GENDER-BASED VIOLENCE AND HIV

Final DRAFT Report

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Program on International Health and Human Rights
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Per the terms of the contract between UNFPA and the Program on International Health and Human Rights (PIHHR), Harvard School of Public Health, for the project titled "Gender-based Violence and HIV," PIHHR is submitting this final draft report to UNFPA for review and discussion.

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EXECUTIVE SUMMARY

Introduction

Gender-based violence (GBV) and HIV are significant health and human rights concerns. Today much is being done to establish evidence of linkages between GBV and HIV and test integrated interventions. This report contributes to this work by consolidating existing evidence from peer-reviewed studies on the intersections between GBV and HIV, identifying gaps in research and highlighting key messages. Such an exercise is particularly important in the current climate, as researchers, policy-makers and program staff alike grapple to find the most effective ways to address these intersecting epidemics.

In the context of this report, GBV is understood as any type of violence, including economic, physical, psychological, sexual or social, directed at groups or individuals on the basis of gender. It encompasses violence against women, men, children, transsexual and transgender populations.

Key Findings

The epidemics of GBV and HIV overlap and intersect in complex ways. The vast majority of studies reveal that GBV or the fear of it may interfere with the ability to negotiate safer sex or refuse unwanted sex. Evidence suggests that individuals who have been assaulted in childhood may later exhibit patterns of sexual risk taking, including unprotected sex with multiple partners and transactional sex, that increase their risk of acquiring HIV later in life.

GBV may interfere with the ability to access treatment and care and potentially the ability to maintain adherence to ARV treatment. Evidence also exists that living with HIV may constitute a risk factor for experiencing GBV, with studies finding an increase in violence following disclosure of HIV status or even following disclosure that HIV testing has been sought. Substance use is also associated with increased vulnerability to both GBV and HIV, although researchers are still unclear exactly how substance use impacts on the pathways between GBV and HIV.

There is consensus in the literature that comprehensive GBV and HIV interventions should urgently address the key drivers of the epidemic, such as poverty, gender inequality and stigma and aim to change societal norms and create safer sexual environments. Conceptual frameworks highlighted in the literature as potentially useful for understanding and addressing the intersections include gender, sexuality and human rights.

Key Gaps

Despite the large body of peer-reviewed literature examining the intersections between GBV and HIV, important gaps exist with respect to: where the research is taking place; which populations are being studied; how the various risks and vulnerabilities are defined in the literature; and how both the evidence linking GBV and HIV and the interventions designed to address them are conceptualized.

Almost half of the studies found in the English-language-literature emanate from the United States, with only 15% of studies coming from sub-Saharan Africa, a handful from India and remarkably few studies addressing these issues in Asia, Eastern Europe, Latin America and the Caribbean generally. In general, situations of armed conflict/post conflict and migration (forced or voluntary) are grossly under-examined.

Peer-reviewed literature concerning vulnerable groups such as adolescents and children, ethnic minorities, LGBT, migrants, MSM people in prisons (or other confined populations), sex workers and substance users remains limited. Articles that do consider specific groups tend to focus on limited issues. For example, of a handful of studies that address the intersections of GBV and HIV among men who have sex with men (MSM) many focus only on the associations between childhood sexual abuse (CSA) and risk of acquiring HIV later in life.

Studies vary widely in how they define, measure and use key terms such as GBV, CSA and "HIV risk behaviours," making comparisons across studies difficult. The majority of the articles reviewed focus on violence against women in heterosexual relationships, thus limiting attention to the violence perpetrated against men and transgender populations and within diverse sexual partnerships and practices. Indeed, surprisingly few articles provide in-depth analyses of sexuality or social constructions of gender and how these can exacerbate vulnerabilities to GBV and HIV.

The studies linking GBV and HIV are heavily skewed towards examining GBV as a risk factor for acquiring HIV while fewer studies analyze HIV as a risk factor for experiencing GBV. Fewer still examine the perpetuating cycle between GBV and HIV.

In discussing interventions, consideration of how the legal and policy environment can either promote or curtail access to the interventions being proposed or the research undertaken is generally lacking. Further, while the benefits of integrating GBV and HIV services are widely touted, few articles could be found that discuss successful attempts to do so. Authors highlight the importance of: building skills and strategies that empower women and girls both economically/socially and in terms of gaining control over their sexual experiences; focusing on vulnerable groups; and engaging men as agents of change. However, the specificities of what it would take to carry out relevant interventions in any given context is generally lacking.

The way forward

As research and programming at the intersections of GBV and HIV expand, more understanding is needed of the complexities of the intersections across country contexts and among different population groups. Attention to locally-defined constructs of gender and sexuality and to human rights represent significant opportunities for understanding how these epidemics are linked and how they can be jointly addressed.

KEY MESSAGES

Linkages Between GBV and HIV

GBV and the Risk of Acquiring HIV

- Physical and sexual GBV have been associated with HIV transmission.
- Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- GBV or the threat of violence may prevent women from being able to practice safer sex.
- Experiencing GBV may be associated with engaging in "HIV risk behaviours," such as unprotected sex and transactional sex.
- Male perpetrators of violence may engage in "HIV risk behaviours," such as not using condoms with multiple casual sexual partners.

Child Sexual Abuse and the Risk of Acquiring HIV

- Child sexual abuse is an important facet of GBV with implications for HIV risk and vulnerability.
- Individuals who have been sexually assaulted in childhood may later exhibit a pattern of sexual risk taking.
- Individuals who experience coerced sex in their childhood may have an increased risk of acquiring HIV or other STIs later in life.

HIV Seropositivity and the Risk of Experiencing GBV; GBV and Adherence

- HIV seropositivity may be associated with the risk of experiencing violence.
- GBV or fear of GBV may potentially delay a woman's decision to disclose her HIV status.
- GBV may negatively influence adherence because, for example, it may hinder women from accessing health services.

Substance Use, GBV and HIV

- GBV may be linked to substance use.
- Substance use may be linked to an increase in HIV risk behaviours and GBV even as the exact pathways are not yet entirely clear.
- Gender differences in substance use may impact the ways in which GBV and HIV intersect.

GBV and HIV in Conflict/Emergency Situations

- Conflict and emergency situations may affect the intersections of GBV and HIV.
- In conflict situations, rape and sexual violence are often reported to be high and interventions to address GBV, HIV or their intersections sorely lacking.

Interventions at the Intersections of GBV and HIV

Integrating Services

- Integrated GBV and HIV interventions should include but not be limited to:
  - HIV education, as well as counselling and testing referrals at domestic violence shelters
  - Screening for GBV in HIV services
  - Attention to child sexual abuse in HIV prevention campaigns
  - In concert with comprehensive SRH services, proper counselling and follow-up care, increased availability of and access to post-exposure prophylaxis (PEP) and integrate PEP into SRH and GBV services

Building Skills and Strategies

- In addition to information, education, and communication for women and men, comprehensive GBV and HIV interventions should build and develop skills and strategies. The following skills are especially highlighted:
  - Communication and negotiation skills
  - Skills for sexual assertiveness
  - Behavioural skills training such as problem-solving, coping and help-seeking
  - Condom wear/use skills
  - Strategies to increase physical safety and reduce HIV vulnerability

Focusing on Vulnerable Groups

- Comprehensive GBV and HIV interventions should be inclusive of marginalized and vulnerable groups. These groups include but are not limited to:
  - Aboriginal populations
  - Adolescents and children
  - Ethnic minorities
  - Indigent persons
  - LGBT
  - Migrants
  - MSM
  - Persons in prisons/other confined populations
  - Persons who are homeless
  - Sex workers
  - Substance users
  - Women with histories of incarceration

Addressing Structural Factors

- Comprehensive GBV and HIV interventions that address the key drivers of the epidemic should change societal norms and create safer environments through attention to:
  - Local culture and the importance of cultural sensitivity
  - Gender and local constructions of gender
  - The participation of the community
  - Sustained engagement with men

Gaps in Research and Interventions

Gap: The Evidence Linking GBV and HIV

- There is a need for more work that examines the linkages between HIV seropositivity and the risk of experiencing GBV and the linkages between GBV and adherence to HIV treatment.
- Further attention is warranted to the risks and vulnerabilities that potentially impact the pathways between GBV and HIV, such as substance abuse and mental health.
- More attention is needed to psychological violence and structural violence, including economic violence, in the peer-reviewed literature.
- Studies are also needed that focus on perpetrators of violence beyond intimate partners, including the state, other family members and other adults.
- More attention is needed to the intersections within the context of HIV testing and disclosure, especially in resource-poor settings.
- More attention is need to the intersections between GBV and HIV in conflict settings.

Gap: The Interventions Addressing GBV and HIV

- More open discussions of sex and sexuality both among groups of women, as well as mixed groups of women and men, should be documented and discussed.
- Men should be engaged as agents of change with respect to risk behaviours, gender mores and power imbalances.
- Examination, and if, necessary, reformation of the legal and policy climate within countries is needed to ensure the best support to address the intersections of GBV and HIV.
- Peer-reviewed publications are needed which explain strengths and weaknesses of interventions that work to address GBV and HIV, especially in relation to integrated interventions. These are often called for in the English-language literature but are still rare.
- Policy-makers should be encouraged to support research and programming addressing the intersections among vulnerable populations, even when to do so might be considered to be “politically controversial.”
- Creative and committed efforts are needed to address the intersections at the policy and programme levels. Attention to existing calls for concrete actions to jointly address these two issues in the current literature is needed.
- More attention is needed to both the quantitative and the qualitative research which already exists in this area in order to ensure that policies or programmes are truly informed by evidence and supportive of vulnerable populations.

Gap: The Type of Research Carried Out

- Peer-reviewed publications which explore the conceptual underpinnings of the intersections between GBV and HIV remain lacking.
- More attention is needed in all relevant literature as to how gender is locally constructed and defined.
- Further attention is warranted to human rights as a framework for understanding how these epidemics are linked and how they can be jointly addressed.

Gap: Where the Research is Taking Place

- More research needs to be published in the English-language literature from regions outside the United States. There is a particular lack of studies on GBV and HIV in the Arab region, Eastern Europe, and Central Asia.
- Importantly, this research needs to be published and disseminated in languages other than English.
- It is essential to carry out more research on the intersections between GBV and HIV among vulnerable groups in different parts of the world, such as MSM in sub-Saharan Africa.

Gap: The Population Groups Involved

- Explicit attention to different age groups (e.g. children and the elderly) will strengthen what is known about the intersections of GBV and HIV and what can be done to address them.
- A greater focus on male perpetrators in work at the intersections of GBV and HIV is needed.

Gap: Definitions and Measures

- Differences in terminology and approach amongst different researchers needs to be more clearly acknowledged
- Consideration is needed as to whether harmonization of terms, definitions (e.g. the definition of GBV), and measurements of risk is preferable in interpreting findings.

A. INTRODUCTION

a) Background and Purpose

Gender-based violence (GBV) is a significant health and human rights concern. Violence and the threat of violence can increase vulnerability to HIV by making it difficult or impossible to set the terms of sexual relationships, especially for women.[1] Violence can also be a barrier, particularly for women, in accessing HIV prevention, care, and treatment services.[2] Furthermore, people living with HIV can face an increased risk of violence as a result of their HIV positive status.[3] Women, especially, have been blamed for bringing HIV into the home and suffer physical, psychological, and economic violence as a result of disclosing their HIV status.[4]

The HIV/AIDS epidemic has had a devastating impact on both women and men around the world. In 2007 an estimated 33 million people were living with HIV worldwide, with the annual number of new infections at 2.7 million. Two thirds of people living with HIV/AIDS live in sub-Saharan Africa, and in 2007 75% of reported deaths from HIV occurred in this region.

Globally, approximately half of all people living with HIV are women, and in sub-Saharan Africa, that figure rises to nearly 60% overall.[5] Young women in sub-Saharan Africa are most acutely affected. Among young people aged 15-24 in the region, 76% living with HIV are female. As noted by Thoraya Obaid, Executive Director of UNFPA, "[t]he HIV/AIDS epidemic has exposed the deadly consequences of gender inequalities and violations of girls and women's human rights. Where AIDS is concerned, gender inequality has become fatal."[6]

Increasingly, research at the intersections of GBV and HIV both seeks to establish evidence for causal linkages and to test integrated interventions. There is increased understanding that this work is essential to fully understand and address the multiple pathways that link GBV and HIV.

This document seeks to:

a. Consolidate the existing evidence from peer-reviewed studies on the intersections between GBV and HIV;

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1 See Appendix 1.

2 See e.g. Diniz NM, De Almeida LC, Ribeiro BC, De Macedo VG. Women victims of sexual violence: adherence to chemoprevention of HIV. Rev Lat Am 2007;15(1):7-12; Lopez EJ, Jones DL, Weiss SM. Domestic violence and its impact on physical health among minority HIV-positive women. Ann Behav Med 2008;35:S24.

3 See e.g. Gielen AC, McDonnell KA, Burke JG, O'Campo P. Women's lives after an HIV-positive diagnosis: disclosure and violence. Matern Child Health J 2000;4(2):111-20.

4 See e.g. Myer L, Rebe K, Morroni, C. Missed opportunities to address reproductive health care needs among HIV-infected women in antiretroviral therapy programmes. Trop Med Int Health 2007;12(12):1484-9; Hamilton C, Okoko D, Tolhurst R, Kilonzo N, Theobald S, Taegtmeyer M. Potential for abuse in the VCT counselling room: service provider's perceptions in Kenya. Health Policy Plan 2008;23(6):390-6; Le Coeur S, Khlat M, Halembokaka G. Increased HIV infection rate among violent deaths: a mortuary study in the Republic of Congo. AIDS 2008;22(13):1675-6.

5 UNAIDS. Report on the global AIDS epidemic. 2008. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp. Accessed 11 September 2009.

6 UNFPA. Protecting the health of women and girls. Available at: http://www.unfpa.org/hiv/women.htm. Accessed 11 September 2009.

b. Extract the key findings;
c. Identify the gaps in research; and
d. Based upon the key findings and the gaps, suggest preliminary research, policy and programme implications and highlight key messages.

b) Definitions of Gender-based Violence for the Purposes of this Report

In defining the term "Gender-based Violence," the *UNFPA Strategy and Framework for Action to Addressing Gender-based Violence* draws on the definition found in the 1993 UN Declaration on the Elimination of Violence against Women ('the Declaration').

