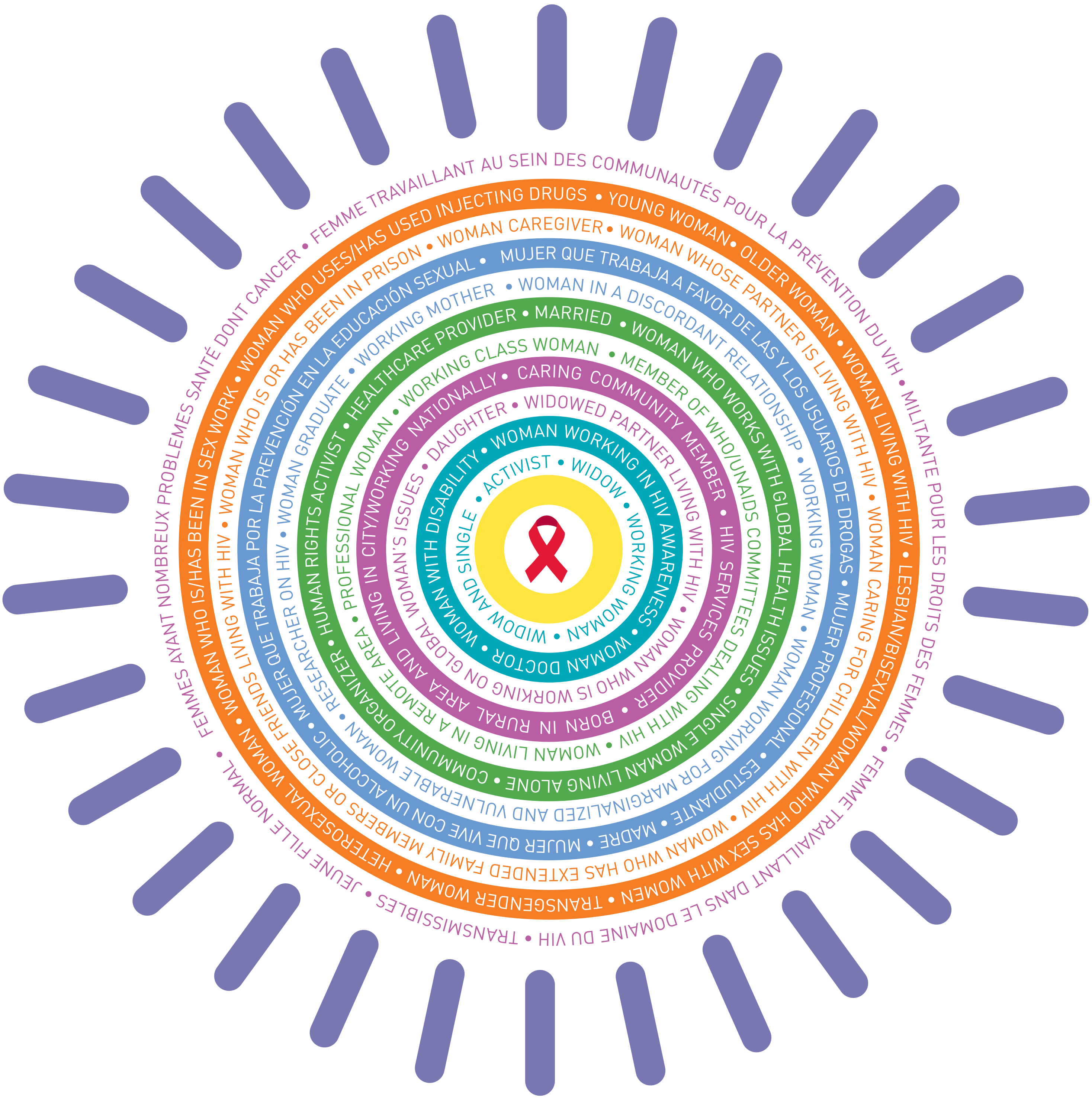
COMMUNITY INNOVATION

Achieving an end to gender-based violence through the HIV response



The Global Coalition on Women and AIDS

ATHENA

Acknowledgments

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We also would like to acknowledge the pioneering individuals, communities, networks and organizations who are leading innovation to address gender-based violence (GBV) as an integral part of effective HIV responses.

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For a list of participating entities and contact details, please see the section "Participating entities, contacts and related links" at the back of this report.

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INTRODUCTION

Addressing gender-based violence (GBV) is an essential part of realizing the rights and achieving the health, dignity and welfare of all people, and it is an essential component of the global response to HIV. There has been a growing recognition of (and attention to) gender inequality – including GBV and harmful gender norms – as a contributing factor to and consequence of HIV. Current evidence demonstrates that women who have experienced violence are more likely to have HIV, and that women living with HIV are more likely to have experienced violence.[1]

While the linkages between GBV and HIV are increasingly recognized not enough is being done to address GBV in the context of HIV responses. GBV and HIV can be prevented, and that is why the ATHENA Network and the Global Coalition on Women and AIDS (GCWA) – with support from the Joint United Nations Programme on HIV/AIDS (UNAIDS) – have partnered to produce this compilation of innovative case studies. It builds on the 2011 *Community Innovation* report, which explored community-led action to advance sexual and reproductive health and rights through the HIV response (and vice-versa) from different community perspectives, by showing how communities themselves are taking action on these vital issues.[2]

The case studies provided are examples of what can be done, how results can be achieved in ways that meaningfully include communities and empower women, and how sustained action and real innovation comes from local initiatives that are born in communities, but that also serve as lessons for the international community. As a result, the case studies are strong examples of community actions and women's innovation and leadership.

Definitions

Violence against women

"any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"
Declaration of the Elimination of Violence against Women, UNGA 48/104

Intimate partner violence (IPV)

"behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours"
World Health Organization (WHO), Violence against women: intimate partner and sexual violence against women fact sheet. Available at: http://www.who.int/mediacentre/factsheets/fs239/en/index.html

Violence against women living with HIV

"any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV"
Hale F and Vazquez M, Violence against women living with HIV/AIDS: a background paper, 2011

EXECUTIVE SUMMARY

Gender-based violence and HIV are closely linked. There is growing evidence indicating that women who experience IPV are more likely to acquire HIV, while women and girls living with HIV experience high rates of IPV and other forms of violence.[3] Understanding and addressing the linkages between GBV and HIV is thus vital to ensuring that the rights of women – in all our diversity, living with, affected by or vulnerable to HIV – are upheld.

Women face multiple forms of GBV, including IPV, structural violence and institutional violence. Manifestations of such violence can include violence committed by a partner in the home, abuse of power by police officers or other government officials that perpetrates violence, and forced or coerced sterilization of women living with HIV. In order to reflect the multiple forms and arenas in which GBV exists and is experienced by women and girls, this report explores GBV broadly across sites, communities and in different manifestations.

The case studies presented here are a testament to what communities are doing to address GBV and respond effectively to the needs and rights of women within the HIV response. Each study demonstrates the capacity for innovation, resilience and passion that communities –and women themselves – bring to the table. While further evaluation is needed to build the case for the use of these approaches, experiences on the ground already reveal promising practices that demand further investment and consideration for future interventions.

This report presents case studies detailing promising community-led interventions that address the intersections of GBV and HIV. They are drawn from across regions, although in the process of producing this report, it became evident that there are significant variations in responses to HIV and GBV between and within regions, with more innovative and advanced approaches evident in some settings than others. It is hoped that the included case studies will inspire the sharing of additional case studies from stakeholders across the globe, and that they will inform innovative responses in diverse settings, regions and communities.

This report complements the UNAIDS advocacy paper *Unite with women, unite against violence and HIV*, as well as the World Health Organization (WHO) and UNAIDS programming tool *16 Ideas for addressing violence against women in the context of the HIV epidemic*, building on the work of these publications and ensuring that community-led innovations are documented and recognized.[4,1] In fact, many of the case studies presented in this report intersect with the programming ideas set out in the *16 Ideas* document.

The breadth and diversity of the innovation featured in this report reflects the priority that women living with HIV, women affected by HIV, and other leaders in the HIV response have attached to addressing GBV in their communities. A clear theme that unites many of the projects and interventions, however, is the challenge of securing sustainable funding. Many of these innovations are pilot projects that, despite promising results, have struggled to secure funding for further implementation, scale-up and evaluation. While women living with HIV, activists and allies all are developing and implementing innovative responses to GBV in the context of HIV, more coordinated action and resources are needed to fund, evaluate and sustain this work. Many of the projects and implements profiled here are in the early stages of development, and evaluation – including independent evaluation – is needed to grow them from potential innovations to fully fledged interventions.[5]

Achieving the aims of protecting, respecting and fulfilling the rights of all women living with, affected by or vulnerable to HIV – as well as halting and reversing the HIV epidemic – can only be achieved by addressing GBV. To achieve this bold aim, women activists and leaders must be recognized and supported, and promising and effective practices must be expanded and replicated (where applicable). In a policy context of increased recognition and evidence of the interlinkages between HIV and GBV, there is a real opportunity to learn from community-led responses to this interplay and to help end both the AIDS epidemic and GBV in all its forms.

