, Malawi)*

- Focus group discussions with thirty people held after a performance in **Ghana** of a theatrical performance with HIV-positive and HIV-negative performers that dramatized issues concerning living with HIV, such as disclosure of serostatus, found that the performance challenged assumptions among audience members to understand that, as one focus group participant put it, "..What a normal fellow can do, a person with AIDS can equally do." Another participant stated: "I was so happy because though some were positive and some were not, they all came together to act the play and related very well with one another. This means that we can also do things together with our own folks who are HIV-positive" (Boneh and Jaganath, 2011). (Gray IV) *(stigma, discrimination, Ghana)*

2. **Training for providers, along with access to the means of universal precautions, can reduce provider discrimination against people with HIV/AIDS.** *[See also Structuring Health Services to Meet Women's Needs]*

- Training for service providers in county hospitals Yunnan, **China** in 2005-2006 resulted in a stronger belief in patient confidentiality (4 times higher), respecting patients' rights for HIV testing (7.5 times higher) reduced negatives views of people living with HIV (2.2 times higher) and better knowledge and practice of universal precautions (2.6 times higher). 138 providers (doctors, nurses and lab technicians) were assigned to an intervention or control group and followed for six months. The intervention included interactive sessions of game playing based on equal medical treatment, role playing emphasizing the prevalence of discrimination in society and discussions of experiences with HIV care (Wu et al., 2008). (Gray II) *(providers, training, discrimination, stigma, China)*

- A study in **Vietnam** that provided training to 975 hospital workers who received a one and a half day training on HIV and universal precautions, along with testimonials from people living with HIV and training to 617 hospital workers who received the same training with an additional half day training on social stigma co-facilitated by people living with HIV found that both interventions were successful in reducing discriminatory behaviors and hospital practices, with the additional half day training on stigma resulting in a greater impact on reducing discrimination and stigma. For example, hospital workers who felt that HIV/AIDS is a punishment for bad behavior declined in one hospital form 44% before the intervention to 19%. After being trained, staff developed their own hospital policies/codes of conduct. These were put on posters and put up around the hospital. The hospital workers who had additional stigma training were 2.3 times less likely to report placing signs on beds indicating HIV status than hospital workers without the stigma training. Training also used the resource "Understanding and Challenging HIV Stigma: A Toolkit for Action" (Kidd et al., 2007; http://www.icrw.org/docs/2003-StigmaToolkit.pdf). The intervention also provided sharps containers for safe needle disposal as well as providing hospital workers with a manual on the "safe and friendly hospital worker in the presence of HIV/AIDS". Guidelines for testing for HIV were created and having hospital policies in place reduced stigma. Approximately 70% of hospital workers were women (Oanh et al., 2008). (Gray IIIa) *(providers, training programs, discrimination, stigma, Vietnam)*

- A five-country study in **Lesotho, Malawi, South Africa, Swaziland and Tanzania** that paired 134 nurses and 41 PLHA to plan and implement interventions to reduce stigma resulted in reductions among PLHA in reported stigma and increases in self-esteem. A significantly higher percentage of nurses who participated in the intervention had an HIV test as compared to nurses who did not participate in the intervention. The interventions were designed to improve information sharing, increase contact with the affected group and improve coping through empowerment (Uys et al. 2009). (Gray IIIb) *(providers, training programs, stigma, HIV testing, Lesotho, Malawi, South Africa, Swaziland, Tanzania)*