The Declaration states in Article 1:

For the purposes of this Declaration, the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

The Declaration goes on to note in Article 2 that:

Violence against women shall be understood to encompass, but not be limited to, the following:

a. Physical, sexual and psychological violence occurring in the family
b. Physical, sexual and psychological violence occurring within the general community
c. Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs

A list of examples of the types of violence that fall under the above categories are provided in the Declaration.[7] These include: spousal battery; sexual abuse, including of female children; dowry-related violence; rape, including marital rape; female genital mutilation/cutting and other practices harmful to women; non-spousal violence; sexual violence related to exploitation; sexual harassment and intimidation at work, in school and elsewhere; trafficking in women; and forced prostitution.[8]

The definition of GBV in the Declaration specifically focuses on violence against women. Since that time the UN family and its partners have also used broader definitions of GBV. For example, the UN High Commissioner for Refugees (UNHCR):

> Gender-based violence is physical, mental or social violence and abuse (including sexual violence) that includes acts (attempted or threatened) carried out with or without force and without the consent of the victim. ***The violence is directed against a person because of her or his gender (because she is a woman or because he is a man) or gender role in a society or culture***. Forms of gender

7 UNFPA. Strategy and Framework for Action to Addressing Gender-based Violence. Available at: www.unfpa.org/webdav/site/global/.../2009_add_gen_vio.pdf. Accessed 11 September 2009.
8 UN. United Nations convention on the elimination of all forms of discrimination against women, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46. New York: United Nations, 1979.

> violence include sexual violence, sexual abuse, sexual harassment, sexual exploitation, early or forced marriage, discrimination, the denial of food, education or freedom, domestic violence, female genital mutilation and incest.[9]

The concept of GBV can be understood to encompass all acts of violence perpetrated against anyone based on gender. This includes gender-based violence against women generally, as well as against men (including men who have sex with men), sex workers (male and female), girls and boys, and transsexual or transgender individuals.

The various definitions emphasise that GBV can be physical, sexual, psychological, or social and can occur at the individual, relationship, community, national, and global levels.

Historically, work in the area of GBV has focused primarily on violence experienced by women. The 2005 WHO multi-country study revealed that violence against women is widespread and is a major contributor to the ill health of women.[10] Women's groups advocating for a focus on violence against women and girls point to the disproportionate impact of violence and HIV on these groups. More accurately, violence against women can be described as *gender-based violence against women* thus distinguishing it from gender-based violence against men, including men who have sex with men (MSM), transgenders, or transsexuals. Moreover, as women are not a homogeneous group, differences, for example in terms of age, HIV status, sexual orientation, should be recognized to the extent possible in research, policy and programming.

The aim of this report was to capture the links between all types of GBV and HIV, as well as the experiences of different populations. As a result, the examples of GBV captured in the literature search include GBV against women, men, MSM, transsexual sex workers, children and so forth. Nonetheless, the bulk of the report focuses on the links between gender-based violence against women and HIV.

A Note on Terminology

The studies reviewed use a variety of different terms when referring to gender-based violence. These include "domestic violence," "intimate partner violence" and "violence against women." In this report, when quoting or paraphrasing from a study, the authors' terminology for GBV is used, be it "domestic violence", "intimate partner violence" or "gender-based violence". At all other times the term GBV is used, except in the case of child sexual abuse (CSA) where CSA is used.

As a general note, throughout this report information extracted from the studies are described using the authors' own terminology. The issues raised by these variations in language are noted in the Key Gaps section.

9 UNHCR. How to guide: sexual and gender-based violence programme in Liberia. 2001. Available at: www.rhrc.org/resources/h2g008.pdf. Accessed 11 September 2009.
10 WHO. Multi-country study on women's health and domestic violence against women. 2005. Available at: http://www.who.int/gender/violence/who_multicountry_study/en/index.html. Accessed 11 September 2009.

c) Methodology

Peer-reviewed literature published between January 2000 and December 2008 was collected and analyzed.[11] The year 2000 was chosen as the starting point of this review as it was the year in which Maman *et al* published an important review on the intersections between HIV and violence.[12] This report aims to build from this starting point. Searches included all English-language articles published (including "e-publications" ahead of print) during the given time period. Non peer-reviewed materials were excluded.

Internet searches were conducted using databases that specialized in the social sciences, law, health policy, public health and medicine. The final set of databases used are: Medline, Social Science Citation, EconLit, PAIS, PolicyFile, LegalTrac and Lexis/Nexis. Early on, it was discovered that four databases (SocioFile, Current Contents, PsychFile, ArticleFirst) were not yielding many articles relevant to the topic and these were therefore excluded.

Five search term combinations were used as keywords to identify articles dealing with the intersections of GBV and HIV.[13] The first three combinations were designed to capture articles that explicitly mention GBV or violence against women along with HIV. The last two search combinations were designed to capture intersections between violence and HIV in cases where gender and women were not explicitly referenced – including articles that dealt with the intersections between GBV and HIV amongst MSM, children, transsexual populations, etc. The terms "rape" and "abuse" were used in the search combinations to capture specific and relevant types of violence.

- HIV + gender + violence
- HIV + women + violence
- HIV + girls + violence
- HIV + sex + abuse
- HIV + rape

After the initial searches, some abstracts were eliminated because they clearly did not relate to intersections between GBV and HIV. For instance, the search term "abuse" yielded a number of false hits that dealt with HIV and substance use but did not address GBV. Likewise, GBV and HIV sometimes only appeared in a footnote or in a reference citation, while the article itself dealt with a different subject matter altogether. Finally, some citations seemed very relevant, but as the abstracts or articles were simply unavailable (either digitally or in hard copy), they could not be analysed as part of this review. After excluding these citations, 204 abstracts remained that either substantively mentioned or focused directly on GBV and HIV.

11 Even with 2000 as the official start date of this review, in rare instances articles published prior to 2000 were caught. These articles were, if particularly relevant, left in the list of final results.
12 Maman S, Campbell J, Sweat M, Gielen A. The intersections of HIV and violence: directions for future research and interventions. Soc Sci Med 2000;50: 459-78.
13 The Boolean search terms used to most efficiently capture these five combinations were: 1) HIV AND violence AND (women OR gender or girls) and 2) HIV AND (rape OR (sex AND abuse)

d) Limitations

As stated above, the review included only English-language articles from the databases listed above, the time-span was restricted to the years 2000-2008, and only peer-reviewed articles were included. Thus, articles published in other languages, prior to 2000 and after 2008, and in the grey literature are not included.

Today, there is much programmatic work at the intersections of GBV and HIV but much of this work has not yet been published in the peer-reviewed literature. Literature describing those few interventions that have been published in the given time period are referenced in Appendices 6-10. Also discussed are explicit references to interventions made in the conclusions of empirical studies examining the linkages between GBV and HIV (Appendices 1-5).

A number of useful documents exist among the grey literature. These include the new UNAIDS Outcomes Framework 2009-2011 which explicitly lists ending violence against women as one of its top priorities.[14] WHO, in collaboration with UNAIDS and the UN Office on Drugs and Crime has examined the intersections between GBV and HIV among prison populations in a report entitled "Effectiveness of Interventions to Address HIV in Prisons."[15] The UN Office on Drugs and Crime has also produced other materials focusing on this vulnerable population.[16] In addition, WHO's landmark multi-country study on women's health and domestic violence against women, as well as various other documents put out by the organization highlight the intersection of violence against women and HIV/AIDS.[17,18] In particular, WHO's review on "Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers and Outcomes" is especially relevant.[19] Relevant documents or reports have also been put out by the Global Coalition on Women and AIDS, USAID and the American Foundation for AIDS Research.[20,21,22] Other useful documents include: "Strengthening Resistance: Confronting Violence Against Women and HIV/AIDS," published by the Center for Women's Global Leadership, as well as an upcoming report entitled "Together we must…end violence against women and girls and HIV and AIDS: A review of promising practices on the

14 UNAIDS. Joint action for results: UNAIDS outcome framework, 2009–2011. Available at: http://www.unaids.org/en/knowledgecentre/resources/featurestories/archive/2009/20090421_joint_action.asp. Accessed 10 September 2009.
15 WHO, United Nations Office on Drugs and Crime, UNAIDS. Effectiveness of interventions to address HIV in prisons, evidence for action technical papers. 2007. Available at: http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf. Accessed 10 September 2009.
16 United Nations Office on Drugs and Crime, UNAIDS. Women and HIV in prison settings. Available at: www.unodc.org/.../hiv.../Women%20and%20HIV%20in%20prison%20settings.pdf. Accessed 11 September 2009; United Nations Office on Drugs and Crime. Handbook for prison managers and policymakers on women and imprisonment. Criminal Justice Handbook Series. New York: United Nations, 2008.
17 WHO. Multi-country Study.
18 WHO. Interaction of violence against women and HIV. Available at: http://www.who.int/gender/violence/gbv/en/index2.html. Accessed 11 September 2009.
19 WHO. Gender dimensions of HIV status disclosure to sexual partners: rates, barriers and outcomes. 2004. Available at: www.who.int/gender/documents/en/genderdimensions.pdf. Accessed 11 September 2009.
20 Global Coalition on Women and AIDS. Violence against women. Available at: http://womenandaids.unaids.org/themes/theme_2.html. Accessed 11 September 2009.
21 Interagency Gender Working Group of USAID. Addressing gender-based violence through USAID's health programmes: A guide for health sector programme officers. 2006. Available at: www.prb.org/pdf05/GBVReportfinal.pdf. Accessed 11 September 2009.
22 American Foundation for AIDS Research. Gender-based Violence and HIV among Women: Assessing the Evidence. Issue Brief no. 3. 2005.

intersection," published by UNIFEM and ActionAid USA.[23,24]

UNFPA materials that are particularly relevant to the intersections of GBV and HIV include "Ending Violence against Women: Programming for Prevention, Protection and Care," and "UNFPA's Strategy and Framework for Action for Addressing Gender-based Violence." [25,26] Moreover, the UN Trust Fund is currently supporting actions to eliminate violence against women and has specifically made a window of grant-making available that aims to encourage projects that build multi-sectoral partnerships and increase attention to the links between violence against women and the spread of HIV and AIDS.[27] The Global Fund has also come out with a Gender Equality Strategy that highlights the issue of GBV and HIV.[28]

Looking ahead, UNESCO and the Social Science Research Council will be publishing a peer-reviewed book entitled "The Fourth Wave: Violence, Gender, Culture and HIV in the 21st Century." The book highlights research that offers insight into and analysis of socio-cultural factors that shape the gendered course of the HIV pandemic and global responses to it.[29] Other important documents that will increase holistic understanding of the intersections between GBV and HIV are slated for publication by the UN and its partners in the near future.

Although some broad reviews of programmatic activities have been carried out, more are required particularly at this time, as researchers, policy-makers and program staff alike, grapple to find the most effective ways in which to work at this intersection.[30]

The UN family is currently developing a review of studies (both peer-reviewed and within the grey literature) that specifically focuses on programming at the intersection of GBV and HIV. As there are a number of important publications among the grey literature, this review is eagerly awaited.

23 Rothschild C, Reilly MA, Nordstrom SA. Strengthening resistance: confronting violence against women and HIV/AIDS. Center for Women's Global Leadership, 2006.
24 UNIFEM, ActionAid USA. Together we must…end violence against women and girls and HIV and AIDS: A review of promising practices on the intersection. This report will be launched shortly and will be available at: www.genderandaids.org.
25 UNFPA. Ending violence against women: programming for prevention, protection and care. Available at: http://www.unfpa.org/public/site/global/pid/399. Accessed 10 September 2009.
26 UNFPA. Strategy and Framework.
27 United Nations Trust Fund to End Violence Against Women. Call for proposals. 2009. Available at: www.unifem.org/.../trust_fund.../UNTFEVAW_2009_Call4Proposals_en.pdf. Accessed 11 September 2009.
28 The Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund's strategy for ensuring gender equality in the response to HIV/AIDS, tuberculosis and malaria ("the gender equality strategy"). www.theglobalfund.org/.../strategy/TheGenderEqualityStrategy_en.pdf. Accessed 11 September 2009.
29 UNESCO. The fourth wave: violence, gender, culture & HIV in the 21st century. Available at: http://portal.unesco.org/en/ev.php-URL_ID=44163&URL_DO=DO_TOPIC&URL_SECTION=201.html. Accessed 15 September 2009.
30 Guedes A. Addressing gender-based violence from the reproductive health HIV sector: a literature review and analysis. Interagency Gender Working Group, USAID, 2004. Available at: http://www.igwg.org/priorityareas/violence.htm. Accessed 11 September 2009.

B. KEY FINDINGS

This section of the report provides a summary of the key findings from the articles reviewed. Three different types of findings arise:

a) **Conceptual Linkages and Frameworks.** The conceptual articles summarized here concern potential casual pathways linking GBV and HIV and present frameworks recommended as fundamental to understanding and addressing the roots of the intersections. These are the frameworks of economics, gender, sexuality, culture, and human rights.

b) **Linkages Between GBV and HIV.** The findings presented here focus on the primary pathways between GBV and HIV including:
   i. GBV and the risk of acquiring HIV
   ii. Child sexual abuse and the risk of acquiring HIV
   iii. HIV seropositivity and the risk of experiencing GBV
   iv. GBV, substance use, and HIV
   v. GBV and HIV in conflict/emergency situations

c) **Interventions at the Intersections of GBV and HIV.** These findings present the issues that authors generally agree need to be incorporated into interventions in order to be more effective. These include the need to:
   i. Address structural factors
   ii. Integrate GBV and HIV services
   iii. Build skills and strategies
   iv. Focus on vulnerable groups

Each of these will be discussed in turn.

a) Conceptual Linkages and Frameworks

The conceptual literature reviewed hypothesizes several causal linkages between GBV and HIV (see Box 1).

Box 1

Conceptual Linkages Between GBV and HIV[31]

1) GBV→HIV: GBV as a risk factor for acquiring HIV infection. There are three common hypothesized mechanisms:

a) GBV in the form of forced or coercive sexual intercourse, where condoms are not used, may increase the risk of HIV transmission from an infected perpetrator to an uninfected survivor of violence. This is because the tears and damage that can result to the vaginal/anal wall increase the risk of HIV transmission (see Appendix 1).

31 The articulation of these linkages is partly based upon and adapted from: Maman S, Campbell J, Sweat M, Gielen A. The intersections of HIV and violence: directions for future research and interventions. Soc Sci Med 2000;50:459-78.

b) GBV or the threat of GBV may limit women's ability to negotiate safer sexual behaviours, thereby increasing the risk of HIV transmission[32] (see Appendix 1).

c) Individuals who have been assaulted in childhood, adolescence or adulthood may later exhibit a pattern of sexual risk taking that increases their risk of acquiring HIV (see Appendices 1 and 2).

2) HIV→GBV: HIV as a risk factor for GBV. The mechanism hypothesized behind this linkage is that individuals who are living (or thought to be living) with HIV may be at an increased risk of experiencing GBV as a result of gender-based stigma and discrimination. For example, a woman may be subjected to violence upon disclosing her HIV-positive status or if it becomes known that she is living with HIV. Studies that discuss this linkage are now beginning to discuss the possible impact of GBV on people living with HIV by examining how GBV impacts adherence to ARV medication (see Appendix 3).