1. Breaking the silence on taboo issues

NAMIBIA

Women living with HIV mobilizing to address rights violations: halting forced and coerced sterilization in Namibia

Institutionalized violence

Forced and coerced sterilization of women living with HIV is a human rights violation and an act of institutionalized violence against women, and it has been reported by women living with HIV in different regions as one way in which their sexual and reproductive rights are violated.[6] Driven by ignorance, stigma and discriminatory attitudes – including misinformed beliefs around doing what is best for the woman and the community-at-large – health-care services and workers remove or compromise the ability of women to make their own reproductive choices, thereby violating their reproductive rights.

In Namibia, women living with HIV who had been subjected to forced or coerced sterilization came together and mobilized for change. The Namibia Women's Health Network (NWHN), a national network of women living with HIV, joined with advocates from the International Community of Women Living with HIV (ICW) to develop a multifaceted strategy to mobilize women, document abuses, build awareness and seek justice around forced and coerced sterilization.[i] The campaign – which provides both legal redress and community support and action to comprehensively respond to GBV – constitutes a groundbreaking model of community leadership and advocacy in addressing violence against women living with HIV.

The success of the campaign relied on NWHN's strong and effective partnership with a number of organizations, including ICW, the Legal Assistance Centre of Namibia and the Southern Africa Litigation Centre, as well as other allies from the HIV, sexual and reproductive rights and women's rights movements. It also built on earlier work by actors – including the Center for Reproductive Rights, ATHENA and ICW – that had recognized and documented forced and coerced sterilization of women living with HIV.

Collecting evidence and building a case

NWHN and ICW's campaign on forced and coerced sterilization in Namibia emerged through a five-day Young Women's Dialogue held in January 2008. Of the thirty young women living with HIV who participated in this dialogue, three reported their experience of forced and coerced sterilization.[7] Following the dialogue, research was undertaken by ICW in Namibia that engaged 230 women living with HIV in interviews and focus groups to explore their experience of discriminatory treatment within the health system. The research was supplemented with training and education on human rights for women living with HIV.

The research revealed that the forced and coerced sterilization of women living with HIV was widespread. Of the research participants, most reported some form of discrimination, and 40 of the 230 respondents reported experiencing forced and coerced sterilization. In these cases, participants indicated that they had not given their informed consent to a sterilization procedure. In some cases, a pile of paperwork that the women were unable to fully understand was provided

i. Links to the websites of the organizations mentioned in this report are included in the section "Participating entities, contacts and related links."

for them to sign while they were in labor; in other cases, women only learned that the procedure had been carried out after the fact. All women reporting forced or coerced sterilization were referred for legal support.

After the completion of the research, NWHN and ICW initiated a campaign in Namibia – the first of its kind – to seek justice for women affected by coerced and forced sterilization on the basis of their HIV status. The campaign also called for an end to such practices in Namibia.

Seeking justice and working for change

ICW published a report that presented the research findings, a review of the relevant legal obligations violated by the practice of coerced and forced sterilization, and recommendations to policy-makers.[7] Legal violations implicated in cases of forced and coerced sterilization include violations of the right to human dignity and bodily autonomy, the right to freedom from discrimination and the right to be free from cruel, inhuman and degrading treatment.

Of the 40 cases identified, 15 were taken as legal cases with the support of the Legal Assistance Centre of Namibia, and six were subsequently lodged with the courts.[8] The litigation process led to increased media attention, and it gave the campaign added weight and momentum. Furthermore, by working with national, regional and global partners – and by building bridges between the legal and human rights communities – the campaign gathered pace, leading to exponential growth in its visibility and impact.

Ultimately, three of the cases were heard in court in 2012, and the judge ruled that the women had been sterilized without their informed consent and should receive compensation.[9] The Namibian government subsequently filed for appeal. On 3 November 2014, the Namibian Supreme Court upheld the initial ruling, finding that the government was responsible for subjecting the three women to sterilization without informed consent.[10] This ruling represents a significant victory for the campaign and an important step forward for the rights of women living with HIV.

Alongside the legal process, the NWHN undertook an advocacy process to mobilize women living with HIV, leaders of HIV support groups and community advocates to create a social movement at the local level against forced and coerced sterilization. The campaign included community mobilization, education interventions, dissemination of campaign materials, press conferences, and radio and social media campaigns.[11] One activity was the Stop Forced Sterilization advocacy project, which was launched in September 2011 to inform traditional and community leaders about forced and coerced sterilization, and to secure their support for the campaign and the women affected. Other activities – led by women living with HIV and focusing on leaders of local HIV support groups – included the development of an advocacy road map, a radio advocacy campaign and a press conference, as well as the development and dissemination of education materials.

Support for this work was secured from the Ministry of Regional and Local Government, Housing and Rural Development, through which local councilors acted as patrons of the campaign. This political engagement and endorsement helped promote the visibility of the campaign and helped elevate the visibility of the campaign and the issue.

Support group leaders and members also participated in a five-day capacity-building training session, which covered topics such as human rights, leadership, advocacy, engaging the media and family planning. The training fostered the development of skills and mobilized further action in the campaign.

The campaign succeeded in raising awareness of the issue of forced and coerced sterilization of women living with HIV both nationally and internationally. It also succeeded in promoting the availability of information and legal support to women who may have been individually affected by forced and coerced sterilization. The campaign garnered significant media coverage at the local, national, regional and international levels, and across print, online, radio and TV.[8] This was partially achieved through the development of a broad coalition of civil society organizations and partners in support of the campaign.

The work has sparked growing recognition in international policy debates of the issue of forced and coerced sterilization among women living with HIV. It has also led to the inclusion of the issue in multi-country data collection and advocacy efforts (such as the Stigma Index). Furthermore, it has provided a model for replicating the process of evidence collection and documentation used in Namibia, as well as the methods of documenting cases, raising awareness about the issue, and campaigning for redress and justice for affected women at the country level (including in Kenya and Uganda, where similar campaigns have been implemented). This work continues to be led by ICW, in collaboration with national and international partners.

MALAWI

We Have Rights Too! Women living with HIV claiming their rights in Malawi

Educating to empower

In response to the violation of their rights by service providers and others within the community, the Coalition of Women Living with HIV and AIDS in Malawi (COWLHA) established a human rights education and empowerment programme between 2012 and 2014 for women living with HIV. The programme, entitled We Have Rights Too!, aimed to inform women about their rights and the standard of services and inclusion to which they are entitled. By doing so, it intended to enable them to claim their rights.

This is crucial because women living with HIV who participated in the project reported experiences of stigma, discrimination and violence, including being denied treatment and service in health centres and receiving abusive language and treatment from health workers on the basis of their HIV status. Within the community, women living with HIV were denied the right to marry and found a family, and they did not have access to social support (including social security). In fact, many reported that they believed they were not entitled to these things because they were living with HIV. Through We Have Rights Too!, COWLHA engaged women living with HIV, community leaders and health-service providers to collectively inform and promote change.

Promoting participation: making rights accessible

As a first step, COWLHA worked to translate laws and policies detailing the protection of the sexual and reproductive rights of women living with HIV – including their right to live free of violence – into Chichewa, the local language. These documents had previously been available only in English, making them inaccessible to many people. The translated texts were circulated as pamphlets to support groups for women living with HIV in order to promote their discussion and dissemination, including through guided discussions for those with lower levels of literacy. This increased accessibility was a vital and innovative foundation for ensuring the project reached grass-roots women, many of whom had reported that while they were aware that laws existed, they were unclear what rights and protections these offered (or how they could be accessed).

Participatory media campaigns on community radio also were used. Radio broadcasters were sensitized to issues around sexual and reproductive health and rights, HIV and GBV to ensure the coverage was of the highest quality. A weekly radio show was developed that included a phone-in component where people could ask questions and seek advice on sexual and reproductive health and rights; the radio show also covered topics such as laws and rights, means of seeking redress, and broader HIV and GBV issues. Interviews and programming featuring case studies – such as experiences of violence in health-care settings or violations of rights by police – also were used, as was expert and service provider input and the sharing of best practices. Ultimately, the radio programme allowed the campaign to reach more people across a wider geographical area, amplifying the project's influence.

In addition to working with women, We Have Rights Too! also worked with their male partners to ensuring their involvement in the campaign and working to transform harmful gender norms.

A peer educator approach was adopted, and 14 couples (composed of women living with HIV and their male partners) were trained using the Stepping Stones methodology to act as role models and community advocates who could provide information and guidance on violence to others in the community.[ii]

A further twenty individual peer educators, all women living with HIV, were trained to promote and advocate for the sexual and reproductive health and rights of

ii. Stepping Stones is a comprehensive training programme that addresses gender norms, communication and relationship skills; it also supports transformation in community and individual behaviours and attitudes about gender, HIV and violence. The methodology is explained in more detail in Chapter 3 of this report.

women living with HIV. Their role included providing information, guidance and referrals for services – including access to justice for women affected by violence – as well as working towards engaging traditional, religious and government leaders and officials. This helped to secure the longevity and the sustainability of the programme.

