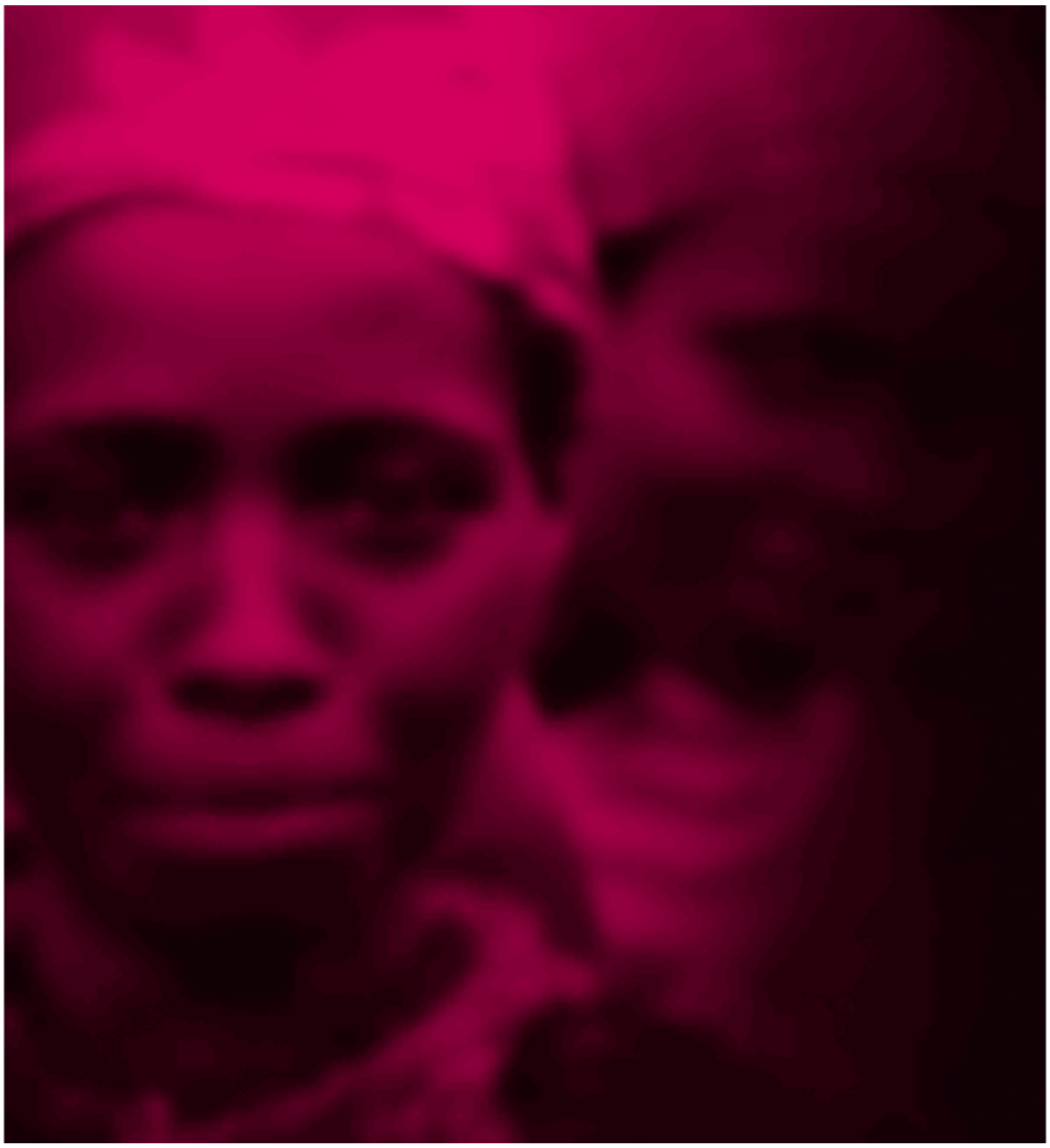
Women WON'T wait

End HIV & Violence Against Women. NOW.



