UN WOMEN

Policy and Programme Guidance:

HIV AND GENDER-BASED VIOLENCE

Preventing and responding to linked epidemics in Asia and the Pacific Region

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PURPOSE OF THIS GUIDANCE

This guidance provides a summary of the latest global targets and evidence on HIV and gender-based violence (GBV) in Asia and the Pacific Region. It presents case studies on emerging good practice, ideas for cross-collaboration and guidance for advocates, programmers and policy-makers working toward achieving gender equality, ending AIDS and eliminating GBV. The brief is intended to provide a resource for advocacy, policy and program development for use by civil society organizations, NGOs, UN Agencies and governments in the region.
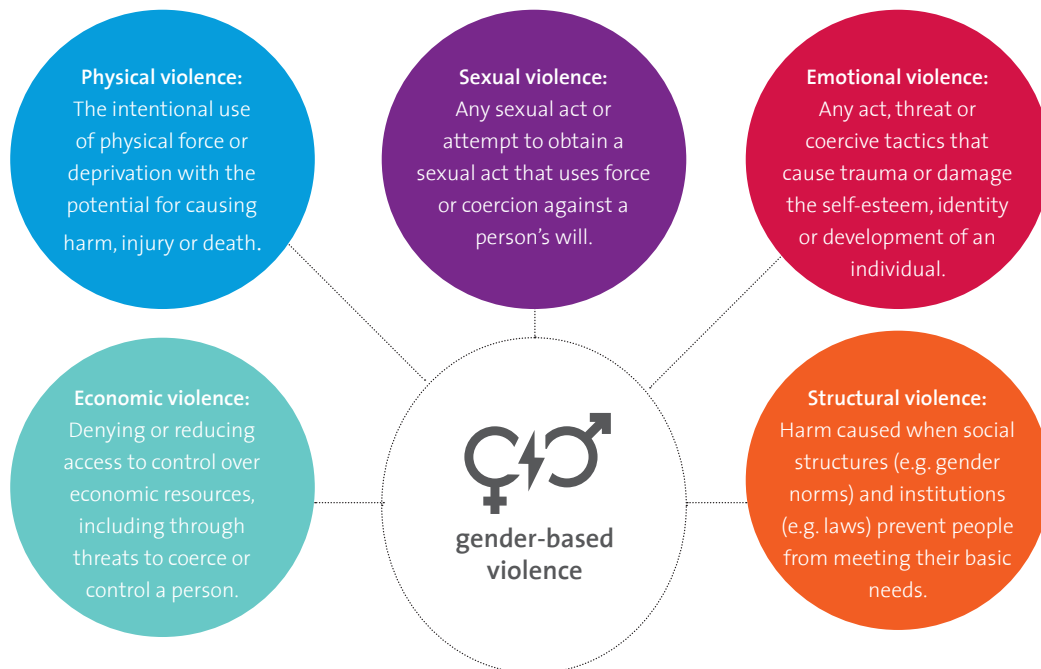
Gender-based violence affects men, women and transgender people – it is a grave abuse of human rights, a risk factor for HIV infection, and a consequence of stigma and discrimination against people living with HIV. Violence against women and girls in particular constitutes a global health challenge of epidemic proportions, and is one of the most pervasive and extreme manifestations of gender inequality.[1] Addressing violence and gender inequality is therefore essential to ending the AIDS epidemic and protecting the human rights of all people to safety, equality and the highest attainable standard of health.

WHAT IS GBV?

GBV is any act 'that results in, or is likely to result in, physical, sexual or psychological harm or suffering' that is directed against a person because of their biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity*. GBV includes intimate partner violence and can be physical, sexual, emotional, economic or structural where that violence targets someone because of their gender or non-compliance with gender norms. It can be experienced by women and girls, men and boys, and transgender and intersex people of all ages and has direct consequences on health, social, financial and other aspects of their lives.

It has been widely acknowledged that the primary targets of GBV are women and girls and they also suffer exacerbated consequences as compared with men due to unequal distribution of power between men and women and existing gender-discrimination, harmful social norms and practices[2]. However, men (particularly gay men, men who have sex with men), transgender and intersex people who do not conform to traditional gender roles are also targeted by perpetrators of GBV. Men and boys may also become subjected to physical and sexual violence including exploitation, trafficking and also domestic violence.[1]

FIGURE 1:
Types of GBV**

Physical violence: The intentional use of physical force or deprivation with the potential for causing harm, injury or death.