Claiming rights

We Have Rights Too! has resulted in improvements in the standards of treatment and care that women receive from health-service providers. An example of this was reported by one participant, who prior to the project had experienced denial of care during pregnancy and labor, eventually giving birth alone and unsupported in a health-care facility:

> **Things have changed now: I am able to access all the proper medical care from the health-care workers. I can access my CD4 count information, we are given drugs to give the baby when born away from hospital, and the health personnel are friendlier to us than before. Honestly, when I go to the hospital to access any medical care or family planning services, I don't fear anything because the health-care workers that the project has linked us with are always there to support us, and we are free to ask as many questions as we can.**

Improvements also were witnessed in the ability of women to claim their rights within their homes and communities. For example, work with community leaders and peer educators led to women living with HIV reporting that they were now able to access social support (such as paid community work and subsidized agricultural materials) that had previously been denied to them. Work with service providers also has established ongoing links between COWLHA activists and clinical providers that have resulted in improvements in the care received by people living with HIV. COWLHA is now seeking sustainable funding to maintain and expand the project.

NEPAL

Using media to reach rural communities to address GBV: the VOICES project in Nepal

Mutual understanding: raising awareness about the linkages between violence against women and HIV

Equal Access Nepal is a nongovernmental organization (NGO) that uses radio and other media to achieve social change by empowering listeners with information and transformative tools and ideas. Recognizing the prevalence and linkages between HIV and GBV in Nepal, the organization developed a project to promote knowledge and awareness of HIV and violence against women, and to reach rural and geographically isolated communities that may be missed by other interventions.

The result was the VOICES project, a radio-based intervention that brought information on HIV and violence against women to individuals and communities across Nepal. Implemented with a grant from the UN Trust Fund to End Violence against Women, the VOICES project was built on a recognition that previous programmes had addressed violence against women and HIV separately, leaving attitudes and behaviors around the links between them unchallenged. VOICES was therefore designed to tackle HIV and violence against women as interconnected issues.

Equal Access Nepal implemented the VOICES project between August 2007 to May 2010, combining the radio show, Samajhdari ("mutual understanding"), with community outreach and other initiatives. Twelve women living with HIV and/or with experience of violence joined the programme as community reporters. Trained in the collection and presentation of case studies, the community reporters worked within their communities to find women affected by violence and HIV in order to present their stories, which were then featured on the programme. The radio show also invited guests – including people living with HIV, survivors of violence, sex workers and relevant experts – to participate in debates, interviews, phone-ins, competitions and other content. In total, eighty-eight 30 minute episodes were created and aired.

Each programme opened with a short listener dilemma involving experiences of HIV and/or violence. The programme then moved to a discussion involving studio guests and listeners that was shaped by content gathered by the community reporters. Topics included the linkages between HIV and GBV, violence in the home, sex workers rights, disclosure of HIV status, family violence and more. Twelve episodes focused exclusively on the links between HIV and GBV, and all of the episodes addressed those links to some extent, either through case studies or interviews of women affected by both HIV and violence.

A three-pronged approach: mutually reinforcing strategies

The project included three core strategies:

1. **Capacity-building.** Equal Access Nepal recruited and trained as community reporters twelve women living with HIV and/or with experience of violence. Their task was to lead the delivery of the content and the radio programmes. A so-called training of trainers also was provided for 30 women who had been identified as community leaders (including women living with HIV and/or with experience of violence); these women in turn trained women in their communities on violence against women and HIV. Finally, the VOICES project provided six professional journalists with fellowships to support investigative reporting on the links between violence against women and HIV.

2. **Outreach and advocacy activities.** Trained facilitators were supported to lead weekly group discussions with 60 listener groups created in the target communities, with discussions focused on the content of the radio show, to ensure engagement and learning beyond the programme itself. Equal Access Nepal also supported collective action at the community level, including awareness campaigns.

3. **Awareness-raising.** After their initial broadcast, all of the radio programmes were recorded and

made available on DVD to radio stations for future rebroadcast. Equal Access Nepal also published a book featuring the investigative features developed by the journalists who had been awarded fellowships, and it produced a documentary focusing on the experiences of the community reporters.

Mutual respect: recognizing rights

The results of the project included direct benefits for participants. The community reporters, for example, noted that not only did they have increased confidence and skills, but they found support through sharing experiences. Some community reporters also indicated that their participation in the project led to further economic opportunities, including professional journalism.

Surveys and focus groups with listeners and listening group participants revealed significant change in knowledge, attitude and individual behavior. In particular, the endline survey found that among regular listeners, 78% of women and 69% of men were able to identify a link between HIV and violence against women (compared to 70% and 59%, respectively, at baseline).

Results reported in the endline survey, which was carried out at the end of the project, include:

- **78.0% of women and 69.3% of men respondents to the endline survey reported that a woman experiencing violence is at risk of contracting HIV** (compared to 69.6% and 59.4% respectively at baseline).
- **67.9% of women respondents disagreed or strongly disagreed with the statement that "women should tolerate violence"** (compared to 41.2% at baseline).[12]
- **79% of men and 89% of women agreed that intervention to stop violence against women is necessary** (compared to just 13% and 26%, respectively, at baseline).[12]

Listeners also reported increased knowledge of violence against women and behaviors to respond to HIV and violence against women. Increases were seen in the number of women asking their husbands to test for HIV (11%, compared to 4% at baseline)[13] and in listeners who agreed that it was not acceptable for a husband to force his wife to have sex without her consent (60% at endline)[14].

Participants in interviews and focus group discussions observed their experiences of change as a result of the project:

> **"I have realized how violent I was, and now I regret what I have done. Now I tell other men to listen to Samajhdari, hoping that I can clean my sin.**
>
> Man who listened to radio programmes[15]

> **"I broke my 15-year-long silence after listening to Samajhdari and learning that forced sex, even by a husband, is rape, and Nepal's law has defined it as crime by giving it the name marital rape.**
>
> Woman member of listening group in Dang[16]

The endline survey also indicates the action taken by project participants as a result of increases in knowledge and changes in attitudes, reporting that for women participants:

After listening to the Samajhdari radio program, 78.3% shared the knowledge with others, 44.8% carried out activities against HIV/AIDs and violence against women, 21.3% took legal counselling service, 20.4% discussed with partners about sex, 11.3% practiced safe sex and 8.3% tested for HIV or persuaded their partners for the test.[12]

As this project demonstrates, embracing media in order to reach more people and achieve community coverage is a promising way of achieving change in attitudes and behavior. By supporting wider engagement through listener groups, the project's impact was amplified. The VOICES project has been evaluated as a model for other development programmes, and it won the Special Award at the One World Media Awards in 2010.[17] Equal Access Nepal has continued projects addressing HIV and GBV, but funding is a major barrier to carrying out further VOICES project work.

SUB-SAHARAN AFRICA

Addressing violence against children: Together for Girls

Building partnerships for global change[iii]

Together for Girls is a global public-private partnership focused on ending violence against children, particularly sexual violence against girls. The partnership brings together five United Nations agencies, led by the United Nations Children's Fund (UNICEF), as well as the U.S. government – including the Centers for Disease Control and Prevention (CDC), the President's Emergency Plan for AIDS Relief (PEPFAR), and the United States Agency for International Development (USAID) – and the private sector. Together, these organizations work to comprehensively prevent and respond to violence.

In partnership with national governments, civil society and the private sector, Together for Girls generates national data illuminating the issue of violence against children, and it mobilizes support for country-driven efforts for change. Collectively, the partners combine their unique strengths and expertise to ensure a coordinated and robust response, and to enable three practical and effective steps:

1. **create national surveys and data** to document the magnitude, nature and impact of physical, emotional, and sexual violence against children in order to inform government leaders, civil society and donors;

2. **implement evidence-based coordinated policy and program actions** in countries to address issues identified through the surveys, including legal and policy reform, improved services for children who have experienced violence, and prevention programs; and

3. **promote global advocacy and public awareness efforts** in order to draw attention to the problem and encourage evidence-based solutions.

Building the evidence base: growing a global understanding of violence against children

While violence against children occurs in every country in the world, Together for Girls' work is focused on lower-income nations.[iv] In sub-Saharan Africa, national-level surveys have found that about one in three girls and one in seven boys have experienced sexual violence before the age of 18. About one in four girls report that their first sexual intercourse was forced, and more than half of both girls and boys have experienced physical violence during childhood.

The data provide a rich and detailed picture of not only the prevalence of violence, but also the circumstances surrounding it and some of the long-term consequences. Violence occurs in homes, in schools and in the streets, and the contexts for this violence range from war to dating to parenting. This violence is perpetrated most frequently at the hands of people children know, including parents, relatives, neighbours, teachers, friends and dating partners – the very people who should be keeping them safe.

While violence against children is a human rights violation of the highest magnitude, there are other reasons to care. Girls who experience sexual violence are three times more likely to have an unintended pregnancy, and pregnant girls under 15 are five times more likely to die in childbirth. Girls who experience sexual violence also are two to three times more likely to contract HIV and other sexually transmitted infections.

Galvanized by the data, several governments are leading the way in their response and engaging every sector. For instance, while it is still in the early stages of implementing its action plan, the United Republic of Tanzania has already made progress by developing child protection systems in pilot districts. This comprehensive approach includes: children and gender desks at police stations; ethical codes

iii. With thanks to Sandra Taylor and her colleagues at Together for Girls for their support in drafting the case study on this initiative.

iv. To date, the partnership has completed surveys in Haiti, Kenya, Swaziland, United Republic of Tanzania and Zimbabwe. Field work or survey analyses are underway in Cambodia, Indonesia, Lao People's Democratic Republic, Malawi and Nigeria. In addition, Botswana, Côte d'Ivoire, Mozambique, Uganda and Zambia are scheduled to begin Violence Against Children surveys in 2014 and 2015.

of conduct for teachers; additional social workers, police officers, justices, and health officers; a hotline to report abuse; and community training for local volunteers.