Publication for Latin America and the Caribbean

FUNDACIÓN PARA ESTUDIO E INVESTIGACIÓN DE LA MUJER

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Buenos Aires, Aregentina

Printed by
Altuna Impresores

Buenos Aires, Argentina
April 2007

Printed in Buenos Aires, Argentina

PRESENTATION

"Women Won't Wait" is an international coalition of organizations and networks committed and working for many years to promoting women's health and human rights in the struggle to comprehensively address HIV and end all forms of violence against women and girls now. **WWW** seeks to accelerate effective responses to the linkages of violence against all women and girls and HIV by tracking and; where necessary; calling for changes in the policies; programming and funding streams of national governments and international agencies.

WWW was officially launched on 6 March 2007. A baseline analysis of key HIV&AIDS donors' and agencies' policies conducted by the campaign (available at www.womenwontwait.org) will be followed by reports and regular scorecards toward tracking donors' and key agencies' policies and practices in depth.

Published by **Action Aid** for the **Women Won't Wait** campaign; in collaboration with: African Women's Development and Communications Network (FEMNET); Association for Women's Rights in Development (AWID); Centre for Health and Gender Equity (CHANGE); Center for Women's Global Leadership; Foundation for the Study and Research on Women (FEIM); International AIDS Women's Caucus (IAWC); Latin American and Caribbean Women's Health Network (LACWHN); Open Society Initiative of Southern Africa (OSISA); Program on International Health and Human Rights, Harvard School of Public Health; SANGRAM and VAMP.

Members of the **"Women Won't Wait"** campaign: Action Aid; African Women's Development and Communications Network (FEMNET); Association for Women's Rights in Development (AWID); Centre for Women's Global Leadership (CWGL); Centre for Health and Gender Equity (CHANGE); Foundation for the Study and Research on Women (FEIM); GESTOS -Soropositividade; Comunicação & Gênero; International Community of Women Living with HIV&AIDS Southern Africa (ICW-Southern Africa); International Women's AIDS Caucus; International Women's Health Coalition (IWHC); Latin American and Caribbean Women's Health Network; Open Society Initiative for Southern Africa (OSISA); Program on International Health and Human Rights, Harvard School of Public Health; SANGRAM; United Nations Fund for Women (UNIFEM); VAMP; and Women and Law in Southern Africa (WLSA).

EXECUTIVE SUMMARY

A potent and deadly spiral

Two pandemics threaten the health, lives and rights of women throughout the world: one is HIV&AIDS and the other is gender-based violence against women and girls. Violence against women and girls is a major contributor to death and illness among women, as well as to social isolation, loss of economic productivity, and loss of personal freedom. Research confirms that violence, and particularly intimate partner violence, also is a leading factor in the increasing "feminization" of the global AIDS pandemic, resulting in disproportionately higher rates of HIV infection among women and girls. Simultaneously, evidence confirms HIV&AIDS as both a cause and a consequence of the gender-based violence, stigma and discrimination that women and girls face in their families and communities, in peace and in conflict settings, by state and non-state actors, and within and outside of intimate partnerships. For more than two decades, international women's movements have fought for both international recognition of, and concrete action to promote, the human rights of all women. At the core of this are the principles that every woman has the human right to be free from violence, coercion, stigma and discrimination, and that every individual has the right to achieve the highest attainable standard of health, including sexual and reproductive health. In response to the growing body of evidence on violence and HIV&AIDS, and in response to calls by human rights advocates for effective action on these issues, international institutions and national governments have articulated a concern to address gender-based violence, including within the context of HIV&AIDS. Little is known, however, about what is actually being done to address these issues in policies, programming and funding, and whether the efforts that are underway are truly based on the human rights and health agenda advocated for so long by women's movements throughout the world.