Sexual violence: Any sexual act or attempt to obtain a sexual act that uses force or coercion against a person's will.

Emotional violence: Any act, threat or coercive tactics that cause trauma or damage the self-esteem, identity or development of an individual.

Economic violence: Denying or reducing access to control over economic resources, including through threats to coerce or control a person.

gender-based violence

Structural violence: Harm caused when social structures (e.g. gender norms) and institutions (e.g. laws) prevent people from meeting their basic needs.

* Based on definition of violence against women in *General Assembly Resolution 48/104 Declaration on the Elimination of Violence Against Women (1993)* and definitions of GBV in the UN High Commissioner on Human Rights report to the UN General Assembly on violence and discrimination based on sexual orientation and gender identity (A/HRC/19/41) and Khan, A (2011) *Gender-based Violence and HIV: A Program Guide for Integrating Gender-based Violence Prevention and Response in PEPFAR Programs,* USAID

** Definitions based on *Guidelines for Producing Statistics on Violence against Women* (UN Statistics Division, 2013) and *Violence against women: Intimate partner and sexual violence against women* (WHO, 2013); definition of institutional violence from Galtung, J (1969) *"Violence, Peace and Research", Journal of Peace Research,* 6(3), 167.

WHAT CAUSES GBV?

Research shows that GBV is a manifestation of unequal gender relations and harmful gender norms that create unequal power dynamics between genders.[3] These norms assign strict gender roles to men as providers and women as care providers, prizing physical strength, aggression and sexual experience in men, and submissiveness, passivity and chastity in women.[4] This leads to acceptance of male dominance and violence against women, and others who do not conform to heteronormative* masculine "ideals," including men who have sex with men and transgender people. There is a growing evidence that lesbian, bisexual and transgender women who do not conform to traditional norms of sexuality and gender representation face increased violence based on SOGI status. GBV functions as a mechanism to reinforce and sustain gender inequality.

Regional research shows that perpetrators use violence to police women's sexuality, punish same-sex sexual acts and target markers of femininity, including through acts aimed at mutilation of women and transgender people.[5] A multi-country study of male violence against women in Bangladesh, Cambodia, China, Indonesia, Sri Lanka and Papua New Guinea found that the most common self-reported motivation for rape was a sense of entitlement.[3]

WHY IS ELIMINATING GBV CRITICAL TO THE HIV RESPONSE?

The WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care identify ending GBV as a critical enabler for ending HIV.[6]

GBV increases HIV risk directly and indirectly by limiting power to maintain healthy sexual relationships, refuse sex, negotiate condom use and through the impact of fear and trauma on help-seeking behaviors.

HIV is associated with increased experience of violence: People living with HIV and Key Populations** experience high levels of GBV. This has grave impacts on their rights and wellbeing, and undermines the HIV response.

Safety from violence is an essential foundation for achieving gender equality and realizing the right to the highest attainable standard of health. GBV and gender inequality are key drivers in the HIV epidemic. Without addressing GBV we cannot meet global commitments to achieve gender equality and empower women and girls, ensure all people enjoy safe and healthy lives and end AIDS by 2030. Achieving these ambitious targets will require accelerated efforts and increased investment to better understand and respond to the intersecting impacts of GBV and HIV.

* Heteronormative views/heteronormativity refers to assumptions that men and women fall into traditional gender roles (including that intimate partnerships are between a man and a woman, not people of the same-sex).
** UNAIDS Terminologies Guidelines 2015 defines Key Populations as population groups who are key to the HIV epidemic's dynamics or key to the response. Key Populations are distinct from vulnerable populations, which are subject to societal pressures or social circumstances that may make them more vulnerable to exposure to infections, including HIV. In Asia Pacific region, Key Populations are: sex workers; people who use injecting drug; transgender persons; men who have sex with men; and people living with HIV.