Catalysing innovative approaches at the community level

Partner countries also are pioneering innovative programs to engage children and teach them about their rights – a crucial first step to breaking the silence and stigma surrounding violence against children. Examples include:

- **In Swaziland, a local NGO called Swaziland Action Group Against Abuse (SWAGAA)** leads nearly 40 girl empowerment programmes at primary and secondary schools each week in all four regions of the country. The clubs are led by peer mentors and provide a safe space for girls to discuss issues affecting them and their community. The clubs facilitate confidence building, leadership and friendship, and they encourage girls to use art – such as poetry, drama, music, dance, drawing, writing, speech and debate – as a form of expression. The peer mentors also discuss and disseminate information about child abuse, human trafficking, sexual health education, and other risks and challenges that girls face, as well as possible solutions.

- **In Kenya, the Lwala Community Alliance, a local NGO, is piloting mentorship programs for girls called Salama Pamoja ("safe together")** to help at-risk girls negotiate the threat of GBV and empower them to become agents of their own safety and success. The programme is currently completing its first cycle, having successfully trained nine female mentors and organized weekly clubs for 45 in-school and 50 out-of-school girls at high risk of violence. Lessons focus on self-esteem, life skills, personal safety skills and tactics, and sexual and reproductive health, and they provide a space for girls to openly share their experiences. Girls also are taught income generating activities.

- **In the United Republic of Tanzania, Tuseme ("let's speak out!") clubs** composed of both girls and boys come together three times a week outside of regular school hours to learn about both their rights as children and the new laws and resources that have been established to protect them. More than 40 of these clubs – for children aged nine to 13 who have been elected by their peers and teachers – have been established in four pilot districts. With guidance and counselling from teachers, children discuss issues such as HIV and AIDS, female genital mutilation, neglect, child labour and other perils all too common in their environment. They also learn when and where to report abuse, and why speaking out is critical to protecting their future.

Violence against children is an egregious violation of human rights that causes significant trauma to the individual. It also has far-reaching negative impacts on society-at-large, with a wide range of public health, social, and financial effects that impair long-term development objectives. By working together to better understand the fundamental sources and drivers of this violence, and by helping governments and civil society mobilize to address it, we are protecting and nurturing the well-being of the world's most precious and vulnerable resource – our children.

2. Prioritizing women on the margins: bringing the margins to the centre

UKRAINE

Women who use drugs challenging GBV in Ukraine

Denial of services and increasing risk

The prevalence of HIV in Ukraine is amongst the highest in eastern Europe and central Asia, and drug use is a major driver of the HIV epidemic in that country.[18] Women who use drugs are at particular risk of acquiring HIV and experiencing violence, and they are further affected by lack of access to services, in part because most shelters for women affected by violence refuse to admit women who use drugs. Furthermore, women who use drugs or do sex work often cannot access free medical and social services or obtain secure housing because such access is contingent upon having a passport and formal residency status, and women who have been imprisoned lose their passport.[19]

When Women Move Forward the World Moves with Them is a project devised and led by Club Svitanok, a community-based organization established in 2002 by people living with HIV and people who use drugs in Ukraine. The organization's mission is to improve the quality of life of people from these groups, increase their access to services, reduce stigma and discrimination against them, and work for the realization of their human rights. Club Svitanok piloted the project with financial support from the United Nations Office on Drugs and Crime (UNODC), and later from the All-Ukrainian Network of People Living with HIV and Health Rights International. The project – which began in 2012 and continues to date – was established to improve the mental, physical and social well-being of women and girls living with (or affected by) HIV by providing gender-sensitive HIV programmes for women. It also sought to address GBV in harm reduction settings, including through the establishment of a shelter for survivors of violence.

Club Svitanok implemented the project in Donetsk, Ukraine, and in six towns in Donetsk Oblast. The project focused specifically on women who use drugs and/or do sex work who are either accessing services or outside existing services, women service providers living with HIV, and women who had experienced violence. Its objectives were to promote gender sensitivity in harm reduction and other services, and to provide direct support to women affected by violence. The project adopted a combination approach of meeting the immediate needs of women who were experiencing (or vulnerable to) violence, as well as addressing longer-term interests.

Meeting basic needs and addressing strategic interests

A number of activities were carried out through the project. This included the establishment of a shelter for women affected by violence and peer-led harm reduction outreach services offering counselling, social support and professional legal or psychosocial support to women who use drugs and women who do sex work. Social support to women with children – including childcare, nutrition, baby formula, nappies and baby clothes – also was provided.

Specialist materials were developed to provide information and signposting on HIV and violence, and information workshops were held with women. Advocacy using peer-led and multidisciplinary

approaches to promote gender sensitivity in harm reduction and care and support services also was undertaken.

The project reached 580 women with social, legal, counselling, medical or other support in the first year of operation. This included 200 women who had not previously accessed HIV services, and 100 women who received material aid (including practical and household items). Twenty-five women and five men attended training on HIV, gender, violence against women, and sexual and reproductive health and rights, and 20 women and their children participated in a summer camp providing peer support. The project also trained and supported a group of women living with HIV as peer counselors and advocates, instructing them in counselling, activism and other skills. These women are now active in national and regional campaigning.

Club Svitanok also established a cohort of trained and HIV-sensitized health-care workers and other professionals though the project. This was done to provide discrimination-free comprehensive services and support for women living with HIV that incorporated HIV prevention, testing, care and treatment, as well as harm reduction and other targeted interventions.[20]

Preparing the ground for scale-up

In addition to the 580 women living with or affected by HIV who were reached in the first year of the project, specific interventions targeted at violence prevention were delivered successfully for twelve women living with HIV and their families. As a result of these interventions, the families reported improved relations within the home. A group of women living with HIV (who had been trained and equipped as peer counselors) also was established to organize and manage education, counselling and social support around HIV, violence, advocacy and empowerment. These peer counselors are currently involved in work to estimate and address violence against women regionally by documenting cases of violence against women who use drugs.

Based on the positive evaluations of the pilot project, Club Svitanok sought and received additional funding to take targeted violence prevention work into new settings. This represents a change in direction for the project as it expands to reach people otherwise unable to access services.

The project already has expanded to include working with people in prison to address the prevention of violence against women. Club Svitanok has previously worked in prisons providing care, support, treatment and prevention of HIV (including advocating against treatment interruptions); now, two psychotherapists (one man and one woman) with specialist training in working in prisons have been recruited to work directly on violence against women with prisoners. The intervention begins with a diagnostic interview to determine the participant's experiences and understanding of different forms of violence (including sexual, physical and emotional violence). Group work with facilitated discussions and informational training – where participants are able to learn about violence and its multiple forms – is then provided. The informational training focuses on the causes and impact of violence and its relation to HIV, and additional therapy is provided to people with experience of violence. The intervention supports women and men to understand and recognize violence, and it also supports behavior change among those who have perpetrated violence (or who may do so in the future).

Taking interventions to prevent violence against women into prisons is a promising way to reach people who are vulnerable to violence or who may perpetrate violence, as they are difficult to reach with other programmes. The pilot project has received strong levels of engagement and positive feedback from participants, and it also has identified and started to address the needs of this vulnerable population.

GLOBAL

Women with disabilities address violence

Links between disability, HIV and GBV

As a group, people with disabilities often experience marginalization, which can result in their needs and inclusion being overlooked during the development of programmes and policies addressing sexual and reproductive health, HIV and GBV. This is despite the fact that people with disabilities have an equal or increased risk of HIV infection and sexual violence.[21] That risk can be even greater for women living with disabilities.[22]

The term disability includes a wide range of conditions, including physical, sensory, intellectual and mental impairments. In relation to HIV prevention, care, treatment and support, people living with disabilities face a number of hurdles, such as *"limited access to HIV education, information and prevention services; [living with] at risk behaviors leading to HIV infection; limited access to HIV treatment, care and support; high vulnerability to sexual violence; limited knowledge and capacity of services providers to render inclusive services; and stigma and discrimination."*[21]

Handicap International has identified vulnerability to sexual and gender-based violence (SGBV) as a significant issue for disabled people, and it is addressing the linkages between SGBV, HIV and disability by building capacity, raising awareness, removing barriers, increasing accessibility, fostering policy change, encouraging participation of people with disabilities, and monitoring indicators and evaluation.[23]

Unmasking SGBV against people with disabilities

Recent research in Rwanda by Handicap International has found that able-bodied people commonly held discriminatory and stigmatizing attitudes towards people with disabilities. This made it nearly impossible for people with disabilities to access justice in cases of SGBV.[24] Some research participants felt that the community did not regard them as human or in need of human rights; others believed they were not seen as sexual beings, making it difficult for community members to imagine the possibility of them being affected by sexual violence. At the same time, men with mental impairments were more likely to be thought of as the perpetrator of SGBV than to be considered a victim. This is problematic because both notions mask the very real and often heightened vulnerability of disabled people to such violence. Another research study conducted by Save the Children and Handicap International in Burundi, Madagascar, Mozambique and the United Republic of Tanzania found that the marginalization and stigmatization of children with disabilities increases their susceptibility to SGBV.[25]

Making a difference in communities around the world

Poor understanding and limited data on the linkages between HIV and GBV among women, men and children with disabilities – combined with the challenges of reaching this population with information and services – necessitates responses that are flexible, innovative, community-driven and responsive.