TWO PANDEMICS

> *"Around the world, women are facing a catastrophic assault on their bodies, rights and health as a result of the prevalence of HIV/AIDS and the unrelenting omnipresence of violence against women."*
>
> Cynthia Rothschild, Mary Anne Reilly and Sara A. Nordstrom

While each constitutes a health and human-rights crisis on its own, the combination of gender-based violence against women and girls and HIV produces a particularly potent poison. An ever more convincing body of data establishes that violence against women and girls is a crucial driver of the HIV&AIDS pandemic and HIV&AIDS is also both a cause and a consequence of gender-based violence.

Women and girls are more likely than men and boys to become infected with HIV for several reasons. Women are biologically more vulnerable to HIV infection through sexual intercourse than men. As a result of gender inequality and unequal power relationships, they are often less able to negotiate condom use or to refuse sex even with intimate partners, in part because of threats or acts of gender-based violence and coercion. Stigma and discrimination mean that HIV serostatus and even some aspects of HIV testing and treatment increase the risk of violence faced by women and girls. Increasingly, women are dealing with the way violence puts them at greater risk of contracting HIV while women who are HIV positive are more likely to be targets of violence because of additional layers of discrimination and stigma.

The impact of both HIV&AIDS and violence against women is exacerbated by inadequate services and protection of sexual and reproductive health and rights; laws that are weak or discriminatory toward women and people living with HIV&AIDS; social and community standards that validate gender inequality and the subordination of women; and the forms of multiple discrimination faced by women and girls because of their race, language, sexuality, ethnicity, and other, similar factors.
We understand violence against women to be a form of gender-based violence and, more generally, a manifestation of gender inequality and unequal power relationships. Violence against women and girls has a lethal dynamic by itself, as well as when it is combined with HIV&AIDS. The impact of these two pandemics limits the capacities of women and girls to move and express themselves freely, to fully participate in society, to achieve economic independence and to access health services including vital HIV counseling, treatment, support and care.

FEMINIZATION OF HIV&AIDS

Worldwide 39.5 million adults were living with HIV&AIDS in 2006, of these, 17.3 million were women, accounting for nearly half of all HIV-positive people. Globally, and in every region, more adult women (15 years or older) than ever before are now living with HIV, with an increase of over one million compared to 2004[1]. The feminization of the epidemic is undeniable, during the last years, the number of women and girls infected with HIV has increased in every region of the world with rates rising particularly rapidly in Eastern Europe, Asia and Latin America[2].

HIV-positive women as a percentage of total HIV-positive population over 15 years of age, 2006 estimates by region.

Sub-Saharan Africa	**59%**
Caribbean	**50%**
Middle East and North Africa	**48%**
Oceania	**47%**
Latin America	**31%**
Eastern Europe and Central Asia	**30%**
East Asia, South and Southeast Asia	**29%**
West and Central Europe	**28%**
North America	**26%**

Source: UNAIDS

Women account for the 30% of adults living with HIV in Latin America and for the 50% in the Caribbean[3]. According to the UNAIDS 2006 report "The Caribbean's largely heterosexual epidemics. Occur in the context of harsh gender inequalities. And are being fuelled by a thriving sex industry, which services both local and foreign clients".

The decrease of the men/women living with AIDS ratio across the Latin American and Caribbean region is clearly reflected in the rising number of women and girls living with HIV.

- In **Argentina** the first woman with AIDS was recorded in 1987, in 1988 the man/woman ratio was 14 men for every woman and in 2005 the ratio decreased to 2.24/1, indicating the increasing rate in women.
- In **Brazil**, the man/woman ratio is systematically decreasing, passing from 15 men for every woman in 1986, to 1.5 men for every woman in 2005[4].
- In **Chile** for every woman with AIDS in 1990 28.4 men were diagnosed, down to 7.2 men for every woman in 2001.
- In **Colombia**, the man/woman ratio has narrowed from around 10 men for every woman at the beginning of the 1990s to a ratio of 2-3/1 en 2003-2005.
- In **Nicaragua**, in 1998 the man/woman ratio was 7 to 1; in 2003 it dropped to 3 men for every woman with AIDS[5].
- In **Peru** while in 1990 there was one woman for every 11 men with AIDS, in 2002 3.3 men were reported for every woman[6].
- In **Honduras** in 1980 the proportion of men to women living with AIDS was 4 men for every woman; in the last decade, the ratio has almost equalized, now at 1/1.2.[7]
- In **Panama** in 1986 the man/woman ratio was 17 men for every woman, while in recent years the ratio dropped to 3 men for every woman.[8]