- A pre/post-test study in **India** of training for health workers in a hospital in India with a survey for 885 health workers resulted in less stigmatizing attitudes and practices by health workers. Based on interviews with health workers and HIV-positive patients, the project developed a "PLHA Friendly Checklist" (http://www.popcouncil.org/pdfs/horizons/pfechklst.pdf) and trained health workers. When presented with data from their hospital, managers instituted hospital-wide initiatives to

combat stigma and discrimination. The number of ward staff who reported that HIV cannot be transmitted by touching someone with HIV increased significantly from 80% to 96%. After the intervention, doctors were more likely to agree that patients should not be tested for HIV without consent, increasing from 37% to 67%. Following training, a significantly greater proportion of doctors reported that they always arranged pre-test counseling (from 31% to 46%) and post-test counseling (56% to 69%). Following training, more doctors wore gloves (64% to 93%) and more ward staff wore gloves to carry blood samples (29% to 93%) (Mahendra et al., 2006). (Gray IIIb) *(providers, training programs, stigma, discrimination, India)*

- A study of 357 medical and dentistry students in **Turkey** found that differences between first year and last year students indicated that lectures and increased knowledge about HIV/AIDS decreased stigmatizing attitudes towards HIV/AIDS patients (Turhan et al., 2010). (Gray IIIb) *(training programs, providers, stigma, discrimination, Turkey)*

- A study in **China** with 1,750 health service providers randomly selected from 40 country hospitals in two provinces found that availability of universal precautions supplies was associated with adherence to universal precautions which in turn led providers being less likely to avoid patients with HIV. "The accessibility and availability of universal precautions supplies at work are necessary conditions for providers complying with universal precautions guidelines in their medical practice" (Li et al., 2011b). (Gray IIIb) *(training programs, providers, stigma, discrimination, China)*

Promising Strategies:

3. Recruiting and training opinion leaders can reduce stigmatizing behaviors in the community.

- In **China** in 2005-2007, analysis of randomized control trial data on use of popular opinion leaders recruited among market workers in Fuzhou to reach their peers with messages about HIV and AIDS resulted in significantly reduced stigmatizing attitudes at 12 and 24 months of follow up. Of the 4510 participants, 2,262 (50.2%) were in the intervention group and the test in the control group. Popular opinion leaders attended four weekly group training sessions and 10 to 12 reunion sessions over a two year period. The intervention was part of the National Institute of Mental Health Collaboration HIV/STD Prevention Trial, designed to reduce HIV/STD incidence and risky sexual behavior through use of community popular opinion leaders trained to convey HIV risk-reduction messages (NIMH Collaborative HIV/STD Prevention Trial Group, 2007). Perceptions of stigma did not differ between the intervention and control groups at baseline. At the 12 month follow up, the estimated odds of a higher level of HIV-related stigma were almost twice as high and more than five times as high at the 24 month follow up. No changes were seen in the control group over time. Stigma was measured by asking whether participants agreed with statements such as "A person with HIV must have done something wrong and deserves to be punished." One limitation of this study is that the stigmatizing views of PLWA were not measured, nor were the data disaggregated (Li et al., 2010a). (The NIMH Collaborative HIV/STD Prevention Trial Group). Note: because the RCT was not designed to answer the question about stigma and discrimination, it this analysis is treated like a cross-sectional observational study with a comparison group (Gray IIIa) *(opinion leaders, stigma, China)*

- A study in **China** with ethnic minorities (the Dai), where most believe in Buddhism, found that training for Buddhist monks improved significantly villagers attitudes score toward people living with HIV. A group of 3,128 villagers was educated by 27 Buddhist monks. Monks were trained in basic knowledge of HIV/AIDS, transmission and prevention and elimination of discrimination against people living with HIV/AIDS. Monks preached HIV/AIDs related information to collectively worshipping villagers who came to the temple. Of the 666 villagers tested at baseline and post-intervention, attitude scores increased from 1.5 to 2.1. "The care and tolerance of the AIDS patient is consistent with the spirit of Buddhist compassion" (Wu et al., 2010: 1015). (Gray IIIb) *(opinion leaders, religious leaders, stigma, China)*

4. **Support to voluntarily disclose positive serostatus, along with ongoing support, increases HIV-positive women's ability to cope and reduces perceived stigma in the community.** *[See also Treatment: Adherence and Support & Care and Support: Women and Girls]*