GLOBAL TARGETS AND GUIDING FRAMEWORKS FOR ENDING GENDER-BASED VIOLENCE AND AIDS BY 2030

Ending violence against women is a core component of the gender equality and women's rights agendas, though GBV against men and transgender people and the impact of this violence on HIV risk has only recently begun to gain recognition. The global framework for ending violence against women and the UN human rights framework provide a foundation for work to address GBV more broadly. New global commitments, including the 2030 Agenda for Sustainable Development provide the beginnings of an ambitious roadmap and fresh impetus for integrated work on gender equality and ending GBV and HIV.[8]

Global framework for ending violence against women

The rights of women and girls to live free from violence are upheld by the Convention on the Elimination of All forms of Discrimination against Women (CEDAW),[9] CEDAW Committee General Recommendations 12 and 19 on violence against women,[10] and the 1993 UN Declaration on the Elimination of Violence Against Women.[11] Work to prevent and respond to violence against women is supported by global mechanisms such as the Commission on the Status of Women, the UN Secretary-General's Campaign to End Violence Against Women (UNiTE), the UN Trust Fund to End Violence against Women and the Special Rapporteur on Violence against Women.

The Sustainable Development Goals (SDGs)

In 2015, governments around the world committed to 17 new global development goals to be met by 2030 – the Sustainable Development Goals (SDGs). A number of goals are relevant to the HIV and GBV responses, with specific targets aligned to programming priorities and new and existing strategies to address the epidemics. SDG 3 and 5 are the most directly relevant to eliminating GBV and ending HIV, SDG 10 (reducing inequalities), SDG16 (peace, justice and strong institutions) and SDG 17 (partnerships for sustainable development) are also relevant.

SDG3: Ensure healthy lives and promote well-being for all at all ages

SDG 3 includes targets to:

- end AIDS by 2030.

- strengthen prevention and treatment of substance abuse.

- achieve universal health coverage by 2030.

The SDG target of ending AIDS by 2030 is supported by the *UNAIDS Strategy 2016-2020 – On the Fast Track to End AIDS*,[12] which establishes 10 strategic goals to be met by 2020 in order to achieve its goal of "zero AIDS-related deaths, zero new infections and zero stigma and discrimination" by 2030. Target 1 in the current UNAIDS Strategy requires that 90% of people living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment and 90% of people on treatment have suppressed viral loads.

SDG5: Achieve gender equality and empower all women and girls

SDG 5 includes targets to:

- end all forms of discrimination against women.

- eliminate all forms of violence against women and girls.

- recognize and value unpaid care and domestic work through social protection policies and the promotion of shared responsibility.

- ensure universal access to sexual and reproductive health and reproductive rights

- reform to give women equal rights to economic resources.

- enhance use of technology to empower women.

- adopt and strengthen policies and legislation to promote gender equality and women's empowerment.

SDG 5 is supported by the global framework to eliminate violence against women and the agenda for gender equality under the Beijing Platform for Action and CEDAW. Practically, it is supplemented by UN Women's Flagship Program Initiatives, in particular ending violence against women, women's economic empowerment and women's political environment.[14] The target on sexual and reproductive health and rights is supported by the framework developed for the *International Conference on Population and Development Program of Action* and target 4 under the UNAIDS Strategy: 90% of women and men, especially those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services.

Target 7 of the UNAIDS Strategy also recognizes the importance of gender equality and eliminating violence against women and girls to ending HIV. It requires: 90% of women and girls live free from gender inequality and gender-based violence to mitigate the impact of HIV by 2020.

> Targets under SDG 10 and 16 provide important support for realising SDG 5 including through directly addressing important components of the GBV and HIV responses, through reduction of all forms of violence, equal access to justice, and enforcement of non-discriminatory laws and policies.

SDG 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development

> This incorporates targets directed at institutional capacity-building, including through South-South cooperation and at systemic issues including data, multi-stakeholder partnerships and policy and institutional coherence. It also highlights the importance of a multisectoral approach to the GBV and HIV responses that draws on the diverse expertise of partners in government, community, civil society, the UN and private sectors.

ENDING VIOLENCE AND DISCRIMINATION AGAINST LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX PEOPLE

The international human rights framework establishes the rights of everyone, including transgender people, to equality, the highest attainable standard of health and safety from violence under multiple international instruments including the Universal Declaration on Human Rights, International Covenant on Civil and Political Rights and International Covenant on Cultural, Economic and Social Rights. These obligations are supported by the Universal Periodic Review process, which requires all countries to report on their progress against international human rights standards.