In Cambodia, Handicap International launched a participatory learning action project in 2007 to increase rights awareness among people with disabilities who were susceptible to HIV and sexual violence.[26] The project focused mainly on women who are deaf and their families, working to provide both a support network and information about medical, psychosocial and legal support.

An unforeseen challenge soon presented itself, however: in the absence of access to formal sign language education, many of the women had created their own sign language to use within their family. This made it difficult for the women to communicate outside their own families, increasing their isolation, familial dependence and vulnerability to violence. With the support of its local partner, Deaf Development Programme Cambodia (DDP), the project therefore focused on teaching the women Cambodian sign language. The team also was forced to create new sign language terminology for reproductive health, sexual violence, and HIV, as Cambodian sign language did not

include these terms, illustrating the extent to which information was lacking for the deaf population in Cambodia.

The educators taught the women about sexual and reproductive health by providing the information through sign language, visuals and participatory demonstrations. The multifaceted learning approach was essential to the project's success; learning sign language first-hand, creating key signs for vocabulary, using easy-to-understand pictures along with constant practice of sign language within the family – provided the women with a better understanding of their rights.

In Rwanda, a nationwide project worked to ensure that the needs and rights of people with disabilities were included in the HIV and GBV responses at the country level. The project worked with four disabled peoples' organizations to support their institutional and technical capacity to respond to HIV, and with three community-based organizations to improve their capacity to include disability issues in their HIV response. In addition, a national technical working group was established to support the integration of HIV, disability and GBV in national policies. The project has witnessed improved capacity and integration at the local level, resulting in more (and better) access to services for HIV and GBV for people with disabilities. Furthermore, the Ministry of Health of Rwanda and the Rwanda Biomedical Centre are integrating training on SGBV against people with disabilities into the core HIV training modules for health-care professionals.

These projects indicate the importance of assessing the specific needs of people with disabilities related to SGBV, and they work towards ensuring that these needs are communicated effectively with actors at the local, voluntary and national levels. Collaborating with communities to identify needs and develop innovative strategies – from sign language development and teaching to technical support – is essential to meeting the under-recognized needs of marginalized communities.

3. Communities addressing harmful gender norms in complex settings

SOUTH AFRICA

Combining Stepping Stones and livelihood intervention tools in informal settlements

Intricately linked: poverty and GBV

Poverty and gender inequality are interlinked and intersecting drivers of IPV and HIV.[28] For women experiencing poverty and marginalization, the inability to secure work, the unstable nature of livelihoods and the scarcity of food all overlap with gender inequalities. This forces women to be economically and socially dependent on men, increasing their risk of engaging in transactional sex, limiting their ability to negotiate condom use and placing them at higher risk of IPV.[1] Correspondingly, it has been suggested that that in similar situations of poverty and marginalization, men can respond to a sense of limitation in certain areas of their lives by seeking to control women, often violently.[29] By utilizing a dual approach that inclusively addresses gender norms and builds livelihoods, it may be possible to reduce men's perpetration and women's experience of IPV, while ensuring that economic empowerment does not lead to increased violence.

Informal settlements in South Africa are affected by particularly high prevalence of HIV, IPV and livelihood insecurity. Working in urban informal settlements, a 2012 Stepping Stones and Creating Futures project adopted this dual approach to reducing HIV vulnerability and IPV with a young cohort of participants (the average age of participants was 21.7 years). The project aimed to enable participants to address and improve their livelihoods, to redefine their knowledge, understanding and behavior around gender norms, and to reduce behaviors that increase the risk of acquiring HIV. In particular, the intervention

Introduction to Stepping Stones methodology

Stepping Stones is a comprehensive training programme addressing gender norms, communication and relationship skills; it also supports transformation in the behaviors and attitudes of individuals and communities. A foundation stone of the methodology is that it should be used with men and women, in at least four groups disaggregated by gender and age (older men, older women, younger men, younger women), to address and change behaviors and norms about gender (including violence against women). The programme thereby works to address HIV prevention, stigma and discrimination, and by working across generations and genders, it can address intergenerational sexual relationships and power imbalances.[27]

The Stepping Stones programme has been used and adapted in multiple settings and with different communities, and it has been translated into 20 languages.[27] The case studies presented below represent further innovative ways in which Stepping Stones is being adapted to address GBV and meet specific needs in complex and challenging settings.

focused on younger people in recognition of both the increased violent behaviors of men in that age group and the particularly high risks of IPV and HIV experienced by younger women.

A dual approach: combining structural and behavioral interventions

The project was devised and implemented by the Health Economics and HIV and AIDS Research Division (HEARD) at the University of KwaZulu-Natal (UKZN), the Gender and Health Unit of the South African Medical Research Council (MRC) and Project Empower, a Durban-based NGO. It combines two methodologies. The first is the South African version of Stepping Stones, a widely validated behavioral intervention tool that addresses gender norms, violence and HIV. The second is Creating Futures, a structural intervention designed by the project partners that utilizes participatory methodologies to engage participants in reflecting on their livelihoods and acting to pursue improvements to them.[30]

The project worked in two informal settlements in Durban. Due to a mixture of constrained finances and the social instability of informal settlements, the team decided to work just with young men and women. Project Empower used their community knowledge and contacts – as well as tools such as flyers, SMS and community meetings – to identify participants. Participants also were able to refer friends and family. In total, 232 young women and men (110 men, 122 women) were engaged in the project.

The curriculum consisted of 21 sessions, 10 drawn from Stepping Stones and 11 from Creating Futures. Each session lasted for three hours and included about 20 participants in single gender groups (except for one mixed session). The project was delivered by trained peer facilitators over a period of 12–14 weeks. The facilitators were all under the age of 25, and some came from informal settlements.

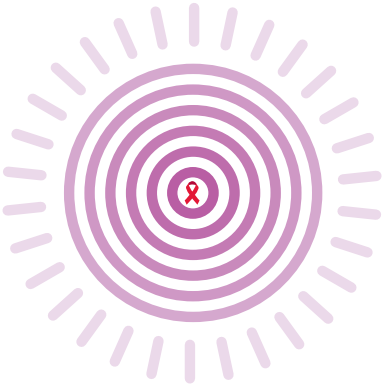
Participatory methodologies and adult learning approaches were adopted, with participants encouraged to reflect on and address the causes of their actions; they also were engaged in activities such as drama, mapping exercises and group discussions. As the participants were young, and seeking employment, they were highly mobile, and so the decision was taken to adopt a shorter time frame for delivery of the intervention.

Strengthening livelihoods and reducing IPV

At the start of the project, only 65.2% of men and 36.1% of women reported working or earning within the past 12 months. Many reported hunger, food insecurity and high rates of IPV: 30.3% of women had experienced either physical or sexual IPV within the past three months before the project initiation, while 25% of men reported having perpetrated either physical or sexual IPV within the past three months.[31] A pilot evaluation of the project was conducted over a 12-month period, and it found that the project was effective in improving livelihoods, with a statistically significant increase in earnings in the past month before the evaluation was conducted of 280% for men and 346% for women. Participants also reported being more able to find money to cover an emergency, and they described lower levels of stress relating to their livelihoods.

In terms of IPV, women reported a reduction in their experience of sexual IPV in past three months (from 11.1% at the baseline of the project to 3.6% at the 12-month evaluation). Experience of physical and/or sexual IPV also declined, from 30% to 19%. While male participants did not report a statistically significant reduction in the perpetration of violence, there was a significant decrease in reported controlling behaviors over women partners. Gender attitudes also were improved.[31]

This project demonstrates the value of using tried and tested interventions to develop an innovative dual approach to HIV and GBV prevention that tackles the structural drivers of HIV vulnerability and IPV. By including men, engaging youth and addressing livelihoods alongside gender norms, positive results were achieved in terms of women's reported experience of violence.



DEMOCRATIC REPUBLIC OF CONGO

Utilizing Stepping Stones in conflict-affected settings

GBV in conflict-affected settings

The challenges of addressing harmful gender norms and GBV can be compounded in situations of conflict and social instability. For instance, conflict and instability persists in the Democratic Republic of Congo, with ongoing violence (including widespread sexual violence), militia activity and humanitarian challenges, all remnants of the war that gripped the country from 1998–2003.[33] In this context, violence against women, sexual violence and harmful gender norms have proliferated, and the prevalence of HIV among adults (15–49 years of age) in the Democratic Republic of Congo is 1.1%, with an estimated 480 000 people living with HIV.[32]

In September 2011, a project supported by the United Nations Development Programme (UNDP) sought to address these challenges in the Democratic Republic of Congo. Utilizing the Stepping Stones programme, the project worked with a community affected by conflict to address harmful gender norms and GBV and in an effort to achieve significant change.