- A qualitative study of interviews with 75 HIV-positive people (43 females, 32 males) from 20 countries, including **Australia, Botswana, India, Kenya, South Africa, Thailand, Uganda, Zambia, and Zimbabwe**, conducted between 1997 and 1999, found that immediately following diagnosis, most respondents felt shame and a sense of worthlessness. Most carefully guarded the secret of their serostatus for fear of negative repercussions. The average time between diagnosis and public disclosure was 2.6 years, as most people needed to time to talk through their fears with peers or a counselor. Motivation for disclosure was to prevent further infections, challenge stigma, or both. Contributing to community AIDS prevention provides a sense of purpose for many of those interviewed: "It makes you feel like you've done something worthwhile" (Paxton et al., 2005: 564). (Gray IV) *(stigma, discrimination, disclosure, Australia, Botswana, India, Kenya, South Africa, Thailand, Uganda, Zambia, Zimbabwe)*

- A study carried out from 1999 to 2001 in **Thailand,** with 329 HIV-positive women found that HIV-positive women who reported that they could disclose their HIV serostatus gained increased acceptance and support from family and community, accessed support groups that increased their ability to cope with the disease, and increased their access to treatment regimens. Of the 329 women, 57% participated in one or more HIV-positive support groups. One woman stated: "At that time, when I knew I was HIV-positive, I thought, how could I live! Then, I had a chance to learn about a support group. I joined this group. I feel good cause I can meet others who're the same as me..." (p. 37). Another stated: "I can get more knowledge from others who have had the same experiences. I feel that there are many people living with HIV, not only me. I feel warm when I join in the group" (p. 37-38) One woman stated: "In the village, everybody knew my HIV status. At first, they did not accept me, but now they have a good relationship with me. I can eat and talk with them. I think that I can live well in the village" (p. 37). The women were interviewed using a structured questionnaire. In-depth interviews were conducted among 60 HIV-positive women. Four participatory workshops were held on data analysis and report writing. A week long counseling training session was held for the women conducting interviews. Women interviewed were selected non-randomly from support groups, clinics, ANC clinics, NGOs, and communities using dimensional sampling method. The dimensions used were ages 15-25, 26-35, or 36-49, and number of years from diagnosis. Women who met the criteria for both dimensions were selected based on convenient or snowball sampling techniques. Six focus group discussions were held with six to eight men (Yoddumnern-Attig et al., 2004). (Gray IV) *(stigma, discrimination, disclosure, Thailand)*

- A study in **Vietnam** with 24 widows living with HIV found that stigma was reduced by joining support groups. Widows, whether HIV-negative or positive, are stigmatized. Support groups helped them to overcome low self-esteem and lack of confidence. As one widow put it: "Talking to others and learning from their experiences has really helped me and given me hope. My partner, whom I met through the group, had the same experience and this had made our love stronger" (Oosterhoff et al., 2010: 30). (Gray IV) *(stigma, discrimination, widows, Vietnam)*

11F. Gaps in Programming—Reducing Stigma and Discrimination

1. Further interventions and research are needed to reduce stigma and discrimination against women, specifically, who are at high risk or living with HIV.

2. Judicial action, legislation, and training on legal rights can protect people living with HIV from discrimination.

3. Provision of ART can reduce stigma, but additional interventions are needed.

4. Increased dissemination of basic knowledge on HIV is needed to reduce stigma.

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1. **Further interventions are needed to reduce stigma and discrimination against women, specifically, who are at high risk or living with HIV.** *[See also Safe Motherhood and Prevention of Vertical Transmission: Treatment]* Studies found that women and girls are highly stigmatized if they test positive for HIV. Stigma impacts the HIV-positive woman, herself, as well as her children, her siblings and her family. Some providers also discriminate against those living with HIV.