In a Human Rights Council Resolution (A/HRC/32/L.2/Rev.1) on establishing Special Rapporteur on protection against violence on grounds of sexual orientation and gender identity, an independent expert for the period of 3 years has been assigned with a mandate to assess the implementation of existing international human rights instruments with regard to ways to overcome violence and discrimination against persons on the basis of their sexual orientation or gender identity; raise awareness of violence and discrimination against

persons on the basis of their sexual orientation or gender identity, and to identify and address the root causes of violence and discrimination; and engage in dialogue and to consult with States and other relevant stakeholders. The Council also requests the Independent Expert to report annually to the Human Rights Council and to the General Assembly.

Additionally, in an unprecedented joint initiative, 12* UN agencies issued a powerful joint call to action on ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex (LGBTI) adults, adolescents and children on 29 September 2015.

"All people have an equal right to live free from violence, persecution, discrimination and stigma. International human rights law establishes legal obligations on States to ensure that every person, without distinction, can enjoy these rights. While welcoming increasing efforts in many countries to protect the rights of LGBTI people, we remain seriously concerned that around the world, millions of LGBTI individuals, those perceived as LGBTI and their families face widespread human

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* ILO, OHCHR, UNAIDS Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP and WHO

rights violations. This is cause for alarm – and action. Failure to uphold the human rights of LGBTI people and protect them against abuses such as violence and discriminatory laws and practices, constitute serious violations of international human rights law and have a far-reaching impact on society – contributing to increased vulnerability to ill health including HIV infection, social and economic exclusion, putting strain on families and communities, and impacting negatively on economic growth, decent work and progress towards achievement of the future Sustainable Development Goals. States bear the primary duty under international law to protect everyone from discrimination and violence. These violations therefore require an urgent response by governments, parliaments, judiciaries and national human rights institutions. Community, religious and political leaders, workers' organizations, the private sector, health providers, civil society organizations and the media also have important roles to play. Human rights are universal – cultural, religious and moral

practices and beliefs and social attitudes cannot be invoked to justify human rights violations against any group, including LGBTI persons."[6]

It sets out specific steps that member states, in particular, should take to curb violence and protect individuals from discrimination – including measures to improve the investigation and reporting of hate crimes, torture and ill-treatment, prohibit discrimination, and review and repeal all laws used to arrest, punish or discriminate against people on the basis of their sexual orientation, gender identity or gender expression.

Together, the framework for ending violence against women and girls, the international human rights standards and mechanisms, and new global development commitments provide the beginnings of a strategy for addressing GBV more broadly, including in the context of the HIV response.

COMMISSION ON STATUS OF WOMEN

At its 60th Session, the Commission for the Status of Women delivered the Secretary-General's report on action taken by member states and the UN under its resolution 58/3 on *Women, the girl child and HIV and AIDS*, providing further guidance for integrated work.[13] The report includes recommendations for:

- greater alignment between HIV and gender equality programming including through multisectoral cooperation and mainstreaming gender and human rights.

- expansion of evidence-based approaches to address the specific vulnerabilities of young women and girls to HIV and improved dissemination of comprehensive sexuality education.

- interventions that transform gender norms and power relation that increase risk of HIV.

- enhanced meaningful participation, contribution and leadership of women living with HIV and women's organizations.