The AIDS epidemic predominates globally in young people between 15 and 24 years old and among them infection is more frequent in women than in men. OMS points out: "Young people represent half the new HIV infections, a third of which occur in women"[9].

[1] UNAIDS, 2006
[2] UNDP/UNFPA, UNICEF and WPF Background Document, Gender Dimensions of HIV, 2007.
[3] PAHO, 2005
[4] National STD and AIDS Program, Ministry of Health, Epidemiological AIDS-STI Bulletin, Brazil, 2006.
[5] OPS, 2005.
[6] RSMLAC, ATENEA: Monitoring as a citizenship practice of women, 2004.
[7] OIT, Systematization of the impact of HIV/AIDS in the workforce in Honduras, 2005.
[8] OIT, Systematization of the impact of HIV/AIDS in the workforce in Panama, 2005.
[9] WHO, 2004. "Women, Girls and HIV/AIDS." Advocacy Note. World AIDS Day, 2004. p. 4.

- In **Trinidad and Tobago**, according to a 2005 study, the levels of HIV infection are 6 times higher among women between 15 and 19 years old than among men of the same age[10].
- In the **Dominican Republic** women younger than 24 have had almost doubled the probability of becoming infected with HIV than the corresponding male population[11].
- In **Jamaica**, according to a 2003 study adolescent girls have had a probability 2.5 times greater of being infected than boys in their same age group[12].
- In **Puerto Rico** in the period 2003/2007 in the 10-19 age group, 51% of the cases are women, thus passing the number of men with HIV[13].
- In **Argentina** since the year 2004 new infections predominate in women of the 13 to 19 age group; the man/woman ratio was 0.88/1[14]. In the city of Buenos Aires in the period 2003/2006, the women almost doubled the men in the 15 to 19 year old age range, making the man/woman ratio 0.53, the same also occurred in the 10 to 14 year old group in which the ratio was 0.50[15]

VIOLENCE AGAINST WOMEN AND GIRLS AND HIV&AIDS

In Latin America and the Caribbean women and girls are the direct target of gender-based violence that threatens their physical, sexual and mental health. Perpetrators may be an intimate partner, family members, community members and leaders, police, soldiers or others. According to data collected for the World Health Organization (WHO)'s recent multi-country study on violence against women, 13-61% of ever-partnered women have experienced physical and/or sexual violence by a partner in their lifetime. The WHO study[16] shows that between 6 and 47% of adult women report being abused by their intimate partners and among the young women (ages 10-24) between 7% and 48% report their first sexual encounter as coerced. Women and girls encounter violence in their homes, communities, schools, workplaces, streets, markets, police stations and hospitals. Violence, or the threat of it, not only causes physical and psychological harm to women and girls, it also limits their access to and participation in society because the fear of violence circumscribes their freedom of movement and of expression as well as their rights to privacy, security and health.

Violence, product of gender inequity, is the main factor for women HIV vulnerability. In many cases, women and girls are forced into sex or coerced without their informed consent. For example, the WHO study found as many as 30% of women in some locations reporting that their first sexual experience was coerced or forced. In some countries of the region, nearly one in four women reported sexual violence by their intimate partner, as well as the number of rapes increased progressively. Other studies showed that 36% of girls and 29% of boys have suffered sexual child abuse (PAHO/WHO, 2003).