- Gap noted, for example, in **Uganda** (Medley et al., 2009b); **Malawi** (Namakhoma et al., 2010); **Kenya** (Machera, 2009); **Nigeria** (Adewuya et al., 2009); **China** (STD and AIDS Prevention and Control Center of the Chinese Center for Disease Control and Prevention and ILO, 2011; Parry, 2011; Sullivan et al., 2010a; Zhang et al., 2010b); **India** (Van Hollen, 2010); **Zimbabwe** (Campbell et al., 2011a); **Malawi** (Peters et al., 2010b); **and South Africa** (Brown et al., 2010); **Yemen** (Al-Serouri et al., 2010); **Thailand** (Liamputtong et al., 2009).

2. **Judicial action, legislation, and training on legal rights can protect people living with HIV from discrimination.** Studies found that people reported being denied housing or being evicted for testing HIV-positive but that peer education on legal rights may increase protect people from discrimination. *[See also Transforming Legal Norms to Empower Women, including Marriage, Inheritance and Property Rights]*

  - Gap noted, for example, in **Ethiopia, Tanzania** and **Zambia** (Nyblade et al., 2003).

3. **Provision of ART can reduce stigma, but additional interventions are needed.** Studies found that lack of knowledge of ARV treatment increased stigma, but that ARV treatment alone did not eliminate stigma and discrimination.

   - Gap noted, for example, in **Russia** (Amirkhanian et al., 2011); **Zambia** (Fox et al., 2010a); **Mozambique** (Pearson et al., 2009); **Thailand, Zimbabwe, Tanzania, and South Africa** (Maman et al., 2009; Genberg et al., 2009); and **Tanzania** (Roura et al., 2008).

4. **Increased dissemination of basic knowledge on HIV is needed to reduce stigma.** A study found that both men and women attending HIV testing lacked basic knowledge on how HIV is transmitted, with a majority believing for example, that HIV is transmitted by sharing food and about half refusing to associate with an HIV-positive individual.

   - Gap noted, for example, in **Iraq** (Hayyawi et al., 2010); **Kuwait, Bahrain and Jordan** (Badahdah and Foote, 2010); and **Yemen** (Badahdah and Sayem, 2010).

11G. *Strengthening the Enabling Environment:* Promoting Women's Leadership

Strengthening women's rights and health NGOs and supporting women leaders who can mobilize in-country efforts in the interests of women and girls affected by HIV is critical. "…It is not enough for programmes and strategies to be designed on behalf of those living with AIDS; we have much to learn from their experiences, and how they struggle to negotiate being positive and maintaining sex lives and social linkages" (Gupta et al., 2011a: S379). "However, meaningful civil society participation has often eluded HIV/AIDS programs in Africa" (IOM, 2010: 93). And where NGOs are active, "HIV and AIDS

"While before I had been a victim and doomed, I started to become an actor in the fight against this terrible illness through my active participation in prevention campaigns." — Efficace, HIV-positive woman, Cameroon (cited in Offe and van Roenne, 2007: 7)

"…When we meet with someone who is positive, we chat. We give each other ideas" — HIV-positive woman, Malawi (cited in Mkandawire-Valhmu and Stevens, 2010)

NGOs are male dominated" (Bechange, 2010). Fostering social capital among and within these groups is also important. Just as the gay movement in the U.S. spurred activism and cohesion around HIV and AIDS early in the epidemic (Fauci, in Goldman, 2008), women in the Global South need support for the NGOs that can provide this mobilization of support and attention (Wellings et al., 2006). However, social capital, through participation in groups, can have positive as well as negative outcomes (Szreter and Woolcock, 2004; Pearce and Smith, 2003). Smith and Rimal (2009: 141) put it succinctly that "integration into a social system can serve to smother or inspire." For women, integration in groups dominated by male leadership can serve to smother.