3) GBV⇔HIV: GBV and HIV are mutual risk factors and together create a vicious cycle. This point was raised by several of the conceptual articles in the review.[33]

Additional factors that may impact the relationship between GBV and HIV include:
- Drug and alcohol use (see Appendix 4)
- Conflict and emergency situations (see Appendix 5)
- The social/cultural/economic/political/legal climate (see Appendix 6)

There are 20 conceptual articles in this review. In general, the articles make broad references to the linkages between GBV and HIV and suggest possible frameworks to understand and address the intersections. Many argue that solely looking at the issues of GBV and HIV without considering other relevant factors is insufficient. These authors appear to be investigating new perspectives that can help clarify and address the root causes of the intersections.

The potential causal pathways noted in Box 1 suggest that the dynamics that weave together GBV and HIV are far more complicated than just the issues of GBV and HIV as seen on their own. Bringing them together, a more holistic framework can shed light on numerous factors integral to the intersections.

The following frameworks are highlighted as fundamental to comprehending and addressing the intersections:

- **Economics:** Five (20%) of the conceptual articles raise the importance of paying attention to economics. A framework that considers the general economic context is said to be useful to understanding the root causes of the intersection of GBV and HIV.[34] An understanding of the economic context is said, for example, to reveal that men inflicting violence are themselves "likely to be living amidst

32 For the purposes of this report, this mechanism is understood as relevant to all individuals subjected to violence.

33 See e.g. Ferguson L, Gruskin S, Ahmed S, Fried S. The nexus of sexuality, gender and human rights: addressing common underlying factors linking gender-based violence and HIV. Cult Health Sex 2007;9 (Suppl 1):S7-S8; Greig A, Peacock D, Jewkes R, Msimang S. Gender and AIDS: time to act. AIDS 2008;22(Suppl 2):S35-43.

34 Welbourn A. 'Man hunt intimacy: man clean bathroom': women, sexual pleasure, gender violence and HIV. Institute of Development Studies Bulletin 2006;37(5):123-6.

conditions of economic and social hardship." Awareness of this fact can help create more effective interventions. The concurrence of violence and HIV is therefore understood to happen within a "larger structural control of social and economic resources and their distribution."[35] An economic perspective also includes a focus on *economic violence* as a type of GBV. Economic violence can include limited access to funds and credit, being excluded from financial decision-making, and discriminatory traditional laws on inheritance, property rights, and use of communal land. Several authors note that economic violence may deepen poverty, increase the risk of physical violence and promote sexual exploitation and the risk of contracting HIV infection.[36] To address these risks, one article calls specifically for the implementation of economic interventions, such as conditional cash transfers, microcredit, and economics livelihoods programmes.[37] Those articles focusing on transactional sex and the increased risks of GBV and HIV for women who engage in transactional sex also highlight the role played by economics and the pressures faced by women as a result of poverty.[38]

- **Gender:** A number of conceptual articles (almost 40%) focus on the issue of gender inequality and its role in the intersections. Applying a conceptual framework that takes gender into account is said to require an examination of what gender means in the local context of the intervention and how gender differences manifest themselves. Given that GBV is entrenched within systems of power and gender inequality, the authors agree it is essential to address these foundations when considering the intersections. Some articles discuss the need for researchers and programmers to pay attention to constructions of masculinity as a way of better understanding the intersections between GBV and HIV.[39] Others argue that current frameworks deal overwhelmingly with women but that it is enduring and pervasive patterns of male sexual behaviour, involving coercion, violence, and gang rape that perpetuate the vicious cycle of GBV and HIV.[40] A gender framework would, therefore, necessitate engaging men more explicitly.
- **Sexuality:** Although only two conceptual articles (10%) specifically raise the topic of sexuality, this issue is implicitly discussed in numerous empirical articles. Some authors argue that the framework of sexuality is extremely useful for understanding the intersections.[41,42] Gender and sexuality are inherently entwined, and in order to understand the behaviours and actions of individuals with respect to sex, relationships, and perceptions of risk, an understanding of sexuality and how it impacts on and is influenced by gender is essential.[43] Some

35 Zierler S, Krieger N. Reframing women's risk: social inequalities and HIV infection. Annu Rev Public Health 1997;18:401-36.
36 Fawole, OI. Economic violence to women and girls: is it receiving the necessary attention? Trauma Violence Abuse 2008;9(3):167-77.
37 Krishnan S, Dunbar MS, Minnis AM, Medlin CA, Gerdts CE, Padian NS. Poverty, gender inequities, and women's risk of human immunodeficiency virus. Ann N Y Acad Sci 2008;1136:101-10.
38 See e.g. Maganja RK, Maman S, Groves A, Mbwambo JK. Skinning the goat and pulling the load: Transactional sex among youth in Dar es Salaam, Tanzania. AIDS Care 2007;19(8):974-81; Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntryre JA, Harlow SD. Transactional sex among women in Soweto, South Africa: prevalence, risk factors and association with HIV infection. Soc Sci Med 2004;59(8):1581-92.
39 Lepani K. Mobility, violence and the gendering of HIV in Papua New Guinea. Aust J Anthropol 2008;19(2): 150-64.
40 Campbell CA. Male gender roles and sexuality: implications for women's AIDS risk and prevention. Soc Sci Med 1995;41(2):197-210.
41 Ibid.
42 Ferguson L, et al.
43 Lepani K. Mobility, violence.

articles point out that the issue of GBV and HIV is often seen as an issue between heterosexual women and men, and that vulnerable groups such as MSM, lesbian populations, and transsexual populations are largely ignored.[44]

- **Culture:** One conceptual article (5%) makes specific references to culture, while a handful of other empirical articles in the literature make both explicit and implicit references. These authors emphasise that culture, gender, and sexuality are interwoven and together affect the intersections between GBV and HIV. Culture is noted as shaping individuals' understanding of the manner in which gender and power interact and to perpetuate attitudes that fuel the intersections. An understanding of the complex cultural issues at play is said to be essential if more culturally competent interventions are to be designed.[45]
- **Human rights:** Two articles (10%) specifically highlight the importance of conceptualizing GBV and HIV in the context of a human rights framework, while a few others make implicit references to rights. It is suggested that a human rights framework can help to: 1) Demonstrate how HIV/AIDS and gender-based violence are linked; 2) Identify where human rights promotion or violation play a role in the nexus of GBV and HIV; and 3) Suggest ways in which HIV prevention initiatives, reproductive health services, and GBV services can work together, and more effectively improve health and realize human rights.[46,47]

Key Messages:

- GBV, HIV and their intersections are significant health and human rights concerns.
- More research is needed to apply and analyse under-explored frameworks in the context of GBV and HIV, including economics, gender, sexuality, culture and human rights. Such frameworks can aid understanding of the root causes of GBV and HIV and enhance policy and programmatic responses.
- More research is needed on how these frameworks can be combined in order to understand and address the intersections. For example, applying a framework of culture, gender, sexuality *and* human rights to examine and address the full extent of the vicious cycle that can exist between GBV and HIV.

b) Linkages Between GBV and HIV

i) GBV and the risk of acquiring HIV

86 articles address the linkages between GBV and the risk of acquiring HIV (see Appendix 1).[48] 82 of these are empirical studies (approximately 40% of total number of

44 Campbell CA. Male gender roles
45 Weidel JJ, Provencio-Vasque ,E, Watson SD, Gonzalez-Guarda R. Cultural considerations for intimate partner violence and HIV risk in Hispanics. J Assoc Nurses AIDS Care 2008;19(4):247-51.
46 Teti M, Chilton M, Lloyd L, et al. Identifying the links between violence against women and HIV/AIDS: ecosocial and human rights frameworks offer insight into US prevention policies. Health Hum Rights 2006; 9(2):40-61;
47 Ferguson L, et al.
48 Please note these figures are approximate. Many studies draw attention to more than one linkage and hypothesize several questions that may be relevant to the intersection. Referring to the studies in this section as 'studies that address the links between GBV and the risk of acquiring HIV,' simply conveys that this was the link that was most relevant. This comment applies to everywhere in this paper where estimated figures are provided to show the number of studies focusing on particular linkages.

articles), 3 are conceptual articles, and 1 is a review study. These articles typically approach the intersections with a focus on GBV as the exposure of interest and hypothesize that exposure to GBV may be associated with the risk of acquiring HIV.

Of the 82 empirical studies, 38 studies take place in the US (46.3%), 14 in South Africa (17%), and 8 in India (about 9.7%). Research in other countries is limited: 4 studies are from Brazil; 3 from Tanzania; 2 each from Canada and Zambia; and 1 study each from Australia, Bangladesh, China, Hong Kong, Pakistan, Puerto Rico, Senegal, Serbia, United Kingdom, Ukraine, and Zimbabwe. Out of the 3 conceptual articles focusing on linkages, 1 discusses the intersection among women in South Africa, the second examines violence and gendering of HIV in Papua New Guinea, and the third takes a more global approach. The one review study has a multi-country focus.

The empirical studies include primarily quantitative studies, with a handful of smaller qualitative studies. Study designs are diverse. A range of different data-collection methods are employed, including analyses of clinical records, surveys, interviews, and focus groups. Sample sizes in the articles reviewed range from a qualitative study of social constructions of gender among 16 women and men in South Africa, to a vast epidemiological study that gathered data on health risk behaviours associated with intimate partner violence from 70,156 women in 18 US states.[49,50]

More than half of these studies explicitly identify the association between GBV and the risk of acquiring HIV as follows: experiencing GBV (or the fear of GBV) increases the likelihood that one will engage in "risky behaviour" that may, in turn, increase one's risk of acquiring HIV.

These HIV "risk behaviours" are commonly defined as:

- Unprotected vaginal sex
- Unprotected anal sex
- Sex trading
- Sex with multiple partners
- Sex with a partner who is at high risk of HIV
- Sex under the influence of alcohol or drugs[51]

Key findings in support of this linkage include:

- **Women and men experiencing gender-based violence may be more likely to engage in HIV "risk behaviours," such as unprotected sex and exchanging sex, as well as other risky behaviours.**[52] The epidemiological study with the largest sample size concerned with this topic (70,156 US women) revealed that both women and men with a history of intimate partner violence were more likely to report HIV risk factors (and this relationship was more

49 Strebel A, Crawford M, Shefer T, et al. Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa. SAHARA J 2006;3(3):516-28.
50 Breiding MJ, Black MC, Ryan GW. Chronic disease and health risk behaviors associated with intimate partner violence-18 US states/territories. Ann Epidemiol 2005;18(7):538-44.
51 See e.g. Fuentes CM. Pathways from interpersonal violence to sexually transmitted infections: a mixed-method study of diverse women. J Womens Health 2008;17(10):1591-603.
52 Weir BW, Bard RS, O'Brien K, Casciato CJ, Stark MJ. Violence against women with HIV risk and recent criminal justice system involvement: prevalence, correlates, and recommendations for intervention. Violence Against Women 2008;14(8):944-60.

significant for women).[53] Another study of 529 women with histories of criminal justice system involvement in the United States, found that sex risk, especially exchanging sex, was the factor most strongly associated with exposure to violence.[54] A study of 524 African-American women in the US found a positive correlation between level of survival sex and high-risk behaviour. Survival sex was also correlated with violence or fear of violence, relationship loss, and lost shelter.[55]

- **Physical, psychological, and sexual GBV may be associated with HIV transmission**. A study of 1,366 women in South Africa found that intimate partner violence and high levels of male control in a woman's current relationship were associated with HIV seropositivity in the sample of women.[56] A cross-sectional study of 459 women from urban and rural areas in India showed that HIV-positive women were significantly more likely to report a history of forced sex and domestic violence than HIV-negative women. They were also more likely than HIV-negative women to have experienced physical violence if they refused to have sex with their partner.[57]
- **GBV or the threat of violence may prevent women from being able to practice safer sex**. In a study of 39 women in Puerto Rico, the study participants "specifically identified lack of negotiating skills, fear of sexual violence, partner refusal to use condoms, and lack of control over their partner's sexual behaviour as barriers to practicing safe sex."[58] A study of 154 African American and Hispanic women in the US revealed that women in violent relationships indicated less likelihood of using male condoms and greater likelihood of using female-controlled methods, particularly vaginal spermicide, than women in non-violent relationships.[58]

Almost all studies concerning GBV and the risk of acquiring HIV infection focus on physical, sexual, or psychological violence. Only 8 of these studies raise the issue of the role of economics or economic violence and its links to HIV. The common finding among these studies suggests that:

- **Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing women's vulnerabilities.** For example, a study of 178 women in Latin America found that living in poverty and having a STI were correlated, as was lack of access to education.[59] Another study of 1,418 women in Tanzania revealed that a woman had a significantly elevated risk for HIV if she had a partner more than 10 years older, her partner made *low*

53 Breiding MJ, Black MC, Ryan GW. Chronic disease and health risk behaviors associated with intimate partner violence-18 US states/territories. Ann Epidemiol 2005;18(7):538-44.
54 Weir BW, et al.
55 Whyte J, IV. Sexual assertiveness in low-income African American Women: unwanted sex, survival, and HIV risk. J Community Health Nurs 2006;23(4):35-44.
56 Dunkle KL, Jewkes RK, Brown HC, Gray GE, McIntyre JA, Harlow SD. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. Lancet 2004;363(9419):1415-21.
57 Gupta RN, Wyatt GE, Swaminathan S, et al. Correlates of relationship, psychological, and sexual behavioral factors for HIV risk among Indian women. Cultur Divers Ethnic Minor Psychol 2008;14(3):256-65.
58 See e.g. Abreu S, Sala AC, Candelaria EM, Norman LR. Understanding the barriers that reduce the effectiveness of HIV/AIDS prevention strategies for Puerto Rican women living in low-income households in Ponce, PR: A Qualitative Study. J Immigr Minor Health 2008. Epub ahead of print.
58 Saul J, Moore J, Murphy ST, Miller LC. Relationship violence and women's reactions to male- and female-controlled HIV prevention methods. AIDS Behav 2004;8(2):207-14.
59 Gonzalez-Pacheco I, Lartigue T, Vazquez G. Case studies and controls in a group of pregnant with adverse experience in childhood and [full title not available]. Salud Mental 2008;31(4):261-70.

financial contributions to children's expenses, or she experienced coerced first sex before age 18 years. The authors concluded that economic deprivation and experience of sexual violence increased women's vulnerability to HIV.[60] Several authors raised the issue of transactional sex when describing the economic pressures faced by women. One study of women in South Africa found that "[w]omen who reported past experience of violence by male intimate partners, problematic substance abuse, urban residence, ever earning money, or living in substandard housing were more likely to report transactional sex" and that "[t]ransactional sex was associated with HIV seropositivity."[61]

While most studies focus on heterosexual women who are not engaged in sex work, the association between GBV and risk of acquiring HIV is also documented across different population groups:

- Among the 7 studies that focused on female sex workers, GBV was linked to unprotected sex,[62] condom failure, and the reduced capacity for avoiding sexual risk.[63]
- A study of 226 women in lesbian relationships showed an elevated risk of acquiring HIV among women with a history of intimate partner violence.[64]
- In a qualitative study of 58 LGBT people, 28% stated that they felt unsafe to ask their abusive partners to use safer sex protection or that they feared their partners' response to safer sex.[65]
- A study of 539 young MSM in the United States revealed that recent unprotected sex and club drug use (both viewed as "HIV risk behaviours") were significantly associated with a history of threats or violence by both family and partners.[66]

About 10 studies (12%) examine the linkages between GBV and the risk of acquiring HIV among heterosexual men. 6 of these studies focus on men as perpetrators of violence, while the others either examine issues of victimisation and perpetration among men, or discuss male attitudes towards women and sex more generally. The key findings within these studies reveal that:

- **Male perpetrators of violence may engage in more risk behaviours, such as having more sexual partners (including casual sexual partners).** A study of 1,275 men in South Africa found that perpetration was correlated with "higher number of past year and lifetime sexual partners, more recent intercourse, and a greater likelihood of reporting casual sex partners, problematic substance use, sexual assault of non-partners, and transactional sex." The authors of the study concluded that "[y]oung men who perpetrate partner violence engage in significantly higher levels of HIV risk behaviour than non-perpetrators, and more

60 Sa Z, Larsen U. Gender inequality increases women's risk of HIV infection in Moshi, Tanzania. J Biosoc Sci 2008;40(4):505-24.
61 Dunkle KL, et al. Transactional sex.
62 Rhodes T, Simic M, Baros S, Platt L, Zikic B. Police violence and sexual risk among female and transvestite sex workers in Serbia: qualitative study. BMJ 2008;337(7669):337.
63 Choi SY, Chen KL, Jiang ZQ. Client-perpetuated violence and condom failure among female sex workers in southwestern China. Sex Transm Dis 2008;35(2):141-6.
64 Eaton L, Kaufman M, Fuhrel A. Examining factors co-existing with interpersonal violence in lesbian relationships. J Fam Violence 2008;23(8):697-705.
65 Heintz AJ, Melendez RM. Intimate partner violence and HIV/STD risk among lesbian, gay, bisexual, and transgender individuals. J Interpers Violence 2006;21(2):193-208.
66 Koblin BA, Torian L, Xu G, et al. Violence and HIV-related risk among young men who have sex with men. AIDS Care 2006;18(8):961-7.

severe violence is associated with higher levels of risky behaviour."[67] Another study focused on 273 men in methadone treatment programmes in the US had similar findings. The authors found that "men who abused an intimate partner were about 4 times more likely to have more than one intimate partner, almost 3 times more likely to have unprotected anal sex, and 2.6 times more likely to have sex with a drug-injecting sexual partner than their counterparts."[68] A 2007 study of violence occurring against wives of 3,096 Bangladeshi men notes that male perpetrators of violence were more likely to report both premarital and extramarital sex partners.[69]

- **Men with a history of sexual assault may be more likely to accept (and engage in) violence against women and may be at higher risk of HIV transmission.** Two studies examined men with histories of sexual abuse.[70] One study of 435 South African men revealed that men with a history of sexual assault were more likely to endorse hostile attitudes towards women and more likely to accept violence against women. They also were reported greater number of recent sex partners, more unprotected intercourse, more use of alcohol and drugs in sexual contexts and less condom use than their non-sexually assaultive counterparts.[71] The second study examined 242 HIV-positive men in Brazil and found that sexual abuse perpetration was associated with self-reported sexual abuse victimisation.[72]

Although the vast majority of literature in this area (over 80% of articles) suggests that GBV may be associated with an increase in HIV risk behaviours, taken together the data also shows that this association is complex, and requires further interrogation to effectively determine the impact of GBV on HIV risk. In one study of 1,295 rural women in South Africa, for example, the authors found that "[i]ntimate partner violence was associated with HIV in two-way analyses, but the effect was non-significant after adjusting for HIV risk behaviours." Nonetheless, the authors reveal that IPV and HIV among women are linked.[73] Another study examines the intersection by focusing on masculine identities in 309 heterosexual men in South Africa. While not linking GBV to an increased risk of acquiring HIV, the study interrogates the association between men's 'attitudes towards women' and HIV risk behaviours. The study found that men who highly endorsed a "masculine ideology" tended to engage in *fewer* HIV risk behaviours. This surprised the authors, who had initially predicted that the opposite would be true. The authors go on to point out the importance of having a better understanding of the relationship between masculinity, sexism, and power imbalances in sexual relationships as they relate to risky sexual behaviour among men. [74]

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67 Dunkle KL, Jewkes RK, Nduna M, et al. Perpetration of partner violence and HIV risk behaviour among young men in the rural Eastern Cape, South Africa. AIDS 2006;20(16):2107-14

68 El-Bassel N, Fontdevila J, Gilbert L, Voisin D, Richman BL, Pitchell P. HIV risks of men in methadone maintenance treatment programs who abuse their intimate partners: A forgotten issue. J Subst Abuse 2001;13(1-2):29-43.

69 Silverman JG, Decker MR, Kapur NA, Gupta J, Raj A. Violence against wives, sexual risk and sexually transmitted infection among Bangladeshi men. Sex Transm Infect 2007;83(3):211-5.

70 See Appendix 2

71 Kalichman SC, Simbayi LC, Cain D, Cherry C, Henda N, Cloete A. Sexual assault, sexual risks and gender attitudes in a community sample of South African men. AIDS Care 2007:19(1):20-7.

72 Segurado AC, Batistella E, Nasciment V, et al. Sexual abuse victimisation and perpetration in a cohort of men living with HIV. AIDS Care 2008;20(1):15-20.

73 Jewkes R, Dunkle K, Nduna M, et al. Factors associated with HIV sero-status in young rural South African women: connections between intimate partner violence and HIV. Int J Epidemiol 2006;35(6):1461-8.

74 Kaufman MR, Shefer T, Crawford M, Simbayi LC, Kalichman SC. Gender attitudes, sexual power, HIV risk: A model for understanding HIV risk behavior of South African men. AIDS Care 2008;20(4):434-41.

While limited to literature describing significant associations between GBV and HIV, the studies reaffirm that the linkages between GBV and the risk of acquiring HIV are complex. Nearly a decade ago, Maman *et al* concluded that due to the cross-sectional nature of the studies reviewed: "[…] it is impossible to determine whether there is a direct causal relationship between forced sex and HIV from these studies."[75] The current review results in a similar conclusion.

Key Messages:

- Physical and sexual GBV have been associated with HIV transmission.
- Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- GBV or the threat of violence may prevent women from being able to practice safer sex.
- Experiencing GBV may be associated with engaging in "HIV risk behaviours," such as unprotected sex and transactional sex.
- Male perpetrators of violence may engage in "HIV risk behaviours," such as not using condoms with multiple casual sexual partners.

ii) Child sexual abuse and the risk of acquiring HIV

Child sexual abuse (CSA) is defined in different ways in the literature but most commonly as "forced or coerced sex with an adult."[76] Rarely does the definition appear to include physical or psychological abuse.

20 articles (19 empirical studies and 1 review article) specifically address the linkages between CSA and the risk of acquiring HIV (see Appendix 2). These studies approach the intersections with a focus on CSA as the exposure of interest, and hypothesize that exposure to CSA may be associated with the risk of acquiring HIV.

Of these 20 articles, 13 take place in the US (65%), 1 takes place in each of Botswana, Brazil, Canada, El Salvador, Tanzania, and 1 in Latin America. The review article focuses on studies from the USA.

The empirical studies include primarily quantitative studies and a handful of smaller qualitative studies. Study designs include cross-sectional studies, and prospective cohort studies. Sample sizes range from a study of CSA and HIV risk among 40 female sex workers who use crack/cocaine in El Salvador to a study of sexual abuse among 9,136 children in the US.[77,78]

Of the 19 empirical studies, the majority (70%) suggest that CSA is associated with the

75 Maman, et al. The intersections of HIV.
76 See e.g. Brennan DJ, Hellerstedt WL, Ross MW, Welles SL. History of childhood sexual abuse and HIV risk behaviors in homosexual and bisexual men. Am J Public Health 2007;97(6):1107-12.
77 Dickson-Gomez J, Bodnar G, Gueverra A, Rodriguez K, Gaborit M. Childhood sexual abuse and HIV risk among crack-using commercial sex workers in San Salvador, El Salvador: A qualitative analysis. Med Anthropol Q 2006;20(4):545-74.
78 Lindegren ML, Hanson IC, Hammett TA, Beil J, Fleming PL, Ward JW. Sexual abuse of children: intersection with the HIV epidemic. Pediatrics 1998;102(4):e46.

risk of acquiring HIV (see Appendix 2).[79] The other 30% of articles either discuss potential linkages between the two without necessarily pointing to an association or focus on more generalized implications of CSA as it relates, for example, to depression or perpetration of violence against women.

Research shows that MSM often experience high rates of child sexual abuse (CSA), revealing the importance of viewing CSA through a sexuality and gender perspective.[80] Many authors view CSA as an important facet of GBV for both females and males. Further, the Declaration on the Elimination of Violence against Women specifies that sexual abuse of female children is a type of gender-based violence.[81]

Key findings that support this association suggest that:

- **Individuals who have been assaulted in childhood may later exhibit a pattern of sexual risk taking.** A number of authors note that MSM who had experienced CSA were more likely to be in the sex trade,[82] to use sex-related drugs, and to be HIV positive.[83] A study of 1,078 MSM in the US suggested that CSA contributes to the ongoing HIV epidemic by "distorting or undermining critical motivational, coping, and interpersonal factors that, in turn, influence adult sexual risk behaviour".[84] A study of 1,645 women in the US revealed that childhood sexual abuse was strongly associated with a lifetime history of domestic violence and other "high-[HIV] risk behaviours, including using drugs, having more than 10 male sexual partners, and exchanging sex for drugs, money, or shelter."[85] Although 8 of the 9 male-focused studies focused on MSM, the one study that examined the intersections among 242 HIV-positive heterosexual men in Brazil revealed an association between sexual abuse victimisation and sexual abuse perpetration; of the men in the study who reported sexual abuse victimisation, 64.3% reported events before the age of ten.[86]
- **Individuals who experience coerced sex in their childhood may have an increased risk of acquiring HIV or other STIs as adults.** One study carried out with 2,888 gay and bisexual men in the US revealed that those men who had experienced forced sex during their childhood had a higher prevalence of HIV as adults.[87] A multi-site, longitudinal study of 4,295 HIV-uninfected MSM in the US showed a predictive association between a history of CSA and subsequent HIV infection. Study data indicated that HIV-uninfected MSM with CSA histories were at greater risk for HIV infection, reported higher rates of HIV sexual risk behavior, and derived less benefit from prevention programs.[88] A study of 178 pregnant

79 Although there are 20 studies in this section of the review (see Appendix 2), one of the studies is a review study; as a result, only 19 are empirical studies.
80 Friedman MS, Marshal MP, Stall R, Cheong JW, Wright ER. Gay-related development, early abuse and adult health outcomes among gay males. AIDS Behav 2008;12(6):891-902.
81 UN. Declaration on the Elimination of Violence against Women.
82 Braitstein P, Asselin JJ, Schilder A, et al. Sexual violence among two populations of men at high risk of HIV infection. AIDS Care 2006;18(2):681-9.
83 Brennan DJ, et al.
84 Catania JA, Paul J, Osmond D, et al. Mediators of childhood sexual abuse and high-risk sex among men-who-have-sex-with-men. Child Abuse Negl 2008;32(10):925-40.
85 Cohen M, Deamant C, Barkan S, et al. Domestic violence and childhood sexual abuse in HIV-infected women and women at risk for HIV. Am J Public Health 2000;90(4):560-5.
86 Segurado AC, et al.
87 Arreola S, Neilands T, Pollack L, Paul J, Catania J. Childhood sexual experiences and adult health sequelae among gay and bisexual men: defining childhood sexual abuse. J Sex Res 2008;45(3):246-52.
88 Mimiaga M, Noonan E, Donnell D, et al. Childhood sexual abuse and underage male homosexual contact in relation to HIV risk taking behavior and infection. Ann Behav Med 2008;35(Suppl 1):S23.

> women in Brazil showed a significant association between being exposed to either physical, emotional, or sexual abuse as a child and having a sexually transmitted infection in adulthood.[89]

Although the majority of articles (70%) note that CSA may increase the risk of engaging in HIV risk behaviours, one study emphasises the complexities inherent within this association. A study of 242 African-American female teenagers found that childhood sexual abuse was associated with *more HIV testing* (and not more sexual partners, as the researchers had initially predicted). The authors found that although some adverse childhood experiences, such as having a parent with alcohol-related problems, heightened HIV risk, other adverse experiences, such as neglect or sexual abuse actually predicted less HIV risk. The authors concluded that "[s]ome African American female teenagers who have experienced sexual abuse, or emotional and physical neglect subsequently act in ways that reduce HIV risk."[90]

Overall, the general consensus seems to be that CSA may increase the risk of engaging in HIV risk-related behaviours. Nonetheless, it is still not possible to be certain that the association is *causal*, a conclusion that was also reached by a 2008 literature review on CSA and HIV. In that review, the authors called for researchers to begin to ask more sophisticated research questions.[91]

Key Messages:

- Child sexual abuse is an important facet of GBV with implications for HIV risk and vulnerability.
- Individuals who have been sexually assaulted in childhood may later exhibit a pattern of sexual risk taking.
- Individuals who experience coerced sex in their childhood may have an increased risk of acquiring HIV or other STIs later in life.

iii) HIV seropositivity and the risk of experiencing GBV

29 articles (23 empirical studies and 6 review articles) examine the associations between HIV seropositivity and risk of experiencing GBV. The studies vary in their approach. Some examine the violence women are exposed to once they disclose their HIV status or are known to be living with HIV, others focus on GBV as a potential barrier to disclosure, and a few examine how GBV may impact adherence to treatment (see Appendix 3).

Of these 29 articles, 12 take place in the US (41%), 3 take place in Tanzania, 2 take place in each of India, Kenya, and South Africa, 1 takes place in Brazil, and 1 in the Republic of Congo. Among the 6 review articles, 2 are US-focused, 2 are multi-country focused, and 2 take a global approach.

89 Gonzalez-Pacheco,Itzel; Lartigue,Teresa; Vazquez,Gerardo. Case studies and controls in a group of pregnant with adverse experience in childhood. Salud Mental 2008;31(4):261-70.
90 Locke TF, Newcomb M.D. Correlates and predictors of HIV risk among inner-city African American female teenagers. Health Psychol 2008;27(3):337-48.
91 Senn TE, Carey MP, Vanable PA. Childhood and adolescent sexual abuse and subsequent sexual risk behavior: Evidence from controlled studies, methodological critique, and suggestions for research. Clin Psychol Rev 2008;28(5):711-35.