SEXUAL VIOLENCE RATES

- According to facts from the demographic health questionnaires (1997-2000), 11% of the women in Colombia, 10% in Nicaragua and 17% in Haiti between 15 and 49 years old affirm that they have at one time been victims of sexual violence from a husband or partner. En Mexico and Peru, these statistics reach 23%[17].
- In Colombia the Institute of Legal Medicine reported in 2000 a total of 13,542 cases of sexual crimes. 86% of the victims were female.
- En Argentina according to the National Office of Criminal Policy in 2005 10.318 crimes in violation of the sexual integrity were reported in the country, 3,154 were rapes.
- In Jamaica 17% of girls between 13 and 14 years old were victims of a rape or a rape intent[18].

[10] ONUSIDA, 2005 (Inciardi et al., 2005)
[11] Ibid
[12] ONUSIDA, 2005
[13] HARS Reporting System, Cases of HIV confirmed in Puerto Rico since 6/2003-2/2007
[14] "Bulletin about HIV/AIDS in Argentina", National Ministry of Health and the Environment,Year X, N°24, December 2005.
[15] AIDS Coordination: Infosida, Year 5, N°5, Bs. As., December 2006.
[16] WHO – 2002 – World Report on Violence and Health, Ginebra.
[17] OPS/OMS 2002
[18] Walker, et al. (1994). Nutritional and health determinants of school failure and dropout in adolescent girls in Kingston, Jamaica. International Centre for Research on Women; Washington DC.

- In Peru 45% of adolescent girls and 14% of adolescent girls in Brazil living in urban areas report that their sexual initiation was coerced[19].
- In the Caribbean 47% of adolescent girls who had had sex, said that their sexual initiation was forced.[20]
- In Nicaragua, according to the National Police the sexual crimes against girls under the age of 13 increased 46% between 2001 (339) and 2002 (496).

Studies in Rwanda, Tanzania and South Africa[21], show up to three fold increases in risk of HIV among women who have experienced violence compared to those who have not. Indirect links between violence and aids were also found. In Nicaragua, one study found that women who were severely sexually abused in their childhood made their sexual debut more than two years earlier and reported a higher number of sexual partners than those who had experienced no sexual abuse.

A study from South Africa showed that women who experienced forced sex were found to be nearly six times more likely to use condoms *inconsistently* than those who did not experience coercion and, were at higher risk of HIV infection. Among young women (16-23 years) those who had partners older than them had 1.6 fold higher odds of being HIV infected and were 1.5 times more likely to experience violence than women with partners in the peer age group.

When sexual violence occurs, especially in girls and young women, the risk of HIV transmission is likely to be higher, but is very difficult to establish, as different USA studies indicated. There is a lack of statistical information on the frequency of domestic and sexual violence against women and girls in the region. It is necessary to develop researches and studies that document violence rates and its intersections with HIV&AIDS. Although we are waiting for statistics that reflect these links, many life stories from women show these intersections.

The following are testimonies of women from various countries

"I PLAYED GOOD GIRL. . ."
. . . suddenly three guys came up to me and stared bothering me, I told them to leave, but two of them grabbed my arms and told me "shut up and walk, nice and quiet! "First they robbed me, I don't know how much they took. . .I had $35, I think. . .Afterwards, they started to get weird, they were Paraguayan, like me, and they started speaking in guaraní, they thought I didn't understand, and then I started to realize what they were going to do to me. . . I played the good girl, thinking that would save me. . . The two youngest raped me and left. I wanted to go and the other one that was behind came back, grabbed me and told me that now it was his turn, and it wasn't going to go as well as with as with the other two. . . "In that moment I thought that he was going to kill me, that I was going to die that day".
At the hospital that I went to they gave me the morning after pill. Six months later I got tested for HIV and it came out positive. . .
I keep turning over in my mind what wasn't done, what was done wrong. . . if in the hospital they had known to, wanted to o could have done anything, if they had given me TARV immediately after the rape. . .would today be a different reality?. . .I keep asking myself. . ."

By Sandra Barilari, therapeutic companion
Buenos Aires 2007.