Adapting Stepping Stones to local contexts

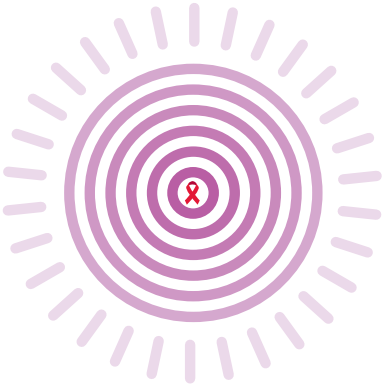
In order to address these issues, the Stepping Stones training package was used in South Kivu province. Based at the Walungu training centre, the project aimed to change gender norms and improve knowledge, attitudes and practices around HIV, while also reducing stigma, discrimination and GBV.[34]

The project was able to work with four peer groups from the community: older men, older women, younger men and younger women. A broad range of participants were engaged, including secondary school students, police, spiritual and religious leaders, health workers, people living with HIV, voluntary blood donors, tradespeople and others.

In the context of widespread sexual violence, the gender transformative approach of Stepping Stones was adopted to address harmful gender beliefs and behaviors. An extensive evaluation of the project (involving a written questionnaire and focus groups) reached 183 people, including Stepping Stones participants and their family members.

Achieving change

The findings of the evaluation are striking, with progress demonstrated on all elements of the project. Between a baseline survey conducted in 2011 and the project evaluation in 2013, progress across a range of indicators is apparent.[35] The percentage of respondents agreeing that women should have the same rights as men increased from 25% at baseline to 41% at the project conclusion. The evaluation also found 78% of respondents reported that a woman could require her husband to use condoms, 69% agreed that a woman had the right to refuse sex with her husband, and 84% agreed that a husband did not have the right to beat his wife. The success of the project has led to plans to implement a national roll-out of the Stepping Stones model.



UGANDA

Stepping Stones in settings affected by violence and small arms proliferation

Adapting Stepping Stones to different settings

The original Stepping Stones training package has now been adapted for use in settings affected by violence. The adapted manual – *Stepping Stones for peace and prosperity* – was developed by Baron Oron of the Network for Stepping Stones Approaches (NESSA), Germina Sebuwufu and Alice Welbourn of the Salamander Trust (and author of the original Stepping Stones manual).

The adapted manual was piloted in Karamoja, in northeastern Uganda, in a setting of violence in order to address small arms proliferation and increasing sexual violence.[27] Funded by the World Bank LOGICA project, the pilot project – named Engaging Male Youth in Karamoja – featured an adaptation of the original manual undertaken by the Salamander Trust, implementation of the adaptation by NESSA, and qualitative and step-wedge quantitative evaluations by the Feinstein International Center (FIC) of Tufts University (USA).

The final adaptation of the manual is near completion and will be published shortly by Strategies for Hope.[36] Following original recommendations in the Stepping Stones training package, the adapted methodology takes an approach that is both intergenerational and cross-gendered, engaging men and women of different ages. This approach in Karamoja led to an increase in respect and positive relations between older and younger men, which in turn supported change in social norms and behaviors.[37]

Working with communities to address gender norms

Karamoja is a pastoral region with a history of cattle raiding and associated violence. The violence has increased in recent years, particularly among young men known as *lonetia*, a group defined by participation in such crime and (in some cases) possession of small arms. This is due to growing social and economic inequalities, with limited access to education and few economic opportunities. These young men lack the resources to own cattle and continue their traditional way of life, and they are unable to marry or start a family without economic security.

The Engaging Male Youth in Karamoja project utilized the tried-and-tested Stepping Stones approach, adapting it to address a combination of ongoing and emerging harmful behaviors (namely cattle theft and associated criminal activity, with the resulting violence exacerbated by the possession of small arms). Although most young men participating in the project were not *lonetia*, those that were reported higher levels of perpetration of violence: among *lonetia* young men, 25% had assaulted a woman in the household in the past two months prior to the survey, compared to 5% of non-lonetia young men.

The project was implemented over ten weeks in seven locations. Participants included men and women in older and younger groups. Sessions were led by peer educators and included facilitated discussions, role playing exercises and guided self-reflection. The project was implemented alongside an existing livelihoods programme (delivered by Concern Worldwide) that offered vocational skills training. NESSA used the long-term links of FIC in Karamoja to gain access to the community.

Addressing GBV: changing harmful norms

An extensive evaluation of the adapted Stepping Stones pilot found clear and positive change as a result of the project, including positive changes in domestic relations and a reduction in domestic violence (as reported by men and women participating in qualitative interviews). At baseline, 43% of the total study population agreed that "it is acceptable to beat your wife if she misbehaves," with this behavior defined to include refusing sex. At the final survey, this number had declined to 23% of respondents. This was found for both direct project participants and those living in project intervention areas who did not participate in the programme.

By contrast, no change was found in control areas, strongly indicating the benefits of this intervention for the entire community in which it is implemented. This positive change also was found to increase over time from the delivery of the intervention, indicating a sustainable positive impact on social norms. This is further reflected in the qualitative data, with

participants reporting changes in community attitudes and responses to domestic violence.

Positive changes also were found in intergenerational relations, with participants suggesting that an increase in respect that the younger men had for the older men had helped to ease community relations and reduce violence.

Some of the findings, however, were mixed. With respect to actions (rather than perceptions) of domestic violence, the quantitative data suggests no statistically significant change. A group of women surveyed in the evaluation summarized the changes achieved by the project:

> **[The program] changed attitudes completely; [things are] totally different since the coming of Stepping Stones. It has brought cooperation [between] family members like mothers and fathers. The man used to be lying under the tree; today they share ideas together. If it's cultivating – they all go together; if it's looking for survival, they share together.**[38]

Alcohol was identified by both men and women as a driver of domestic tensions, with over 90% of respondents (men and women) reporting regular alcohol consumption, a rate that persisted throughout the evaluation period. There was, however, a reported decrease in the average intake of alcohol after the project. Participants cited Stepping Stones as a cause for both the reduction in alcohol intake and the changed behavior, which included a decrease in fighting when alcohol had been consumed.

In order to build on the findings of the pilot, the authors of the evaluation recommended a longer-term operational research programme integrating livelihoods and gender norm interventions. They suggested this should be done by continuing to work with both men and women, and by pursuing an intergenerational approach over a broader geographic area. Future programmes also should feature focused work to support the socioeconomic issues facing the *lonetia*. Overall, however, the evaluation findings indicate that addressing gender norms through an adapted community-specific approach is an effective way to change beliefs around GBV.

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Participants in the Stepping Stones project, Karamoja, Uganda.

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4. Making the personal political: women taking agency to address GBV

SUB-SAHARAN AFRICA

I am/More than: addressing power, autonomy and violence for lesbian and bisexual women in Africa

Understanding power dynamics

The Coalition of African Lesbians (CAL) is a membership-based, feminist coalition of more than 30 organizations working to promote justice for lesbian, bisexual and trans women. While identifying with a lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) framing, CAL adopts a broader feminist approach to analyze issues in terms of power and autonomy (rather than identity). Describing their approach, Dawn Cavanagh, director of CAL, explains:

> **Our framing is around sexuality and gender... within that, to try to get some focus, we are increasingly looking at the issue of a lack of autonomy over our bodies and lives as people who are regulated as women.**

This framing recognizes violence against women who are lesbian, bisexual or trans as being part of a broader structural issue of power imbalance and the regulation of women's lives, bodies and sexualities. Violence, discrimination and constraints are a product of the lack of autonomy.

CAL has invested significantly in developing an intellectual framing and understanding of GBV to inform and underpin their programmatic work, which is a product of a principled and deliberate focus on prioritizing thinking and reflection, in order to enable more effective campaigns and interventions. This includes a deliberate process of adopting an agenda-setting approach, and in so doing, moving away from a reactive space to take a leadership and steering role. As Dawn Cavanagh explains:

> **We are really trying to shift from a politics and a space of victimhood to a place of agency and power, where we set the agenda and we anticipate [government activities that undermine the rights of LGBTQI people].**

Addressing HIV and GBV

In this context, CAL has addressed HIV and violence as themes within the three strands of work they carry out: advocacy and thought leadership, development and capacity-building of members, and a programme supporting women human rights defenders. Both HIV and GBV are understood within the framing of power and autonomy. CAL's philosophy highlights the core feminist ideas of choices, options and agency, and it reveals how women are regulated by social norms and expectations, leading to limited options and increasing their vulnerability to violence and HIV. Dawn Cavanagh described this process as follows:

> **We are regulated as women; we are often the possessions of our fathers and then the possessions of our husbands. By being a possession – by being owned – it means that the decisions about my body and about my life are made by somebody else, and supported by all the institutions in society right across the board: from the household, to the family, right through to the religious institutions and to the state and so on. There is affirmation and recognition and reinforcement of the regulation that constrains**

my ability to choose. Violence is the mechanism through which the regulation over my body and my capability to exercise my autonomy are regulated. Violence regulates our bodies and lives. Violence is not going to go away unless we start addressing gender, because gender-based violence is there to ensure that everybody complies with gender regulation. It's the same problem: HIV and violence. HIV is in part an expression of the constraints that are imposed on women in terms of their ability to exercise their rights.