- human rights and justice for ending all forms of discrimination against women living with HIV.
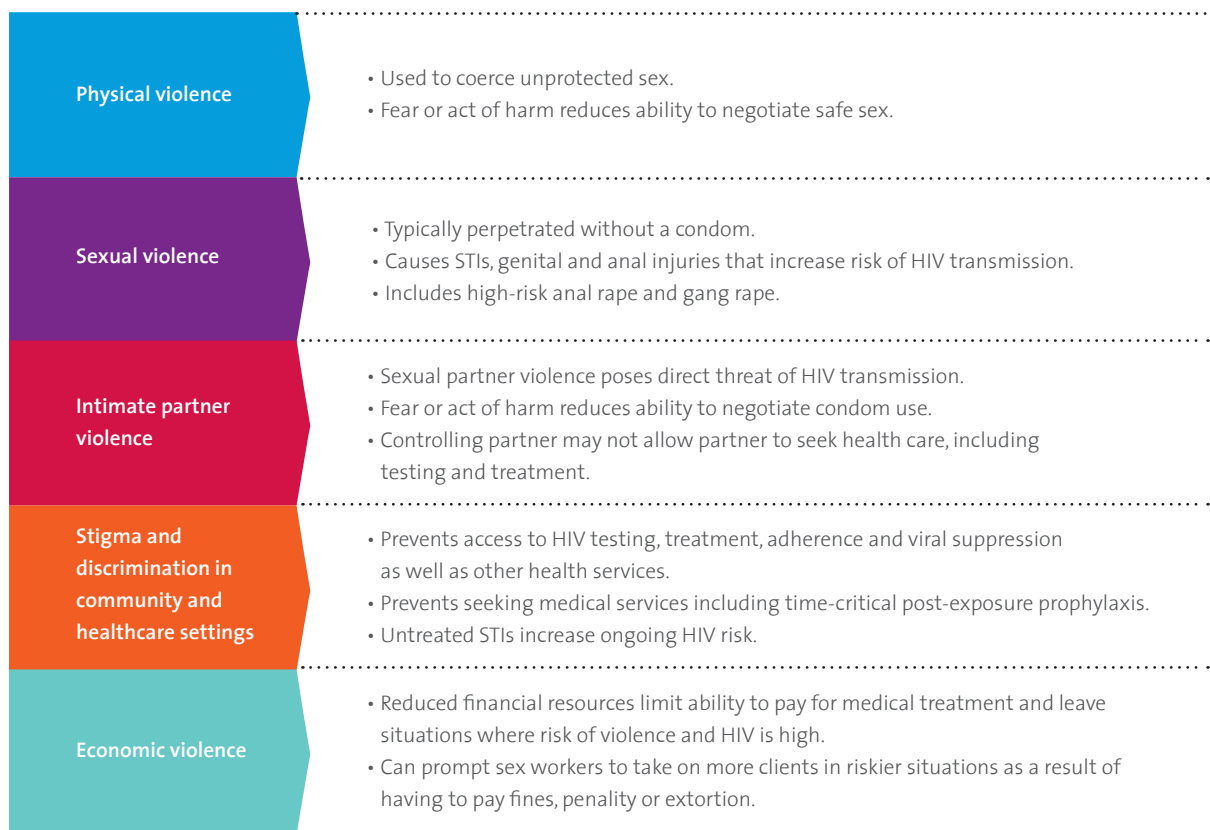
Guided by evidence and lessons learned through ongoing work to eliminate violence against women and girls and international human rights mechanisms, the SDGs and linked strategies, commitments and programming initiatives provide a comprehensive framework for application and adaptation to address GBV and HIV.

Photo: UNAIDS/M.Quraishi

HIV AND GBV LINKED EPIDEMICS IN ASIA AND THE PACIFIC REGION

GBV is a cause and consequence of HIV – it increases risk of HIV transmission and is used against people living with HIV and key populations at higher risk of HIV infection. These linked epidemics require an integrated response. Understanding country contexts, risk factors and their intersecting impacts is essential to developing effective policies and programs to prevent and eliminate GBV and end AIDS.

FIGURE 2:
How GBV increases HIV risk*

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Physical violence	• Used to coerce unprotected sex. • Fear or act of harm reduces ability to negotiate safe sex.
Sexual violence	• Typically perpetrated without a condom. • Causes STIs, genital and anal injuries that increase risk of HIV transmission. • Includes high-risk anal rape and gang rape.
Intimate partner violence	• Sexual partner violence poses direct threat of HIV transmission. • Fear or act of harm reduces ability to negotiate condom use. • Controlling partner may not allow partner to seek health care, including testing and treatment.
Stigma and discrimination in community and healthcare settings	• Prevents access to HIV testing, treatment, adherence and viral suppression as well as other health services. • Prevents seeking medical services including time-critical post-exposure prophylaxis. • Untreated STIs increase ongoing HIV risk.
Economic violence	• Reduced financial resources limit ability to pay for medical treatment and leave situations where risk of violence and HIV is high. • Can prompt sex workers to take on more clients in riskier situations as a result of having to pay fines, penality or extortion.