Partner violence, commonly known as domestic violence, is also a factor that increases a woman's risk of contracting HIV. According to the Panamerican Health Organisation (PAHO), there is a positive association between domestic violence and Sexually Transmitted Infections- (STI)-, a higher prevalence of STI is observed in women that have suffered violence in partner relationships than among women who have not. This is based on the fact that women who have been victims of domestic violence have difficulty negotiating the use of condoms; in many cases, merely requesting condom use can lead to a violent reaction on the part of their partners, meaning that they endure physical, verbal and/or sexual abuse.

[19] Garcia-Moreno 2004
[20] Ibid
[21] UNAIDS-OMS: HIV/AIDS and Violence among intimate partners. Informative Report Nº1

> Brenda (77) is 34. She was in a physically abusive relationship during which she suspected that her husband was having affairs. She wanted to use a condom as a protection against contracting HIV/AIDS, but he refused. Despite knowing that he was HIV positive, he regularly beat her to have unprotected sex with him. Brenda nursed him until he died. She is now HIV positive. She attends church regularly, but dares not disclose her status, as she witnessed how members of the church community treated another woman who was known to be HIV positive."
>
> Amnesty International Report
> Sexual violence against women and girls in Jamaica: "just a little sex", 2006.

In many countries, the highest rates of new infections are among married women, indicating greater vulnerability. The possibility of being a victim of violence and of losing the power to demand condom use is greater in married women, since they traditionally live in situations of greater subordination to their husbands. For example, in Ecuador 66.4% of infected women in 2004 were housewives, while sex workers constituted 11.2%[22]. In Colombia the number of married women seeking governmental medical attention for HIV/AIDS quadrupled in two years[23].

> My name is Evelyn, I am 45 years old and I have two children. I live in a town in the centre of the island of Puerto Rico. HIV has been in my body for 15 years. I was diagnosed when I was pregnant with my second child.
> When I got married I was very happy and excited because I thought that man was better than any other. I convinced myself with him, I had won the lottery! When I was pregnant, we moved to the United States to live and to work. Three months later, that "*spectacular*" man changed his behaviour in a very noticeable way. He became violent until one night when I was four months pregnant he kicked me out of the house. In September of 1992 I returned to my country, to live with my parents. When I went to the family gynaecologist, he gave me the diagnosis. My first reaction was to call my husband and tell him. His first comment was "Oh, what a shame. Go find out who infected you". I began treatment in December of 1992 with the medicine AZT. My son was born with a natural birth and, thanks God, without the virus".
>
> Fragment of the testimony of Evelyn in the launch of the "Women Won't Wait" Campaign in New York, March 2007.

Women with HIV confront a wide range of real and potential violations of their human rights. These range from non-consensual testing, disclosure of results to the partner or other family members without consent, stigmatisation, isolation and the rejection by family and community, to threats and acts of violence that people living with HIV suffer on account of their serological condition. The WHO notes: "Fear of negative outcomes, including fear of violence, is a major barrier to disclosing HIV status. Non-disclosure can hinder a woman's ability to access HIV-related treatment, care and support. Research indicates that between 16% and 86% of women in resource-constrained settings choose to disclose their HIV status to their partners."[24] Many don't tell their partners for fear of being victims of violence, rejection and discrimination.

Women who are HIV-positive may also be at increased risk of being targeted for violence as a result of disclosing their status, as well as because of stigma and discrimination as a result of reporting their condition to men, due to the prejudices about the link between women and HIV, still associated in the common belief to the existence of multiple partners or prostitution.