The empirical studies are mainly quantitative studies. Sample sizes range from a study of abuse in the context of VCT among 31 Kenyan women and men to a large probability sample examining violence victimization after HIV infection among 2,864 HIV-positive women and men in the US [92,93]

Overall, 8 empirical studies (28%) suggest that there may be a positive correlation between HIV seropositivity and the risk of experiencing GBV. Another 6 studies (approximately 21%) suggest that GBV or fear of GBV may negatively impact the decision to disclose or access and adherence to treatment. Conversely, 3 studies reveal no association and argue that it is difficult to determine whether risk of violence is increased by HIV status. Moreover, other studies show a possible but unclear correlation between the two. This is an area where findings are strikingly mixed.

Key findings that support a positive association suggest that:

- **HIV seropositivity may lead to a heightened risk of GBV.** A Tanzanian study of 245 HIV-positive women found that "[t]he odds of reporting at least 1 violent event was significantly higher among HIV-positive women than among HIV-negative women[…][and that the] [o]dds of reporting partner violence was 10 times higher among younger (< 30 years) HIV-positive women than among younger HIV-negative women."[94] A study of 2,864 US adult patients in primary care found that 20.5% of women, 11.5% of MSM and 7.5% of heterosexual men reported physical harm since diagnosis, of whom nearly half reported HIV-seropositive status as a cause of violent episodes.[95] Another study of 272 South African women on ART found that one in 10 women had experienced physical abuse by an intimate partner since their HIV diagnosis; four of the 10% experiencing violence attributed the abuse to their HIV status.[96] Furthermore, a qualitative study of 45 Tanzanian men and women's attitudes towards HIV and disclosure in Tanzania found that many *anticipated* that disclosure of HIV-positive status to an HIV-negative male partner would result in abandonment, divorce or violence against the woman whether she was sero-negative or positive.[97] One study suggested that geography may play a role in the rates of GBV associated with HIV. This study reviewed 71 peer-reviewed articles presenting research on females ages 12 and older in heterosexual relationships over the past decade and in all regions of the world where data was available. The review called for more prospective studies to address issues of causality and temporality when it comes to the intersection between GBV and HIV.[98]

92 Hamilton C, Okoko D, Tolhurst R, Kilonzo N, Theobald S, Taegtmeyer M. Potential for abuse in the VCT counselling room: service provider's perceptions in Kenya. Health Policy Plan 2008;23(6):390-96.
93 Zierler S, Cunningham WE, Andersen R, Shapiro MF, Nakazono T, Morton S. Violence victimization after HIV infection in a US probability sample of adult patients in primary care. Am J of Public Health 2000;90(2):208-15.
94 Maman S, Mbwambo JK, Hogan NM, et al. HIV-positive women report more lifetime partner violence: findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania. Am J Public Health. 2002;92(8):1331-7.
95 Zierler S, et al. Violence victimization.
96 Myer L, Rebe K, Morroni C. Missed opportunities to address reproductive health care needs among HIV-infected women in antiretroviral therapy programmes. Trop Med Int Health 2007;12(12):1484-9.
97 Mlay R, Lugina H, Becker S. Couple counselling and testing for HIV at antenatal clinics: views from men, women and counselors. AIDS Care 2008;20(3):356-60.
98 Campbell JC, Baty ML, Ghandour RM, Stockman JK, Francisco L, Wagman J. The intersection of intimate partner violence against women and HIV/AIDS: a review. Int J Inj Contr Saf Promot 2008;15(4):221-31.

- **GBV or the fear of violence can potentially delay a woman's decision to disclose her HIV status**. For example, a study of 293 HIV-positive women in South Africa revealed that experience of violence was a factor associated with delaying disclosure of their status to their partner as well as to others.[99] A review of 17 studies from peer-reviewed journals found that barriers to disclosure identified by women in developing countries included "fear of accusations of infidelity, abandonment, discrimination and violence. Between 3.5% and 14.6% of women reported experiencing a violent reaction from a partner following disclosure."[100]

Several studies identify a correlation between HIV status and GBV but explain that it is difficult to know whether the abuse is occurring because of HIV status or simply because of underlying gender and power relations. For example, a study of 245 women in India found an association between seropositivity and domestic violence but explained "the cross-sectional nature of the research makes it impossible to determine the temporality of the variables."[101] A review of literature on traumatic events and HIV concluded, "[s]tudies indicate that a history of trauma is relatively common among HIV-positive persons and substantially exceeds that of the general population in the US. The rate of trauma seems to remain elevated even after HIV diagnosis."[102] This latter study found that traumatic events were prevalent among individuals with HIV/AIDS, but that it was impossible to determine if these events were *caused* by one's HIV status. These findings highlight the importance of research to clarify the underlying causality between the identified associations.

Three studies, however found no association between HIV and risk of GBV. A prospective study of 1,087 HIV-infected and uninfected women in the US found that the incidence of abuse over a 4-year period was similar between HIV-infected and uninfected women; in fact, "HIV-infected women with advanced immunosuppression (CD4+ count less than 350 cells/μL) were less likely to experience violence than either more immunocompetent HIV-infected women or uninfected women."[103] A second study of 634 pregnant HIV-positive and HIV-negative women in the US found that "neither experiencing violence nor having an abusive partner differed by serostatus."[104] The third article reviewed literature concerning violence and HIV serostatus, including the risk for violence associated with disclosure of a positive serostatus. The authors stated: "Studies suggest that women with or at risk for HIV come from populations that are also at risk for violence. Violence is not statistically increased among HIV-infected women compared to demographically and behaviourally similar uninfected women. However, for a small proportion of women, violence may occur around disclosure or in response to condom

99 Makin JD, Forsyth BW, Visser MJ, Sikkema KJ, Neufeld S, Jeffery B. Factors affecting disclosure in South African HIV-positive pregnant women. AIDS Patient Care STDs. 2008;22(11):907-16.
100 Medley A, Garcia-Moreno C, McGill S, Maman S. Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: implications for prevention of mother- to-child transmission programmes. Bull World Health Organ 2004;82(4):299-307.
101 Chandrasekaran V, Krupp K, George R, Madhivanan P, et al. Determinants of domestic violence among women attending an Human Immunodeficiency Virus voluntary counseling and testing center in Bangalore, India. Indian J Med Sci 2007;61(5):253-62.
102 Whetten K, Reif S, Whetten R, Murphy-McMillan LK. Trauma, mental health, distrust, and stigma among HIV-positive persons: implications for effective care. Psychosom Med 2008;70(5):531-38.
103 Gruskin L, Gange SJ, Celentano D, et al. Incidence of violence against HIV-infected and uninfected women: findings from the HIV epidemiology research (HER) study. J Urban Health 2002;79(4):512-24.
104 Koenig LJ, Whitaker DJ, Royce RA, Wilson TE, Callahan MR, Fernandez MI. Violence during pregnancy among women with or at risk for HIV infection. Am J Public Health 2002;92(3):367-70.

negotiation."[105] Maman *et al* conclude that "[t]he results [of the studies reviewed]…provide conflicting evidence of an association between HIV serostatus disclosure and risk of violence."[106]

The relationship between HIV seropositivity and risk of experiencing GBV is clearly complicated, and there may be many factors at play that impact the association. For example, a review of 35 US studies on the intersections of HIV and GBV concluded that HIV-positive women appeared to experience violence at rates comparable to HIV-negative women from the same populations; however, their abuse seemed to be more *frequent* and more *severe*.[107] Moreover, there are important differences in how risk or incidence of GBV is being measured in the different studies.

A small number of studies examine the impact of GBV on women's adherence to HIV treatment (see Appendix 3). The studies suggest that:

- **GBV may negatively influence adherence because it can prevent women from accessing health services.** For example, a study of 50 HIV-positive women in the US revealed that abused women were "reluctant to keep appointments [with their health providers] if they were afraid of their partners, if they were depressed, feeling ill or "too worn down," or if they were ashamed of being abused. Abusive partners were sometimes reported to sabotage women's efforts to seek care, keep appointments or take medications. The study authors concluded "domestic violence is an under-recognized barrier to women's ability to obtain regular medical care for HIV/AIDS."[108] Another study of 105 African-American women in the US found that domestic violence appeared to reduce "self-efficacy," by decreasing women's confidence in being able to care for themselves and negatively affecting their ability to maintain high levels of adherence.[109]

One of the studies that explicitly examined the issue of adherence suggested that GBV might negatively influence adherence because it can lead to psychological or emotional disorders. The authors, who focused on 172 women survivors of violence, noted that non-adherence to treatment was partly attributed to "psychological or emotional disorders," and that as a result, professionals ought to pay careful attention to victims of sexual violence who are likely to be psychologically traumatised.[110]

Key Messages:

- HIV seropositivity may be associated with the risk of experiencing violence.
- GBV or fear of GBV may potentially delay a woman's decision to disclose her HIV status.

105 Koenig LJ, Moore J. Women, violence, and HIV: a critical evaluation with implications for HIV services. Matern Child Health J 2000;4(2):103-9.
106 Maman S, et al. Intersections.
107 Gielen AC, Ghandour RM, Burke JG, et al. HIV/AIDS and intimate partner violence: intersecting women's health issues in the united states. Trauma Violence and Abuse 2007;8(2):178-98.
108 Lichtenstein B. Domestic violence in barriers to health care for HIV-positive women. AIDS Patient Care STDS 2006;20(2):122-32.
109 Lopez EJ, Jones DL, Weiss SM. Domestic violence and its impact on physical health among minority HIV-positive women. Annals of Behavioral Medicine 2008;35(Suppl.1):S24.
110 Diniz NM, de Almeida LC, dos S Ribeiro BC, de Macêdo VG. Women victims of sexual violence: adherence to chemoprevention of HIV. Rev Lat Am Enfermagem 2007;15(1):7-12.

- GBV may negatively influence adherence because, for example, it may hinder women from accessing health services.

iv) Substance use, GBV and HIV

17 articles (16 empirical studies and 1 conceptual article) address the associations between substance use, GBV and HIV (see Appendix 4). As with other variations in terminology noted previously, the definition of substance use varies widely across the studies and may, for example, include alcohol use, injecting drug use, crack use and prescription drug use.

Of these 17 studies, 11 take place in the US (65%), 2 take place in South Africa, and 1 takes place in each of Brazil, Ghana, and Tanzania. The sole conceptual article in this section focuses on the intersections of substance use, GBV and HIV in India and Bangladesh.

The empirical studies include quantitative studies and a handful of small qualitative studies. Research methods consist primarily of cross-sectional studies. Sample sizes range from a study of HIV risk among 26 crack-using female sex workers in Brazil to a large study of alcohol abuse and sexual risk behaviours among 2,019 women in Tanzania.[111,112]

14 studies (82%) suggest that substance use has some impact on the associations between GBV and HIV. However, there is a general lack of consensus as to how, precisely, the pathways between GBV and HIV or between HIV and GBV are impacted.

Key findings in this area suggest that:

- **GBV may be linked to substance use.** One study of 2,019 women in Moshi, Tanzania showed that alcohol abuse was associated with physical and sexual violence.[113] A study of 310 HIV-positive women in the US found that drug use was a risk factor for experiencing abuse after diagnosis of HIV.[114] A study of 113 female sex workers in the US found that those who reported exchanging sex for drugs and money as their main source of income, used injection drugs in the past year, had sex in crack houses, and were HIV-positive each were more likely to report combined physical and sexual abuse.[115]
- **Substance use may be linked to an increase in HIV risk behaviours.** In a study of 2,019 women in Moshi, Tanzania, their alcohol abuse was associated with number of sexual partners, and women who had multiple sexual partners were more likely to have an STI compared to women who had only 1 sexual partner.[116] A study of 45 women and men in Ghana revealed that the increasing

111 Malta M, Monteiro S, Lima RM, et al. HIV/AIDS risk among female sex workers who use crack in Southern Brazil. Rev Saude Publica 2008;42(5):830-7.
112 Ghebremichael M, Paintsil E, Larsen U. Alcohol abuse, sexual risk behaviors, and sexually transmitted infections in women in Moshi Urban District, Northern Tanzania. Sex Transm Dis. 2008;36(2):102-7.
113 Ibid.
114 Gielen AC, et al. Women's lives.
115 El-Bassel N, Witte SS, Wada T, Gilbert L, Wallace J. Correlates of partner violence among female street-based sex workers: substance abuse, history of childhood abuse, and HIV risks. AIDS Patient Care STDS 2001;15(1):41-51.
116 Ghebremichael M, et al.

alcohol (Akpeteshie) consumption by both men and women potentially led to male violence, and made it difficult for women to resist or negotiate unprotected sex. Alcohol consumption was said to have "reinforced women's inability to control the sexual lives of their partners in a male-dominated society."[117]

- **Gender differences in substance use may be impacting the intersection of GBV and HIV.** One study of 395 men and women in South Africa found that recent exposure to intimate partner violence among men was associated with all forms of drug use, whereas women who were recently abused were more likely to suffer from depression and problem drinking. Furthermore, exposure to community violence increased reported sexual risk behaviors among men.[118]

Two studies found no relationship between substance use and GBV or HIV. The first study which examined intimate partner violence and HIV status among 611 low-income women in the US found that "the overall relationship between IPV experiences and substance use appears to be stronger for HIV-negative women than HIV-positive women."[119] The second study took place among 322 male methadone users in the US. The authors found that "support was not found for a direct link between male drug use and physical IPV or sexual HIV risk behaviours as predicted based on previous research."[120]

Despite the findings from these two studies, the bulk of research in this area (82%) suggests that substance use has an impact on GBV and HIV, even as the exact pathways are not entirely clear.

Key Messages:

- GBV may be linked to substance use.
- Substance use may be linked to an increase in HIV risk behaviours and GBV even as the exact pathways are not yet entirely clear.
- Gender differences in substance use may impact the ways in which GBV and HIV intersect.

v) GBV and HIV in conflict/emergency situations

Two articles in this review specifically examine associations between GBV and HIV in conflict and/or emergency situations (see Appendix 5). These articles present differing views on the intersections between GBV and HIV in conflict situations.