Positive Women Deserve Meaningful Involvement in the Response to HIV and AIDS
In most support groups and networks of people with HIV, women make up the vast majority of members of the networks yet the paid or elected positions are filled mostly by men (Manchester, 2004). Women living with HIV want substantial and meaningful involvement in policy and program design and implementation, rather than just to be included as honorary speakers or advisory members. As Fria Chika Islandar, a young Indonesian woman living with HIV put it at the International AIDS Conference Plenary in Toronto, Canada in August 2006, "I learned to demand my rights. I don't want to just be listed in a report. I want to be more involved" (Islander, 2006). Few organizations recognize HIV-positive women's organizations' right to involvement "and often assume either that an HIV-positive man can speak for all HIV-positive people, or that a few individual women on their own can be expected, as token women, to carry the burden of representing the views and perspectives of the vast number of women and girls across the region" (Paxton et al., 2004a: 18).

HIV and AIDS programs need more women involved in leadership positions – particularly HIV-positive women and women with relevant skills. "There are many innovative responses by…HIV-positive women and girls worldwide. They show that quality of life does not end with an HIV diagnosis, but that given the right support, women and girls living with HIV can thrive and play a vital role in society, in families, and in prevention and support programmes" (ICW, 2004: 2). Despite significant challenges and limited resources, women and girls are responding positively to the epidemic—setting up support clubs, conducting peer education, providing care and support, looking after orphaned children, and engaging in advocacy and policy dialogue—and their contribution needs to be acknowledged and supported.

Women Need Support and Opportunities to Build Skills
However, programs also need to recognize that it is difficult for women living with HIV or AIDS to participate unless their basic needs are met. Positive women need to earn an income and, consequently, have little time or energy available to volunteer with PLHA organizations. Many are widows with children to support. Of the 764 HIV-positive people interviewed in the Asia Pacific Network of People Living with HIV/AIDS

(APN+) documentation of AIDS-related discrimination, 50 percent of the women but only 8 percent of the men were widowed (Paxton et al., 2004b).

In addition to support and strengthening social capital, women need opportunities to build skills for advocacy, networking, and participation in policy and program design and implementation. Important interventions include establishing mechanisms for meaningful participation of women in policymaking at international, national, community, and organizational levels; building women's policy advocacy and analysis skills; and ensuring that women are aware of their rights. Positive women also need separate networks to ensure that they have a voice. "Experience to date shows that the active involvement of positive women at all levels of decision-making, including the making and shaping of policy, is essential to treatment preparedness and expanded access as well as ensuring respect for positive women's sexual and reproductive health and rights. Yet, HIV-positive women and decision-making bodies continue to lack practical skills and political commitment to promoting meaningful involvement of positive women in shaping policies and programs" (Mthembu et al., 2006).

[See also Prevention for Key Affected Populations for leadership initiatives among sex workers and other marginalized groups.]

11G. What Works—*Strengthening the Enabling Environment:* Promoting Women's Leadership

Promising Strategies:

1. Investment in women's groups, especially positive women's networks, can result in policy engagement and change to better meet women's health and human rights needs.

2. Training on human rights for people living with HIV can increase protection of their rights.

11G. Evidence

Promising Strategies:

1. **Investment in women's groups, especially positive women's networks, can result in policy engagement and change to better meet women's health and human rights needs.**

   - An intervention for adolescent girls in **Nepal** in 2004-2007 based on the premise that adolescent girls in the country could develop leadership skills and raise awareness among their peers successfully trained 504 adolescent peer educators whose leadership self-efficacy

and collective efficacy scores increased through the intervention. The study used pre- and post-intervention surveys of the peer educators (administered to 472 peer educators post-intervention). Both leadership self-efficacy and collective efficacy, or the "shared belief among members of a group that their can work effectively together to accomplish a goal" (p. 287), increased significantly from the pre- to post-intervention surveys. Knowledge of HIV, including the risk that young Nepalese women face related to trafficking, increased 15%, also a significant increase. Knowledge of HIV increased the most for peer educators from lower caste and other marginalized groups, who are most at risk of HIV. Leadership self-efficacy was significantly associated with increased knowledge of HIV (Posner et al., 2009). (Gray IIIb) *(women's empowerment, youth, leadership, self-efficacy, Nepal)*