Building on this, CAL has worked to develop and support partnerships with women activists, human rights defenders and organizations linked by experiences of criminalization and violence. This includes women living with HIV, abortion activists, LBT women, women who do sex work, and young women, all of whom share experiences of legal and state regulation reducing their bodily autonomy. This broad-based coalition is advocating for a transformative agenda of autonomy.

This work is especially relevant in the context of a continuing under-recognition of the vulnerability of lesbian, bisexual and other women who have sex with women to HIV and the high levels of sexual violence that drive this risk.[39] In South Africa in particular, homophobia and prejudice have led to lesbian and bisexual women being specifically targeted for sexual violence and rape.[40] CAL's work is vital to developing leadership amongst lesbian, bisexual and other women who have sex with women to respond to these issues.

Translating thought into action

CAL has developed the I am/More than campaign to engender collective advocacy on issues related to autonomy and to build a shared platform beyond an LGBTIQ identity frame.[41] The campaign builds on the thought leadership work CAL has undertaken and aims to achieve transformative change.

Taking as a basis a sexual rights campaign first conceived by CAL in 2008, the organization convened a seven-day workshop in 2013 to review, revitalize and strategize a new phase of the campaign. Through this process, a regional-level analysis was undertaken and shared issues were identified. The result was the I am/More than campaign, which was further refined by a 2014 sexuality and gender institute.

I am/More than is coordinated by CAL and led by member organizations in each of the participating countries: Botswana, Lesotho, Mozambique, Namibia, South Africa, Zambia and Zimbabwe. There are four major components to the campaign: mobilization, direct action and solidarity; lobbying and legal casework; research and documentation; and media and communications. The framing of I am/More than addresses issues of power and autonomy by recognizing commonalities between diverse women within a feminist framework that acknowledges lesbian, trans and other identities, while also underscoring that women are more than these identities.

Organizations that are members of CAL continue to address violence and implement research and project activities that are informed by CAL's framing. For example, the Triangle Project, a South African NGO providing health and support services, community engagement, research and advocacy to promote the rights of LGBTIQ people, produced a report entitled *Your hate won't change us! Resisting homophobic and transphobic violence as forms of patriarchal social control*.[42] This report contains case summaries of hate crimes, as well as a review of constitutional protection and domestic and international law and human rights legislation for LGBTIQ people. It also details the realities belying these legal protections before concluding with extensive recommendations to advance the rights of LGBTIQ people and to build an understanding of homophobic and transphobic violence as patriarchal forms of oppression.

BOLIVIA

Body mapping tools in Bolivia to identify and address experiences of violence

Identifying shared experiences and building community links

GBV against women in Bolivia is a documented and significant issue. In a 2008 national survey, 47.3% of women who had been (or were) married or in a relationship reported experiencing violence.[43] Although the Bolivian government announced that 2011 would be the Year of Fighting Against all Forms of Violence Against Women and participated in the United Nations-led UNiTE campaign, these activities did not acknowledge links between violence and HIV, or the specific risks of violence faced by women living with (or affected by) HIV. Recognizing this, the Bolivian Network of People Living with HIV/AIDS (REDBOL) undertook a UNAIDS-commissioned project in 2011 to explore and address HIV and GBV as connected issues.

REDBOL designed a project using participatory methodologies and working with women from three key populations: women living with HIV, women who do sex work, and transgender women. Women from each of these groups led and delivered the project as researchers, outreach workers and participants. In particular, the researchers were recruited based on their leadership skills and knowledge of their peer groups, as well as their previous research experience and skills.

The research design included a survey and focus groups, and REDBOL conducted the research in three cities that collectively account for 90% of diagnosed HIV in the country: La Paz, Santa Cruz, and Cochabamba. In each city, a team of three field researchers was formed, including one woman living with HIV, one transgender woman and one woman who engages in sex work. Having researchers from these three key populations helped to ensure access to and participation from each of the communities.

The team model initially caused some challenges, as women from different communities struggled to find commonalities. However, as the research progressed and the extent to which experiences of violence were shared between the women emerged, barriers were broken down. By working together as women – and by recognizing similarity over difference – the field researchers were able to build a strong collaboration. This was a particularly innovative and effective aspect of the research project, with important outcomes in confidence and movement-building.

Using body mapping tools to address GBV

In addition to undertaking a survey that used both quantitative and qualitative methods, REDBOL sought innovative research strategies to enable women to share and discuss their experiences of violence in a safe and supported way. Ultimately, body maps – used by anthropologists to support work with illiterate communities by using visual tools to capture information without language – were adapted for use in the focus groups. This facilitated active engagement from the women and ensured that the discussion of violence happened at a group level.

In each group, 15 participants were drawn from one of the communities represented in the project. Participation was voluntary and based on informed consent. Researchers split the participants into three groups of five, and women worked in their group to draw a body map depicting their experiences of violence and its physical and emotional impact. Women shared their own experiences and discussed this with their group while they drew the body maps; the larger group then came back together for further discussion and interpretation of the different body maps that had been produced.

Subsequently, all nine field researchers came together with the lead researcher to analyze the body maps and survey findings.

In total, 322 women participated in the research, and the results are stark:[44]

- **only 2 per cent reported that they had not experienced any form of violence;**
- **over 70 per cent had experienced physical violence;**
- **half (50 per cent) reported being forced to have sexual relations; and**
- **three per cent had been sterilized without their consent.**

Furthermore, the ongoing impact of experiences of violence – in terms of mental health, self-esteem and self-efficacy – were clear. In the words of one field researcher:

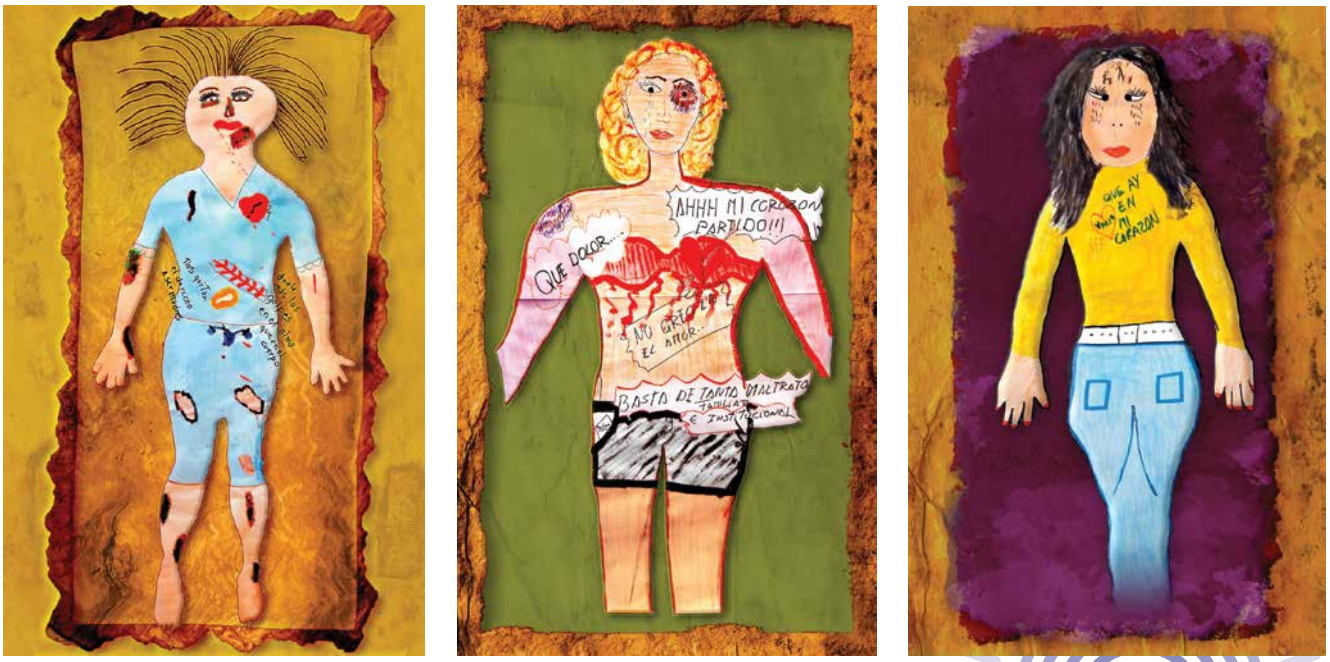
> **"One of the unexpected surprises for me was the magnitude of violence suffered by participants. The majority of them indicated that they had suffered all types of violence. Some participants had the perception that they were obligated to endure violence, that it was something normal.**[44]

Advocating for change

By working with women from diverse communities and building links and understanding of shared experiences, the project provided a strong platform for further advocacy. The field researchers and REDBOL team presented the research findings to local authorities, and given the prevalence of violence demonstrated by the findings, the researchers found them receptive and were able to secure strong participation from them.

The research findings were published in a report and presented at the International AIDS Conference in 2014. REDBOL continues to advocate on violence affecting women who do sex work, women living with HIV and transgender women, and it uses the research findings to build links to the broader women's rights movements advocating against GBV in Bolivia.