The first study reviews 4,715 patient histories and 7 interviews of women survivors of the conflict in Eastern Congo. This study states that the association between GBV and the

117 Luginaah I. Local gin (akpeteshie) and HIV/AIDS in the Upper West Region of Ghana: the need for preventive health policy. Health Place 2008;14(4):806-16.
118 Wong FY, Huang ZJ, DiGangi JA, Thompson EE, Smith BD.Gender differences in intimate partner violence on substance abuse, sexual risks, and depression among a sample of South Africans in Cape Town, South Africa. AIDS Educ Prev 2008;20(1):56-64.
119 Burke JG, Thieman LK, Gielen AC, O'Campo P, McDonnell K. Intimate partner violence, substance use, and HIV among low-income women - taking a closer look. Violence Against Women 2005;11(9):1140-61.
120 El-Bassel N, Gilbert L, Golder S, Wu E, Chang M, Fontdevila J. Deconstructing the relationship between intimate partner violence and sexual HIV risk among drug-involved men and their female partners. AIDS Behav 2004;8(4):429-39.

risk of acquiring HIV is potentially stronger in conflict settings than during peace-time. The article suggests that the HIV prevalence amongst armed combatants is much higher than in the general population. The authors argue that women in conflict situations may face an increased risk of GBV and subsequently, an increased risk of acquiring HIV.[121]

The second study, a review of HIV-prevalence data from seven sub-Saharan African countries states that these data do not show an increase in HIV prevalence during periods of conflict, irrespective of prevalence when conflict began. The authors argue that despite wide-scale rape in many countries, there are no data to show that the rapes increased prevalence of HIV at the population level.[122]

Despite these differences, one point of consensus is that in conflict situations, rape and sexual violence occur and interventions to address GBV or HIV in conflict situations are lacking.[123]

Key Messages:

- Conflict and emergency situations may affect the intersections of GBV and HIV.
- In conflict situations, rape and sexual violence are often reported to be high and interventions to address GBV, HIV or their intersections sorely lacking.

c) Interventions at the Intersections of GBV and HIV

i) Addressing structural factors

A large number of articles highlight the need to understand and address the structural factors underlying the intersections of GBV and HIV. Structural factors are generally discussed in relation to local context, gender inequalities, socio-economic dynamics and cultural issues (see Appendix 6).

There are 34 articles in this section of the review. 23 of these articles focus on interventions. The other 11 articles are empirical studies whose main aim is to examine the linkages between GBV and HIV but in their conclusions, highlight specifically the importance of structural interventions. As a result, they are also referenced in other appendices (Appendices 1-5).

Of these 34 articles, 16 studies take place in South Africa (47%), 8 studies take place in the US (24%), and 2 take place in India. There is one study each from Brazil, Puerto Rico and Kenya, while one study does not specify an area of focus. 4 of these articles can be seen to have a 'global' focus.

The empirical studies are primarily quantitative, with a handful of smaller qualitative studies. Research methods are diverse and include randomised trials and short-term participatory studies. Sample sizes range from 20 qualitative interviews of HIV

121 Longombe AO, Claude KM, Ruminjo J. Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies. Reprod Health Matters 2008;16(31):132-41.
122 Spiegel PB, Rygaard B, Johanna C, et al. Prevalence of HIV infection in conflict-affected and displaced people in seven Sub-Saharan African countries: A Systematic Review. The Lancet 369(9580):2187-95, 2007
123 Longombe AO, et al.

prevention practices among recent-US immigrant Jamaican women, to a large structural intervention in South Africa that enrolled 5,156 low-income women.[124,125]

Some authors suggest that strategies that have been the cornerstone of HIV prevention efforts, such as condom use and monogamy, have largely failed in societies where women do not have the ability to negotiate the terms of their sexual relationships.[126] To increase steady-partner condom use and to strengthen intentions toward casual-partner condom use some authors argue that interventions ought to target structural and contextual attitudes and the beliefs that underlie them.[127]

The articles suggest attention to:

- **Local culture** and ensuring cultural sensitivity, although this is not well defined.[128]
- **Gender**, and, if necessary, tailoring interventions separately for women or men.[129]
- **The participation of the community** and not just particular individuals.
- **Incorporating men into intervention programmes**. This includes involving men as agents who are "responsible for their health behaviour" and engaging communities in "transformative dialogue around ideals of masculinity."[130,131,132]

One article explains that comprehensive GBV and HIV prevention should "urgently include programmes that address the key *drivers of the epidemic*," by aiming to change societal norms and create safer sexual environments.[133]

The following are examples of often-cited interventions that address structural factors:

- Most importantly, in South Africa, the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) trial, a combined microfinance and training intervention, was shown to lead to reductions in levels of intimate partner violence among programme participants (although no reduction in HIV prevalence was observed). The IMAGE study assessed the effect of a structural intervention combining group-based microfinance with a gender and HIV training curriculum on HIV risk behaviour and intimate partner violence. The authors emphasised that the intervention's focus on

124 Gillespie-Johnson M. HIV/AIDS prevention practices among recent-immigrant Jamaican women. Ethn Dis 2008;18(2 Suppl 2):S2-175-8.
125 Pronyk PM, Hargreaves JR, Kim JC, Morison LA, Phetla G, Watts C. Effect of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa: a cluster randomised trial. Lancet 2006;368(9551):1973-83.
126 Maman S, et al. HIV-Positive Women.
127 Beadnell B, Baker S, Gillmore MR, Morrison DM, Huang B, Stielstra S. The theory of reasoned action and the role of external factors on heterosexual men's monogamy and condom use. J Appl Soc Psychol 2008;38(1):97-134.
128 Abreu S, et al.
129 Bastos FI, Cunha CB, Hacker MA; Grupo de Estudos em População, Sexualidade e Aids. Signs and symptoms associated with sexually transmitted infections in Brazil, 2005. Rev Saude Publica 2008;42(Suppl 1):98-108; Wong, et al.
130 See e.g. Campbell CA. Male gender roles; Dunkle KL, et al. Transactional sex; and Kalichman S, Simbayi L, Cloete A, et al. HIV/AIDS risk reduction and domestic violence prevention intervention for South African men. Int J Mens Health 2008;7(3):255-73.
131 Campbell CA. Male gender roles.
132 Dunkle, et al. Perpetration of partner violence.
133 Piot P, Bartos M, Larson H, Zewdie D, Mane P. Coming to terms with complexity: a call to action for HIV prevention. Lancet 2008;372(9641):845-59.

changing attitudes and tackling structural factors by promoting social and economic development interventions had the potential to alter the risk environments for HIV and intimate-partner violence in southern Africa.[134]

- A US study touted its success in developing an intervention that addressed structural issues of gender and inequality, even as the intervention itself was not a structural intervention per se, in that it provided group sessions on ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationship. The study demonstrated that among 146 young women with a history of gender-based violence the HIV intervention led to substantial reductions in HIV-associated sexual behaviours and reductions in frequencies of sexually transmitted infections. The efficacy of the intervention assessed in this study was attributed to its conceptualization within a "gender-tailored framework," that contextualised the intervention within a theory of gender and power.[135]

Key Messages:

- Comprehensive GBV and HIV interventions that address the key drivers of the epidemic should change societal norms and create safer environments through attention to:
    - Local culture and the importance of cultural sensitivity
    - Gender and local constructions of gender
    - The participation of the community
    - Sustained engagement with men

ii) Integrating services

A large number of studies discuss the importance of integration even as there is great variety as to what this means across the studies reviewed (see Appendix 7).

41 articles are included in this section of the review. 18 of these articles focus on interventions. The other 23 articles are empirical studies whose main aim is to examine the linkages between GBV and HIV, but in their conclusions, highlight specifically the importance of interventions that integrate services. As a result, these 23 articles are also referenced in other appendices (Appendices 1-5).

Of these 41 studies, 27 take place in the US (66%), 4 take place in South Africa (10%), 2 take place in India (5%), and 2 are global. One study each takes place in Brazil, Canada, the U.K., and Zambia, and there is one regional study in sub-Saharan Africa and one study in Latin America (Dominican Republic, Peru, and Venezuela specifically).

The empirical studies include primarily quantitative studies, with a handful of smaller qualitative studies. Research methods are diverse and include evaluations of short-term risk-reduction interventions (e.g. through teaching modules), individual interviews, and

134 Pronyk PM, et al. Effect of a structural intervention; Kim JC, Watts CH, Hargreaves JR, et al. Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. Am J Public Health 2007;97(10):1794-1802.
135 Wingood GM, DiClemente RJ, Harrington KF, et al. Efficacy of an HIV prevention program among female adolescents experiencing gender-based violence. Am J Public Health 2006;96(6):1085-90.

surveys of institutions. Sample sizes range from a study of 25 qualitative interviews of women and staff at domestic violence crisis centres in the US, to a study of wills and will-writing among 1,843 HIV-infected cohabiting couples in Zambia.[136,137]

The types of integration referred to in the articles in this section include:

- Integrating GBV services with HIV prevention[138]
- Integrating sexual and reproductive health (SRH) services with HIV services[139]
- Integrating HIV prevention and services with GBV screening[140]
- Integrating GBV and SRH, or GBV, HIV and SRH services[141]

One US study examined 21 domestic violence shelters that attempt to integrate GBV with HIV screening. The study found that "although 90.5 percent of the shelters reported that they routinely ask about their clients' sexual abuse histories, there was no link between a woman's disclosure of sexual abuse and a subsequent provision of appropriate HIV/AIDS services (referrals for testing, treatment) by the shelter." Furthermore, although HIV/AIDS awareness was high among the shelter staff who responded to the survey, actual HIV/AIDS prevention and education were practically nonexistent.[142]

Articles that support integration provide the following recommendations:

- **Train and develop the capacity of service providers** to enable them to integrate GBV and HIV services. This will improve prevention, screening and treatment of both HIV and GBV.[143,144]
- **Increase availability of and access to post-exposure prophylaxis (PEP) in concert with comprehensive SRH services, proper counselling and follow-up care,** and integrate PEP into SRH and GBV services to make it more accessible to survivors of violence, including adolescents and children.[145]

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136 Wilson KS, Silberberg MR, Brown AJ, Yaggy SD. Health needs and barriers to healthcare of women who have experienced intimate partner violence. J Womens Health 2007;16(10):1485-98.
137 Mendenhall E, Muzizi L, Stephenson R, et al. Property grabbing and will writing in Lusaka, Zambia: an examination of wills of HIV-infected cohabiting couples. AIDS Care 2007;19(3):369-74.
138 See e.g. Fox AM, Jackson SS, Hansen NB, Gasa N, Crewe M, Sikkema KJ. In their own voices: a qualitative study of women's risk for intimate partner violence and HIV in South Africa. Violence Against Women 2007;13(6):583-602; Wilson KS, et al; Rountree MA, Pomeroy EC, Marsiglia FF. Domestic violence shelters as prevention agents for HIV/AIDS? Health Soc Work. 2008;33(3):221-8.
139 See e.g. Lang DL, Salazar LF, Wingood GM, DiClemente RJ, Mikhail I. Associations between recent gender-based violence and pregnancy, sexually transmitted infections, condom use practices, and negotiation of sexual practices among HIV-positive women. J Acquir Immune Defic Syndr 2007;46(2):216-21.
140 See e.g. Chandrasekaran V, et al. Cohen M, et al; Klein SJ, Tesoriero JM, Leung SY, Heavner KK, Birkhead GS. Screening persons newly diagnosed with HIV/AIDS for risk of intimate partner violence: early progress in changing practice. J Public Health Manag Pract 2008;14(5):420-8.
141See e.g. Breiding MJ, Black MC, Ryan GW. Chronic disease and health risk behaviors associated with intimate partner violence-18 US states/territories. Ann Epidemiol 2005;18(7):538-44; Braitstein P, et al. Guedes A, Bott S, Cuca Y. Integrating systematic screening for gender-based violence into sexual and reproductive health services: results of a baseline study by the International Planned Parenthood Federation, Western Hemisphere region. Int J Gynecol Obstet 2002;78(Suppl 1):S57-63.
142 Rountree MA, et al.
143 Go VF, Sethulakshmi CJ, Bentley ME, et al. When HIV-prevention messages and gender norms clash: the impact of domestic violence on women's HIV risk in slums of Chennai, India. AIDS Behaviour 2003;7(3):263-72.
144Heintz AJ, Melendez RM. Intimate Partner Violence and HIV/STD Risk among Lesbian, Gay, Bisexual, and Transgender Individuals. Journal of Interpersonal Violence 21(2):193-208, 2006.
145 Ellis JC, Ahmad S, Molynuex EM. Introduction of HIV post-exposure prophylaxis for sexually abused children in Malawi. Arch Dis Child 2005;90:1297-9.

- **Provide HIV education, as well as counselling and testing referrals at domestic violence shelters**. Several authors note that bringing HIV prevention into GBV services is important because abused women may be particularly vulnerable to HIV infection.[146]
- **Screen for GBV in HIV services.** A number of authors note that integrating violence screening into HIV services can help to identify those women who might be at particular risk.[147]
- **Pay attention to CSA in HIV prevention campaigns.** Noting the potential links between CSA and HIV, several authors raise CSA as an issue that should be integrated into HIV prevention programmes.[148]

Key Messages:

- Integrated GBV and HIV interventions should include but not be limited to:
  - HIV education, as well as counselling and testing referrals at domestic violence shelters
  - Screening for GBV in HIV services
  - Attention to child sexual abuse in HIV prevention campaigns
  - In concert with comprehensive SRH services, proper counselling and follow-up care, increased availability of and access to post-exposure prophylaxis (PEP) and integrate PEP into SRH and GBV services

iii) Building skills and strategies

A number of studies discuss the importance of building skills and strategies when responding to GBV and HIV (see Appendix 8).

There are 5 articles of relevance to this section of the review. 1 article focuses primarily on a gender-specific skills-building intervention while the other 4 articles are empirical studies which examine the linkages between GBV and HIV. As a result, these 4 articles are also referenced in other appendices (Appendices 1-5).

Of these 5 articles, 4 take place in the US and one takes place in China. The single intervention-focused empirical study enrolled 152 women who had experienced partner physical abuse.[149]

The studies reviewed all note that interventions that provide information, education, and communication alone are insufficient. Multi-strategy interventions are called for--interventions that will, in the words of one article, "promote equity between women and men, provide economic opportunities for women, inform them of their rights, reach out to men and change societal beliefs and attitudes that permit exploitative behaviour."[150]

146 See e.g. Shelton AJ, Atkinson J, Risser JMH, et al. The prevalence of partner violence in a group of HIV-infected men. AIDS Care 2005;17(7):814-8;Fox AM, et al.
147 See e.g. Koenig LJ, et al. Women, violence and HIV. Maman S, et al. The intersections of HIV; Kaye D. Gender inequality and domestic violence: Implications for Human Immunodeficiency Virus (HIV) prevention. Afr Health Sci 2004;4(1):67-70.
148 See e.g. Braitstein P, et al; Brennan DJ, et al.
149 Ibid.
150 Fawole, OI.