- There is an emerging collective empowerment based on knowledge and understanding of rights. Examples include the alliance of the **Zimbabwean** Network of Positive Women allied with women lawyers to introduce marital rape as a criminal offense in Zimbabwe law and the Treatment Action Campaign in South Africa, where an alliance of women and lawyers resulted in a ruling that pregnant women have the right to ARVs in pregnancy to reduce the risk of MTCT (Manchester, 2004). This study was based on oral sources, workshops and presentations, and memories of conversations with HIV-positive African women since 1992, as well as qualitative research through interviews conducted in 2000, with 10 HIV-positive African men and women (Manchester, 2004). (Gray V) *(women's empowerment, Zimbabwe, South Africa)*

- A project that provided training and networking by HIV-positive women with Parliamentarians from their own country – **Botswana, Kenya, Namibia and Tanzania**-along with NGOs, provided opportunities for HIV-positive women to comment on upcoming legislation that impacted them (Parliamentarians for Women's Health, 2007). (Gray V) *(training programs, women's empowerment, Botswana, Kenya, Namibia, Tanzania)*

2. Training on human rights for people living with HIV can increase protection of their rights.

- Training by ICW and IPAS for women in **Namibia** led to access to post-exposure prophylaxis, emergency contraception, and legal abortion in cases of rape at a clinic that previously had none of these services. Training was conducted for two weeks based on a curriculum developed by Ipas, Gender or Sex: Who Cares? The training resulted in advocacy with Ministry of Health, which in turn led to the availability of these services (de Bruyn and Mallet, 2011). (Gray IIIb) *(rape, post-exposure prophylaxis, contraception, abortion, Namibia)*

- The AIDS Rights Alliance for Southern Africa (ARASA) trained 684 participants representing AIDS service organizations, women's groups and others on human rights and HIV/AIDS, resulting in increased protection of rights. Participants came from **Angola, Botswana, Democratic Republic of the Congo, Malawi, Mauritius, Mozambique, Namibia, Swaziland, Tanzania and Zambia**. Results included a Charter of Rights for People Living with HIV in the Democratic Republic of Congo, removing the clause on criminalization of transmission in Mauritius and inclusion of harm reduction in legislation in Mauritius (ARASA, 2009). (Gray V) *(women's empowerment, human rights, Angola,*

Botswana, Democratic Republic of the Congo, Malawi, Mauritius, Mozambique, Namibia, Swaziland, Tanzania, Zambia)

11G. Gaps in Programming—Promoting Women's Leadership

1. Interventions are needed to promote HIV-positive women's access to funding to start and lead initiatives.

2. Interventions are needed to foster the involvement of HIV-positive women and promote cooperation between people living with HIV and AIDS and health care facilities, government and other agencies creating HIV-related programs and policies.

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1. **Interventions are needed to promote HIV-positive women's access to funding to start and lead initiatives.** Studies found that HIV-positive women's networks lacked funding.

   - Gap noted globally (Paxton et al., 2004a and b; Manchester, 2004).

2. **Interventions are needed to foster the involvement of HIV-positive women and promote cooperation between people living with HIV and AIDS and health care facilities, government and other agencies creating HIV-related programs and policies.** Studies found that little cooperation existed between HIV-positive women and health facilities but that efforts have been underway to educate parliamentarians concerning HIV-positive women's issues.

   - Gap noted, for example, in **Asia and Africa** (UNIFEM and ATHENA, 2010), **Dominican Republic, Bangladesh and Ethiopia** (IPPF et al., 2011); **Ukraine** (Yaremenko et al., 2004) and **Botswana, Kenya, Namibia and Tanzania** (Parliamentarians for Women's Health, 2007).

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