[22] UNIFEM, Andean Region, Reversion of the HIV propagation among women and girls.
[23] Cimac News, Requesting campaign directed a this new high risk group: The number of married women with HIV/AIDS increased 400% in Bogota, Colombia, 10-16-2002
[24] WHO, Sexual and Reproductive Health of Women living with HIV/AIDS. Guidelines on Care, Treatment and Support for Women living with HIV/AIDS and their children in resource-constrained settings, 2006

> Rosa Polanco, 34 years old, was tested for HIV when she was hospitalized for liver disease. "A doctor came in, and was fairly rude. He told me: "You have HIV because you didn't take care of yourself" in front of my little girls." As a consequence of this divulgence of her HIV positive condition, Rosa was expelled from her home by her mother."
>
> Human rights Watch: Proof of Inequality: discrimination against women living with HIV in the Dominican Republic.

Sex workers are very exposed to situations of violence that increase their vulnerability to HIV and AIDS. Many of them experience violence in the street, at work, or in their personal lives, thus elevating their vulnerability to HIV and other health problems. The sexual and partner violence to which many sex workers are exposed limit their ability to negotiate safe sexual relations with clients as well as with their regular partners. In Panama City, approximately 13% of sex workers report having been raped while working and this number increased 41% among those who are drug users[25]. Condom use is also limited by the violence perpetrated by security forces against prostitutes or sex workers. For example, in the United States, if a woman carried condoms it was sometimes used by the police as evidence of prostitution, provoking her arrest[26]. Violence against sex workers is furthermore perpetrated and legitimised by the laws that governments maintain regarding prostitution, that generally elevate the risk of violence against sex workers instead of protecting them.

> *"My name is Janaina, I was born in Recife, Pernambuco in 1976. I live in a refugee home with my two children: Samara who is 6 and Samuel who is 4. As a child I suffered a lot of abuse from my mother and her partners. At age 9 I was "sold" to a woman who converted me into her adopted daughter. She called me Sandra, she changed my name. She raised me as her domestic employee and at age 13 forced me to become a prostitute. I didn´t go to school, I only learned to read and write. When I could I went to the interior of Pernambuco where I worked as a prostitute. I got pregnant twice. During the second pregnancy I was tested for HIV, and it came out positive. That was 10 years ago. Since then I have lived in a home for victims of violence where I also work. Since 2005 I have participated in the Working Group on Human Rights and AIDS and I receive psychotherapy. Less than a month ago I was going to travel to New York to talk about violence against women and AIDS but the USA denied me a visa. I hope that in the future people don't suffer anymore".*
>
> Janaina,
> Pernambuco, Brazil

The lack of political will on the part of the majority of the donors and governments is responsible for the scarce attention paid to the problem. Among donors, funding to confront gender based violence is scarce and generally marginal, while the integration of programs that deal with violence against women in the funding of HIV and AIDS is inadequate and very difficult to access.
The objective of universal access to prevention, treatment, and medical care will not be reached without a restructuring and refocusing that confronts gender inequality and that bases itself in human rights.

SHOW US THE MONEY

The report, **"Show Us the Money: is violence against women on the HIV&AIDS donor agenda?"**[27] developed within the context of the **WWW** coalition, analyses the policies, programming and funding patterns of the four largest public donors to HIV&AIDS: the Global Fund to Fight AIDS, Tuberculosis and Malaria, the President's Emergency Fund for AIDS Relief (PEPFAR/US), the UK Department for International Development (DFID), and the World Bank. The study also included UNAIDS: the Joint UN Programme on HIV/AIDS. The report is the first step in an effort by this coalition to monitor the policies, programmes, and funding streams of international agencies and national governments, and to hold these agencies

[25] Carrington C and Betts C (2001) Risk and violence in different scenarios of commercial sex work in Panama City. Research for Sex Work. 4:29-31
[26] Alexander P (2001). Contextual Risk versus risk behavior: the impact of the legal, social and economic context of sex work on individual risk taking. Research for sex work 4:3-5
[27] Fried, S. "Show Us the Money: Is violence against women on the HIV&AIDS Funding Agenda?", *www.womenwontwait.org*, March 2007

accountable to basic health and human rights objectives. The report is based on a scan of publicly available information of each of the institutions and on interviews with staff, key informants and experts in HIV&AIDS and gender-based violence.