- A structural intervention lauded as a success in improving people's skills was the (IMAGE) study noted earlier. Over a 2-year period, the researchers noted improvements in economic well-being as well as in multiple dimensions of empowerment among program participants. As a result of these improvements in skills and capacity, levels of GBV were reduced by 55%.[151]

- Another well-known structural intervention, Stepping Stones, was found to reduce the incidence of herpes simplex virus-2 and perpetration of intimate partner violence, even as it too did not reduce incidence of HIV.[152] Stepping Stones may have been particularly effective because it "addressed gender norms and provided communication skills that could be used to build better relationships, which was seen as a valued outcome by both men and women." The project also highlighted the role of interventions with women and girls that empower them with relationship skills and challenge the acceptability of gender-based violence.[153]

Articles emphasise the following skills:

- **Communication and negotiation skills,** especially if they can support women to negotiate for safer sex.[154]
- **Skills for sexual assertiveness** although authors warn that such skills must be placed in the context of potential repercussions.[155]
- **Behavioural skills** training such as problem-solving, coping, and help-seeking skills.[156]
- **Condom wear/use skills**, especially for female sex workers.[157]
- **Strategies for women on how they might increase their safety,** for example by reducing risks posed by male partners, risk-reduction decision-making skills, and personal resources for dealing with threats of abuse.[158]

Authors point out, however, that skill-building must also be directed towards men. One article in particular calls for including heterosexual and bisexual men in skill-building efforts.[159]

Key Messages:

- In addition to information, education, and communication for women and men, comprehensive GBV and HIV interventions should build and develop skills and strategies. The following skills are especially highlighted:
  - Communication and negotiation skills
  - Skills for sexual assertiveness
  - Behavioural skills training such as problem-solving, coping and help-

151 Pronyk PM, Kim JC, Abramsky T, et al. A combined microfinance and training intervention can reduce HIV risk behaviour in young female participants. AIDS 2008;22(13)1659-65.
152 Jewkes R, Nduna M, Levin J, et al. Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. BMJ 2008;337:a506.
153 Greig A, et al.
154 Melendez RM, et al.
155 Kalichman SC, Williams EA, Cherry C, Belcher L, Nachimson D. Sexual coercion, domestic violence, and negotiating condom use among low-income African American Women. J Womens Health 1998;7(3):371-8.
156 El-Bassel N, et al. Correlates of partner violence.
157 Choi SY, et al.
158 El-Bassel N, et al. Correlates of partner violence.
159 Kalichman SC, et al. Sexual coercion.

seeking
- Condom wear/use skills
- Strategies to increase physical safety and reduce HIV vulnerability

iv) Focusing on vulnerable groups

Several studies highlight the fact that vulnerable groups should receive increased attention when implementing and designing interventions (see Appendix 9).

13 articles form the focus of this section of the review. 8 of these articles have interventions as their primary focus. The other 5 articles are empirical studies whose main aim is to examine the linkages between GBV and HIV, but in their conclusions, highlight specifically the importance of focusing on vulnerable groups. As a result, these 5 articles are also referenced in other appendices (Appendices 1-5).

Of these 13 studies, 8 take place in the US (62%), and one study takes place in each of Tanzania, Senegal, Jamaica, and Hong Kong. One article does not specify a geographical area of focus.

The empirical studies in this section include primarily quantitative studies and a handful of smaller qualitative studies. Research and data-gathering methods are diverse and include randomised control trials, small qualitative studies that focus on individual interviews, and short-term risk-reduction interventions. Sample sizes range from a small study of 5 qualitative interviews of Jamaican adolescents, to a study of 2,010 female migrant workers in Hong Kong.[160,161]

Vulnerable groups specifically noted in the literature reviewed include:
- Aboriginal populations
- Adolescents and children
- Ethnic minorities
- Indigent persons
- LGBT
- Migrants
- MSM
- People in prisons/other confined populations
- Persons who are homeless
- Sex workers
- Substance users
- Women with histories of incarceration

These articles highlight the following issues:

- **Women are not homogeneous.** Authors agree that it is important to differentiate among sub-groups of women when tailoring interventions to make sure the different vulnerabilities faced by different groups are addressed. One study of 2,010 female migrant workers in Hong Kong, for example, emphasised the

160 Lowe GA, Gibson RC, Christie CD. HIV infection, sexual abuse and social support in Jamaican adolescents referred to a psychiatric service. West Indian Med J 2008;57(3):307-11.
161 Bandyopadhyay M, Thomas J. Women migrant workers' vulnerability to HIV infection in Hong Kong. AIDS Care 2002;14(4):509-21.

specific vulnerabilities faced by this group with regards to sexual violence and its implications for HIV transmission.[162] Another study examined the intersections among 620 mid-life and older women in the US, pointing out the particular vulnerabilities of these women.[163]

- **Focusing on vulnerable groups means specifically tailoring interventions to their needs.** For example, authors found that homeless people may require specifically tailored screening for violence, mental health issues, and HIV.[164] A qualitative study of 5 Jamaican adolescents revealed that adolescents who acquired HIV infection through sexual abuse may require more psychological and social support than others.[165] A risk-reduction intervention for 137 HIV-positive African-American and Latino men in the US with histories of CSA concluded that "additional strategies to heighten HIV risk reduction over time" need to be developed.[166]

Overall, several articles suggest that many population sub-groups particularly vulnerable to the intersections of GBV and HIV are being ignored in research and interventions.

Finally, a number of articles (see Appendix 10) suggest other factors that should be taken into account, such as:

- The importance of making HIV post-exposure prophylaxis more available, especially for children, keeping in mind the necessity of proper counselling, comprehensive SRH services, and integration with comprehensive post-rape care.[167]
- The need for early intervention services, in order to "reduce the chances that survivors of child abuse become early victims of domestic violence or infected with HIV."[168] This suggestion seems an attempt to at least partially address the *cycle* of GBV and HIV.
- The need to make alternative HIV prevention methods (i.e. vaginal microbicidal products) available to women in violent relationships.[169]

Key Messages:

- Comprehensive GBV and HIV interventions should be inclusive of marginalized and vulnerable groups. These groups include but are not limited to:
  - Aboriginal populations

162 Bandyopadhyay M, et al.
163 Sormanti M, Shibusawa T. Intimate partner violence among midlife and older women: a descriptive analysis of women seeking medical services. Health Soc Work 2008;33(1):33-41.
164 Henny KD, Kidder DP, Stall R, Wolitski RJ. Physical and sexual abuse among homeless and unstably housed adults living with HIV: prevalence and associated risks. AIDS Behav 2007;11(6):842-53.
165 Lowe GA, et al.
166 Williams JK, Wyatt GE, Rivkin I, Ramamurthi HC, Li X, Liu H. Risk reduction for HIV-positive African American and Latino men with histories of childhood sexual abuse. Arch Sex Behav 2008;37(5)763-72.
167 See e.g. Kim JC, Martin LJ, Denny L. Rape and HIV post-exposure prophylaxis: addressing the dual epidemics in South Africa. Reprod Health Matters 2003;11(22):101-12; Ellis JC, et al; Speight CG, Klufio A, Kilonzo SN, et al. Piloting post-exposure prophylaxis in Kenya raises specific concerns for the management of childhood rape. Trans R Soc Trop Med and Hyg 2006;100(1):14-8.
168 McDonnell KA, Gielen AC, O'Campo P. Does HIV status make a difference in the experience of lifetime abuse? Descriptions of lifetime abuse and its context among low-income urban women. J Urban Health 2000;90(4):560-5.

169 Saul J, et al.

- Adolescents and children
- Ethnic minorities
- Indigent persons
- LGBT
- Migrants
- MSM
- Persons in prisons/other confined populations
- Persons who are homeless
- Sex workers
- Substance users
- Women with histories of incarceration

C. KEY GAPS

This section of the report is organized according to gaps recognized through review of all materials. The key gaps identified through the literature reviewed include:

a. The Type of Research Carried Out
b. Where the Research is Taking Place
c. The Population Groups Involved
d. Definitions and Measures
e. The Evidence Linking GBV and HIV
f. The Interventions Addressing GBV and HIV

a) Gap: The Type of Research Carried Out

The literature review suggests four broad categories of studies (see Table 1):

a. Empirical studies that examine intersections between GBV and HIV;
b. Empirical studies that test interventions related to GBV and HIV;
c. Articles that put forth a conceptual framework for understanding and/or addressing the intersections of GBV and HIV; and
d. Review articles, which synthesize previous research.

TABLE 1: Types of Research

Type of Research	**Number of Articles (%)**
Empirical studies examining the evidence linking GBV and HIV	144 (70.6%)
Empirical studies testing interventions that aim to address the intersection of GBV and HIV	31 (15.2%)
Conceptual articles	20 (9.8%)
Review articles	9 (4.4%)
Total No. of Articles:	**204**[170]

The majority of articles reviewed (144 articles, 70%) are empirical studies that in some way examine the intersections between GBV and HIV. These studies are diverse, and

170 A given article may include dimensions of each of the above, but articles could generally be categorized into one of the above four areas.

cover a wide range of subjects, including:

- The association between CSA and HIV among MSM populations
- The linkages between GBV and HIV prevention
- The multiple vulnerabilities sex workers face when it comes to both violence and HIV risk
- The evidence linking HIV seropositivity to risk of experiencing GBV

A large number of articles focus on empirical studies that test interventions related to GBV and HIV (31 articles, 15.2%). These studies also differ broadly both in their approach and specific focus and include:

- The effectiveness of HIV prevention interventions among women survivors of GBV
- The benefits of integrating screening for GBV into HIV prevention and reproductive health services
- The potential of using GBV services to broaden HIV prevention efforts

About 20 articles in the review (9.8%) can be described as conceptual, insofar as they do not present empirical research but rather discuss the linkages between GBV and HIV more broadly, summarize potential causal pathways and suggest potential frameworks to help to understand and address the intersections. These articles raise several themes, including:

- Paying attention to structural factors, such as economics and poverty, that lie at the root of GBV and HIV;
- Recognizing the role of sexuality and/or gender within the interplay of violence and HIV;
- Understanding how stigma and discrimination can fuel GBV and HIV; and
- Using human rights as a framework to address the linkages between GBV and HIV.

Finally, the remaining articles (9 articles, 4.4%) can be described as review articles. These are articles that synthesize previous research and attempt to highlight common themes and gaps.

Taken together, four conclusions can be drawn:

1) **The bulk of the articles focus on empirical studies examining the associations between GBV and HIV.**
2) **There are few studies that focus on the issues related to causation as noted earlier.**
3) **Even fewer draw attention to the conceptual frameworks underlying their efforts.**
4) **The bulk of the empirical studies examine evidence linking GBV to the risk of acquiring HIV**. Very little research is focused on the other side of this equation: i.e. the evidence linking HIV seropositivity to the risk of experiencing GBV.

b) Gap: Where the Research is Taking Place

The 204 articles surveyed were categorized according to the country in which the study

took place (see Table 2).[171] This analysis highlights those regions which one can say are over-represented in the English-language literature and importantly those that are under-represented.[172]

TABLE 2. Where is the research taking place?

Regions covered by abstracts (no. of abstracts)	**Countries covered by abstracts** (no. of abstracts)	**Percentage of total abstracts**
No specific country focus (3)		1.5%
Multi-country (2)		0.1%
Global (8)		3.9%
Africa (54)	Botswana (1) Republic of Congo (2) Ghana (1) Kenya (4) Malawi (1) Senegal (1) South Africa (30) Tanzania (8) Zambia (3) Zimbabwe (1) Sub-Saharan Africa (2)	26.5% [14.7% of total abstracts focus on South Africa]
Arab States (0)	(0)	0
Asia and the Pacific (19)	Bangladesh (1) China (1) Hong Kong (1) India (14) Pakistan (1) Papua New Guinea (1)	9.3%
Eastern Europe and Central Asia (2)	Serbia (1)* Ukraine (1)	1%
Latin America & the Caribbean (11)	El Salvador (1) Puerto Rico (1)* Jamaica (1) Brazil (7) Dominican Republic/Peru/Venezuela (1)	5.4%
North America/Canada (103)**	USA (100) Canada (3)	50.5% [About 49% of total abstracts focus on US populations]
Western Europe (1)**	UK (1)	0.5%
Oceania (1)**	Australia (1)	0.5%
TOTAL: 204****		100%

***These countries do not appear in UNFPA's list for this region but have been assigned to these regions because it makes sense geographically.
****These are regions in which UNFPA does not work, and therefore neither these regions, nor the countries included in them appear on UNFPA's list of worldwide countries and regions.
*****These abstracts cannot be categorized as either the abstract or the article is currently unavailable.

As shown in the table, an overwhelming number of studies are carried out in the US (49%), more than three times as many as in Sub-Saharan Africa, for example. Within the English-language peer-reviewed literature there is much less work being published from

171 In the table, countries were categorized according to the regions used by UNFPA on the 'Worldwide' section of their website (http://www.unfpa.org/worldwide/).
172 The results of this exercise perhaps also highlight a difficulty of the search methodology. Given the restriction to English-language abstracts, it is possible that the review was biased towards retrieving studies primarily focused on English-speaking countries in the industrialized world.

Asia (9.3%) although interestingly, India is relatively prominent in the literature, and is – after the US and South Africa - the third highest country where studies are taking place. Even less is published from Latin America and the Caribbean (5.4%) and very little from either Western Europe, (0.5%) Eastern Europe (1%) or Oceania (0.5%). Finally, the Arab States (0.0%) appear to be non-existent in the literature.

In analysing these findings, one main gap becomes clear:

1) **The bulk of published research on the intersections of GBV and HIV is taking place in the United States**. Under-represented are all the other regions of the world. The WHO Multi-Country Study on Women's Health and Domestic Violence against Women revealed that GBV against women is indeed a *global* problem.[173] HIV is also a global issue, although prevalence and epidemics vary widely both between and within regions. The intersections of GBV and HIV are, therefore, likely to be relevant everywhere in the world. In regions such as Eastern Europe and Central Asia, where HIV rates used to be relatively low, but are on the rise, there is virtually no information as to what is happening with respect to the intersections between gender-based violence and HIV.

c) Gap: The Population Groups Involved

There is a wide range in how populations are defined or named in the articles reviewed, with significant implications for the conclusions that can be drawn regarding which groups are well-represented and which are largely ignored.

A sample of the populations named includes:[174]

- "Women" which include: women, married women, aboriginal women, women aged 50-64, women/young women, women who have taken out protective orders against partners, HIV-positive and HIV-negative pregnant women, female prisoners, female migrant workers; etc.
- "Men" which include: men, heterosexual men, men at STI clinics, HIV-positive heterosexual men, etc.
- "Women and men" which include: discordant couples; married/unmarried HIV-positive & HIV-negative individuals, VCT clients & counsellors, aboriginal populations, women & men survivors of sexual assault, immigrants, etc.
- "Children" and/or "adolescents" which include: children/adolescents, female high school students, adolescent males, etc.
- "Sex workers" which include: sex workers, female sex workers, female & transvestite sex workers, female sex workers who use crack, male sex workers, HIV-positive male sex workers, etc.
- "MSM" which include: MSM, MSM and gay and bisexual men, etc.
- "LGBT" which include: Lesbians, transgender populations, LGBT persons, etc.
- "Injecting drug users" (IDUs) which include: women IDUs, female drug users, male methadone users, MSM IDUs, etc.