Furthermore, by establishing a broad coalition and building links outside usual identity networks, the research provided a foundation for further collaborative work. The body mapping process was repeated by partners working with gay men and lesbian women, and based on shared experiences, diverse networks began to work together as allies and partners. This has resulted in collaborative civil society work to jointly advocate around the country coordinating mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria.[45]



Body maps created by participants. From left: body map of woman living with HIV; body map of trans woman; body map of sex worker'

GLOBAL

Women in sex work take action to respond to GBV

Violence against women who do sex work

Women who engage in sex work experience heightened risks of multiple forms of violence.[46] Where sex work is criminalized, these risks can be exacerbated by creating conditions where violence can flourish unchallenged, preventing women from accessing justice or safely seeking services after experiencing violence.

Countering violence is one of the priority areas for the Global Network of Sex Work Projects (NSWP), an international network that promotes the rights of men, women and transgender sex workers by providing its membership network with research and information. In collaboration with the World Health Organization, UNFPA, UNAIDS and other partners, NSWP developed an implementation tool detailing best practices in comprehensive and inclusive HIV programming for sex workers.[47] The tool—the Sex Work Implementation Tool (SWIT)—articulates the factors that increase the risk of GBV for sex workers. This includes stigmatization, which can exacerbate violence by families or communities, by state actors and representatives (including police), and by non-state actors (such as so-called rescue groups that attempt to remove women from sex work without their consent).

SWIT also presents a number of values and principles that should underpin responses to GBV against sex workers. These include promoting the protection of the human rights of sex workers, rejecting so-called raid and rescue approaches, encouraging gender equality and respecting the right to informed choice. In addition to this, SWIT suggests that all programmes should be participatory, and that they should ensure the meaningful involvement and leadership of sex workers.

NSWP member Veshya Anyay Mukti Parishad (VAMP) is a collective of women in sex work in Sangli, India. VAMP emerged out of HIV prevention efforts to become a sex worker-led movement responding to GBV, HIV and other issues facing the community. VAMP upholds the principles outlined by SWIT and has led work to respond to GBV at the family, community and state levels.

Building collectives to foster community empowerment

VAMP was established in the Maharashtra region of India with support from Sampada Grameen Mahila Sanstha (SANGRAM), a health and human rights NGO that provided resources and training to develop the collective. VAMP initially focused on HIV prevention, providing condoms and information to women engaged in sex work using a peer educator model. As the collective grew, its focus expanded to include addressing violence. Women who do various forms of sex work are part of the collective, which also works in partnership with collectives of male and transgender sex workers.

Before forming the collective, women who do sex work in Sangli experienced significant violence and struggled to access redress, as police were often unwilling to offer support. Within the community, stigmatization of sex work led to marginalization, verbal and physical abuse and other forms of violence. Women were often unable to access information and resources, or to negotiate condom use, and this increased their vulnerability to HIV.

Through VAMP, the community of sex workers in Sangli has created a shared space to offer support and share experiences, and to develop knowledge and skills to address HIV and GBV. VAMP members meet weekly in open forums where information is shared and decisions are made collectively. Through a range of activities—including mediation within families or between partners, collective meetings, and advocacy with police or other institutions—violence in different forms is identified and addressed. When women report experiencing violence within the family, VAMP members intervene and provide mediation. As one member relates:

> **One day a *gunda* [thug] came and harassed us. When he was harassing and fighting with us, my son came to intervene. This *gunda* beat my son and**

wanted to forcibly take my son's watch and gold ring. We fought back, and when [the *gunda*] didn't get the valuables, he went and reported to the police, saying that my son beat him and had robbed him. Naturally the police believed the thug and came to arrest my son. But my son had run away in fear of the police. The police came and took me away in lieu of my son and harassed me in the police station. The police also beat me and told me to get a watch and a ring.

Next day, I came and reported [the incident] to SANGRAM. We, as VAMP, wrote to the senior police officer and lodged a complaint against the [involved] policeman. We demanded an enquiry and organized a huge protest. This police officer was suspended and then transferred to another police station. This was only possible because we knew about our rights and were organized and made an official documentation and complaint.

Bhimawwa Gollar, VAMP member

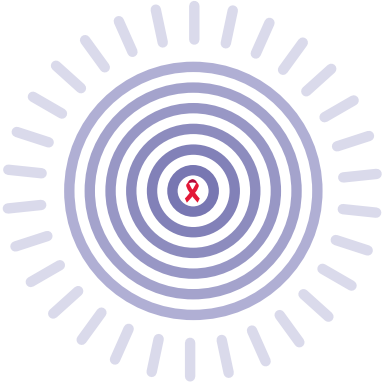
In cases of state or structural violence, women lead protests and advocacy activities to create public awareness and pressure for change, as well as pursuing legal redress through the courts, to achieve justice. VAMP also has supported members who have experienced violence and exploitation from brothel owners by intervening directly and enforcing the power of the collective.[48] In cases of systemic violence—such as in health-care settings or in instances of harassment or violence from police or private landlords—VAMP pursues a two-pronged approach to reach a resolution that includes public advocacy and negotiation or mediation with the perpetrators.

Intervention in cases of intimate partner or family violence is somewhat rarer, as women may be reluctant to seek or allow external involvement. However, VAMP members provide mutual support and a space to share experiences and seek advice from others, which is in itself an important tool for empowering women to respond to GBV.

Collective power to achieve change

VAMP has achieved positive change for its members through building agency and voice, creating both a mutual network of support. It also has established a foundation for a range of activities that promote the rights of women who do sex work, and that respond to HIV and GBV. The collective has conducted advocacy with community leaders, political actors, policy-makers, police and NGOs, and it has carried out education and sensitization activities with different groups,including with members of the judiciary in Delhi. This complements ongoing violence intervention activities and advocacy to promote the human rights of sex workers. In addition to this work, VAMP members are reaching out to other sex worker groups to promote the principle of collectivization and to share their learning and experiences in order to support others to form collectives..

By empowering sex workers and taking collective action, VAMP has exposed GBV in multiple forms, taking action to address violence and to seek redress for its members. The strength in the collective upholds the principle of "nothing about us without us," and it underlines how sex worker-led initiatives are essential to successfully addressing GBV against women who do sex work.



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PARTICIPATING ENTITIES, CONTACTS AND RELATED LINKS

All-Ukrainian Network of People Living with HIV
www.network.org.ua

ATHENA Network
www.athenanetwork.org

Bolivian Network of People Living with HIV/AIDS (REDBOL)
www.redbol.org.bo

Center for Reproductive Rights
www.reproductiverights.org

Club Svitanok
www.club-svitanok.org.ua

Coalition of African Lesbians (CAL)
www.cal.org.za/new

Coalition of Women Living with HIV and AIDS in Malawi (COWLHA)
https:cowlhamalawi.wordpress.com

Gender and Health Unit of the South African Medical Research Council (MRC)
www.mrc.ac.za/gender/gender.htm

The Global Coalition on Women and AIDS (GCWA)
www.womenandaids.net

Health Economics and HIV and AIDS Research Division (HEARD)
www.heard.org.za

International Community of Women Living with HIV/AIDS (ICW)
www.icwglobal.org

Joint United Nations Programme on HIV/AIDS (UNAIDS)
www.unaids.org

Legal Assistance Centre of Namibia
www.lac.org.na

Namibia Women's Health Network (NWHN)
https:nwhn.wordpress.com

NESSA Uganda (c/o Salamander Trust)

NSWP
www.nswp.org

Project Empower
www.projectempower.org.za

Salamander Trust
www.salamandertrust.net
www.steppingstonesfeedback.org

Southern Africa Litigation Centre
www.southernafricalitigationcentre.org

Together for Girls
www.togetherforgirls.org

Triangle Project
www.thetriangleproject.org

United Nations Development Programme
www.undp.org

UNiTE campaign
www.un.org/en/women/endviolence

United Nations Office on Drugs and Crime (UNODC)
www.unodc.org

About ATHENA

The ATHENA Network was created to advance gender equity and human rights in the global response to HIV and AIDS. Because gender inequity fuels HIV and HIV fuels gender inequity, it is imperative that women and girls – particularly those living with HIV – speak out, set priorities for action and lead the response. The Barcelona Bill of Rights, promulgated by partners at the 2002 International AIDS Conference, is our framework for action.

ATHENA's mission is to:

- advance the recognition, protection and fulfillment of women's and girls' human rights, comprehensively and inclusively, as a fundamental component of the response to HIV and AIDS;
- ensure gender equity in HIV-related research, prevention, diagnosis, treatment, care and the development of interventions based on a gendered analysis;
- promote and facilitate the leadership of women and girls – especially those living with HIV – in all aspects of the response to HIV and AIDS; and
- bridge the communities around the world that are addressing gender, human rights, sexual and reproductive health and rights, and HIV.

About the Global Coalition on Women and AIDS (GCWA)

The GCWA is a worldwide alliance bringing together civil society groups working on HIV, women, girls and gender equality, including networks of women living with HIV, women's rights organizations, AIDS service organizations, faith-based organizations, networks of women from key populations, caregiving networks, men and boy's organizations working explicitly for gender equality, the private sector, and the United Nations system, hosted by the UNAIDS secretariat.

Since its inception in 2004, the GCWA has strived to contribute to the strategic positioning of women and girls as integral to the HIV response, ensuring its relevance to the dynamic nature of the HIV epidemic, emerging issues related to women's sexual and reproductive health and rights, and shifting aid architectures, to best meet the needs of women and girls.