"It is vital that the policies, programs and funding streams of national governments and international agencies transparently address the intersection of HIV and AIDS and violence against women. At the same time, civil society must hold both governments and agencies accountable to promoting human rights and the self-determination of women, as this coalition seeks to do".

Mary Robinson, former president of Ireland.

Underlying this research is the principle of every woman's human right to freedom from violence and to the highest attainable standard of health, including sexual and reproductive health and services. The lack of such a clear human rights basis undermines much HIV&AIDS programming and many anti-violence initiatives. For instance, prevention of mother-to-child transmission, laudable in itself, often ignores a woman's own rights to health and services, failing to provide sustained access to anti-retroviral treatment after the baby is born.

This analysis and the **WWW** campaign address the following pressing challenges:

- The difficulty to *engender* mainstream HIV&AIDS policies and programming in order to address increasing feminization of the epidemic.
- Incomplete attention to violence and all forms of discrimination against women and girls in mainstream HIV&AIDS policy, programming and funding.
- The lack of comprehensive and specific tracking of health resource flows.
- Current epidemiological models whose views of women and definitions of risk contribute to feminization of the epidemic.

Policies, programming and funding for work to address the two issues separately fall far short of the level required to meaningfully tackle either one. Although many governments and donors have significantly increased their contributions to the effort to address HIV&AIDS, funding and programming still remain inadequate to need. And few governments have made a serious commitment to eliminating violence against women and girls – in and of itself or in the context of combating HIV&AIDS.

Main Findings:

1. Multi- and bilateral agencies examined continue to treat gender-based violence as an "add-on" rather than as integral to all aspects of their work on HIV&AIDS.
2. Within policy and programmes, violence against women and girls is rarely highlighted as a major driver and consequence of the disease, nor measured statistically as a means of contributing to the evidence base.
3. It is extremely difficult, if not impossible to determine the precise amount of money contributed to work at the intersection because none of these donors specifically track their programming for and funding to violence eradication efforts within their HIV&AIDS portfolio. The difficulty of tracking spending on these areas increases the difficulty of holding donors and other actors accountable and of advocating for increasing funding from national governments as well as from external funding institutions.
4. **The source of the problem rests in gender inequality**. Governments, multilateral agencies and bilateral donors have failed to confront adequately the intersection of violence against women and HIV&AIDS, as well as to seriously face up to the pervasiveness of violence against women and girls, because they lack a serious commitment to challenge gender inequality, integrate a gender analysis, allocate necessary resources to gender equality work

RECOMMENDATIONS

In order to develop and then translate policy into action to integrate violence against women into the HIV&AIDS programming, it is recommended:

1. **Develop and articulate a clear policy framework** that gives priority to violence against women and girls, HIV&AIDS and their inter-linkages.
2. **Create a specific means for measuring work that addresses violence and all forms of discrimination against women and girls in HIV&Aids plans**.

3. **Conduct a follow-up study** that explores the level of support for work that addresses the violence against women and girls and HIV&AIDS intersection at the field level, to assess what programming is taking place, by whom and to what effect.
4. **Encourage cross-issue collaboration** to help groups working on violence against women and girls and those working on HIV&AIDS work together.
5. **Investigate, document and fill the gaps** on the knowledge about the intersection of violence against women and girls and HIV&AIDS.
6. **Establish a framework of accountability** using user-friendly indicators and programming guidelines.
7. **Foster and sustain linkages between HIV&AIDS and the sexual and reproductive health and rights sectors.**
8. **Create or refine global health tracking systems** in collaboration with civil society and social movements.
9. **Lead by example and support political leaders at the national level** to face both of the problems seriously.
10. **Address all forms of violence and discrimination against women and girls**.

Beyond ending violence, gender-sensitive efforts require striving toward a greater goal – achieving gender equality, women's and girls economic, social and political empowerment and creating the conditions for safe, healthy and consensual sexuality and life choices for all – including the possibility of safe and pleasurable sexuality for HIV-positive women and men.

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