Some studies define populations by their race/nationality/ethnic group, such as discordant African-American couples, African-American adolescents, African-American

173 WHO. Multi-country Study.

174 The names used to describe these population groups are taken directly from the studies, using the authors' terminology.

women, HIV positive African-American women, immigrant Jamaican women, Hispanic women, HIV positive African-American and Latino men who have sex with men and women, HIV-positive people of Caribbean origin. At the same time, many studies do not define study populations with this level of specificity.

It is interesting to note that certain populations seem to be studied in relation to particular issues but not in relation to others (see Table 3). For example, many of the studies that examined the association between CSA and risk of acquiring HIV examined CSA primarily among MSM but not with respect to other population groups. Table 4 highlights which populations are studied in the different regions.

TABLE 3: Study Populations and Focus of Study[175]

Focus of Study	Women	Men	Women and Men	Children/ Adolescents	Sex Workers	MSM	LGBT	IDUs	None Specified
GBV and the Risk of Acquiring HIV	38	10	9	11	7	3	5	2	2
CSA and the Risk of Acquiring HIV	5	1	1	2	1	8	0	1	1
HIV Seropositivity and the Risk of Experiencing GBV	18	0	5	0	0	0	0	1	5
GBV, Substance use and HIV	8	0	5	0	2	0	0	1	1

175 Table 3 illustrates types of population groups focused on in the 4 major types of empirical studies that examine intersections between GBV and HIV; Number=Number of Studies. Table 4 illustrates types of population groups and regions covered in the 4 major types of empirical studies that; Number=Number of Studies. In cases of overlap, the study was categorized according to the main topic of focus.

TABLE 4: Population Groups and Regions[175]

	Population Group								
Regions covered	**Women[176]**	**Men**	**Women and Men**	**Children/ Adolescents**	**Sex Workers**	**LGBT**	**MSM**	**IDUs**	**None Specified[177]**
Africa	14	6	12	1	0	0	1	0	0
Arab States	0	0	0	0	0	0	0	0	0
Asia & the Pacific	8	1	0	0	4	0	0	0	1
Eastern Europe & Central Asia	1	0	0	0	1	1	0	0	0
Latin America & the Caribbean	3	2	2	1	2	0	1	0	0
North America/Canada	39	2	6	11	3	4	9	5	2
Western Europe	1	0	0	0	0	0	0	0	0
Oceania	1	0	0	0	0	0	0	0	1

With respect to population groups involved, five main gaps become clear:

1) **Some populations, even when they appear often, are considered with attention to a limited set of issues**. For example, many of the studies relating to MSM focus on how childhood sexual abuse may increase HIV risk behaviours later in life but do not consider other dimensions of the linkages between violence and HIV with respect to this population. To date, most studies pertaining to the MSM community take place in the US. Likewise, all 6 studies that consider married women as a specific population group appear to be carried out in India, and almost all of these studies examine exclusively the risks Indian women who survive violence face in acquiring HIV from their husbands.
2) **Overall, research on vulnerable population groups remains limited**. Populations such as female sex workers, minorities, the poor, illegal immigrants, LGBT populations, drug users and people in prisons are given little attention. In the peer-reviewed literature, prisoners and other confined populations are a particularly neglected group, even as grey literature has shown that this group is especially vulnerable at the intersections of GBV and HIV.[178] Very few studies

[176] Note the total number of studies in this column is no the same as the 'Women" column in Table 3 as one of the articles focusing on women had a multi-country focus.
[177] Note the total number of studies in this column is not the same as the 'None Specified' column in Table 3 as many of the articles that fall into this category had a multi-country or global focus.
178 For studies in the grey literature that provide insight into the vulnerabilities of prison populations at the intersection of GBV and HIV, see footnotes 15 and 16 in this report.

focus on heterosexual men, with the exception of a small number of studies that primarily address their role as perpetrators of violence.

3) **Most studies consider GBV/HIV within the context of heterosexual relationships, with only a few focusing on same sex couples/practices,** or acknowledging that people in heterosexual relationships may also be involved in same-sex sexual activity. Issues surrounding sexuality are explicitly considered in only a tiny proportion of the articles reviewed.
4) **The majority of published studies that include children take place in the United States or in Latin America.** However, in general, very little research was found with respect to children or adolescents. In relation to interventions, children are rarely mentioned.
5) **Elderly people are a neglected population.** Only 1 study focused on the intersections of GBV and HIV in elderly populations.

d) Gap: Definitions and Measures

In examining the intersections of GBV and HIV, the studies are inconsistent with respect to the definitions, terminologies, and measurements used.

Three main gaps become clear:

1) **Studies are inconsistent in how broadly they define GBV** in terms of whether it is defined as physical, sexual, emotional, etc, the severity of GBV examined, and the temporal aspect of when the GBV occurred (e.g. some studies only ask about GBV events in the past three months, others range as far back as GBV in childhood). Articles use a variety of terms, including gender-based violence, domestic violence, intimate partner violence, sexual victimisation, and abuse. All of these variations add to the difficulty in comparing studies and drawing overall conclusions.
2) **Studies lack harmonized definitions and interpretations of terms such as CSA, HIV risk behaviour, risky sexual behaviour, and risk of GBV.** This finding is not new. A previous review of studies on CSA and HIV, found that one of the biggest limitations of the research was the lack of consensus about the definition of CSA.[179] This is a problem in relation to the studies generally. Additionally, even if studies have similar definitions of HIV risk behaviours, the *measurements* of what constitutes risk behaviour often differ.
3) **In defining GBV, many studies fail to draw attention to local constructs of gender** or to discuss how GBV is perceived within the local context. While there is some recognition of the critical role that socially constructed gender roles play in relation to both GBV and HIV, there are few attempts to tease this out or to suggest how best it might be addressed. In general, an inherent assumption in the vast majority of the studies reviewed is that GBV is synonymous with violence against women. Very few articles address men's risk in relation to GBV, and the vast majority of those that do start from a concern about high HIV prevalence and not a concern about GBV or gender norms more broadly. Indeed, surprisingly few articles provide an in-depth analysis of social constructions of gender and how these can exacerbate vulnerabilities to violence and HIV.

179 Senn TE, Carey MP, Vanable PA. Childhood and adolescent sexual abuse and subsequent sexual risk behavior: Evidence from controlled studies, methodological critique, and suggestions for research. Clinical psychology review 2008;28(5):711-35.

Moreover, very few articles consider male perpetrators of violence and the role they play at the intersections of GBV and HIV. The review highlights an association between perpetration of abuse and high-risk behaviour, but not many studies in the peer-reviewed literature are devoted to this crucial topic.

Overall, these differences in definitions and lack of harmonization in measurements of risk do not mean that comparison between studies is impossible. It is essential, however, to pay close attention to definitions, terminology, temporality, and measurement scales in different studies addressing the intersections between GBV and HIV.

e) Gap: The Evidence Linking GBV and HIV

The articles reviewed highlight that the epidemics of GBV and HIV overlap and intersect in complex ways.

In analysing the empirical studies that focus on the associations between GBV and HIV, five main gaps can be noted:

1) **In general, there appears to be a disproportionate focus on the links between *sexual violence* and HIV**, with less attention accorded to physical, emotional, psychological and ecomonic violence and how they are linked to HIV. Few studies focus on perpetrators of violence outside of intimate partnerships, such as family members, other adults, soldiers, the state, etc. Given the many levels at which GBV occurs, it is important to determine how (or if) the *type* of violence affects understanding of the intersections.
2) **Whereas numerous studies aim to uncover the ways in which GBV can increase one's risk of acquiring HIV, few published to date analyse the pathways that put a person living with HIV at risk of gender-based violence**.
3) **Overall, very little is written about links between GBV and HIV in the context of HIV testing and disclosure** and existing articles focus mainly on resource-rich settings.
4) **Only 2 studies were found that examine the association between GBV and HIV in a conflict setting**. In general, armed conflict/post-conflict and migration (forced or voluntary) are under-examined as specific contexts which may exacerbate vulnerabilities to HIV and GBV.
5) **The multiple risks and vulnerabilities that impact on the associations between GBV and HIV are under-explored.** There appear to be serious attempts in the literature to show evidence that the relationship between GBV and HIV is affected by risks and vulnerabilities such as a history of CSA, substance abuse, use of alcohol and incarceration history, but how these connect to one another is relatively unexplored. Additionally, only a few articles underscore the relevance of other factors such as socioeconomic status, poverty, fear of loss of shelter and support, and insecure property rights.

f) Gap: The Interventions Addressing GBV and HIV

The articles focusing on interventions cover a wide range of ground and in particular call for further attention to structural factors, integration, skills-building, and vulnerable population groups.

In analysing the articles that focus on interventions, four main gaps can be noted:

1) **Even in discussions of structural factors, analysis of the legal and policy context is extremely limited.** Very few studies make any sort of reference to how the legal and policy environment is relevant, either in how it promotes or curtails the interventions studied or the research undertaken.
2) **There are very few examples in the peer-reviewed literature of 'successful' interventions to address GBV and HIV linkages.** Even the success stories (such as the IMAGE study and the Stepping Stones study), were unable to show reduction in HIV incidence, even as they did have important success in reducing rates of GBV. Furthermore, even as articles call for integration of services, few examples exist of intervention research looking at integration of services.
3) **With a few notable exceptions, interventions that jointly address GBV and HIV are biomedical**, **despite general acknowledgement of the importance of risk, vulnerability, and social and cultural norms**. A disproportionate number of articles in this area examine post-exposure prophylaxis for HIV among survivors of violence with little attention to other areas.
4) **Gender transformative interventions remain small in scale and within the timeframe reviewed appear to be seldom rooted in national plans**, despite the many international commitments to address the gendered dimensions of the HIV epidemic.

Key Messages Based on Gaps in Research and Interventions:

- There is a need for more work that examines the linkages between HIV seropositivity and the risk of experiencing GBV and the linkages between GBV and adherence to HIV treatment.
- Further attention is warranted to the risks and vulnerabilities that potentially impact the pathways between GBV and HIV, such as substance abuse and mental health.
- More attention is needed to psychological violence and structural violence, including economic violence, in the peer-reviewed literature.
- Studies are also needed that focus on perpetrators of violence beyond intimate partners, including the state, other family members and other adults.
- More attention is needed to the intersections within the context of HIV testing and disclosure, especially in resource-poor settings.
- More attention is need to the intersections between GBV and HIV in conflict settings.
- More open discussions of sex and sexuality both among groups of women, as well as mixed groups of women and men, should be documented and discussed.
- Men should be engaged as agents of change with respect to risk behaviours, gender mores and power imbalances.
- Examination, and if, necessary, reformation of the legal and policy climate within countries is needed to ensure the best support to address the intersections of GBV and HIV.
- Peer-reviewed publications are needed which explain strengths and weaknesses of interventions that work to address GBV and HIV, especially in relation to integrated interventions. These are often called for in the English-language literature but are still rare.
- Policy-makers should be encouraged to support research and programming

addressing the intersections among vulnerable populations, even when to do so might be considered to be "politically controversial."

- Creative and committed efforts are needed to address the intersections at the policy and programme levels. Attention to existing calls for concrete actions to jointly address these two issues in the current literature is needed.
- More attention is needed to both the quantitative and the qualitative research which already exists in this area in order to ensure that policies or programmes are truly informed by evidence and supportive of vulnerable populations.
- Peer-reviewed publications which explore the conceptual underpinnings of the intersections between GBV and HIV remain lacking.
- More attention is needed in all relevant literature as to how gender is locally constructed and defined.
- Further attention is warranted to human rights as a framework for understanding how these epidemics are linked and how they can be jointly addressed.
- More research needs to be published in the English-language literature from regions outside the United States. There is a particular lack of studies on GBV and HIV in the Arab region, Eastern Europe, and Central Asia.
- Importantly, this research needs to be published and disseminated in languages other than English.
- It is essential to carry out more research on the intersections between GBV and HIV among vulnerable groups in different parts of the world, such as MSM in sub-Saharan Africa.
- Explicit attention to different age groups (e.g. children and the elderly) will strengthen what is known about the intersections of GBV and HIV and what can be done to address them.
- A greater focus on male perpetrators in work at the intersections of GBV and HIV is needed.
- Differences in terminology and approach amongst different researchers needs to be more clearly acknowledged
- Consideration is needed as to whether harmonization of terms, definitions (e.g. the definition of GBV), and measurements of risk is preferable in interpreting findings.

D. CONCLUSION

Proposing a Human Rights Framework

This review helps to consolidate the existing evidence from peer-reviewed studies on the intersections between GBV and HIV, extract key findings, and identify gaps where further attention will be useful in moving forward research, policies, and programmes that address the intersection of GBV and HIV.

In line with the UN mandate to adopt a human rights-based approach, this effort raises the potential contribution of human rights concepts and methods to address the underlying issues at the intersections of GBV and HIV and to help shape programmatic interventions.

The potential contribution of a human rights framework, in combination with a focus on gender and sexuality, is currently under-explored and could significantly contribute to work in this area in the following ways:

1) **Human rights can provide a framework for analysis and accountability.**
   - Depending on the circumstances GBV directly violates a number of human rights, including but not limited to: the right to life, the right to health, the right to non-discrimination, and the right to security of person. When considering the root causes of GBV, neglect or violation of the rights to education, information, work, or an adequate standard of living can all contribute to a climate where an individual can be vulnerable to GBV.
   - Individuals living with HIV often suffer from discrimination, as well as violation of their rights to health, education, information, as well as all the rights listed above.
   - A climate of pervasive gender inequality, poverty, lack of access to health services, and lack of access to education increases an individual's vulnerability to HIV and to GBV.

2) **Human rights can highlight the root causes of GBV and HIV and suggest strategic directions for programmatic interventions.**
   - Rights-based approaches, with their emphases on the participation of affected communities, non-discrimination, attention to the larger legal and policy context and accountability for programmatic activities can provide a common context for analysis and action.
   - Human rights provide a framework relevant to people working in all related fields, which can facilitate collaboration.

3) **Human rights norms and standards can and should be applied in various ways to address GBV and HIV, including:**
   - *Using human rights as a legal tool* applied at the level of national and international law. Special attention to the legal and policy context is necessary to identify where laws and policies are supportive of, or an impediment to, programming and therefore where advocacy for legal reform might be appropriate.
   - *Using human rights as a guide to effective programming* and ensuring that interventions designed to address GBV and HIV consciously and systematically pay attention to human rights at each stage of the programme cycle.
   - *Using human rights as a tool for advocacy* to raise awareness and understanding of the intersections of GBV and HIV.

Human rights can serve as a useful way to understand the common vulnerabilities to GBV and HIV and to design and implement effective policies and programmes to address their intersections.