HIV in Asia and the Pacific

There are 5.1 million people living with HIV in Asia and the Pacific, according to 2015 estimates.[15] The epidemic is concentrated among key populations, including men who have sex with men, sex workers, people who inject drugs and transgender people.[16] Other populations, including prisoners, migrants, clients of sex workers and people in sero-discordant relationships are also considered to be at higher risk of HIV.[17] One-third of people living with HIV (1.8 million people) in the region are women while young people aged 15-24 years make up 37% of new infections. Among young males and females newly infected with HIV in 2015, 41% were females.[15] After significant declines between 1990 and 2010, progress in reducing new infections has stalled.[15]

* Based on figure in Fulu et al (2015) *The Right(s) Evidence: Sex work, violence and HIV in Asia – A multi-country qualitative study.*[5]

FIGURE 3:
HIV and AIDS in Asia and the Pacific 2000 - 2015

People living with HIV

New HIV infections

Children living with HIV

Young people living with HIV

Women living with HIV

AIDS - related deaths
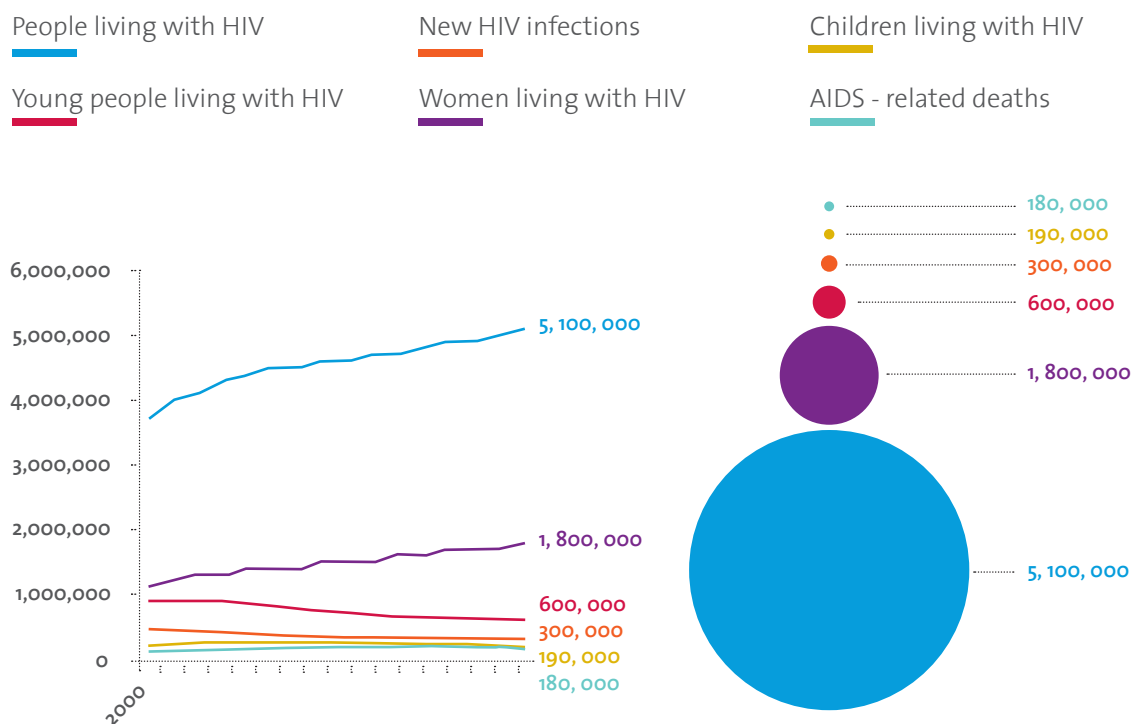
Emerging trends and implications for the regional response

New data shows that in countries with declining epidemics, like Thailand and Cambodia, the largest cohort of people living with HIV are now "low risk" women (women who have either never engaged in, or who do not currently engage in high risk behavior).[18] Similar patterns are emerging in Indonesia, Myanmar and Viet Nam's maturing epidemics.[18] Many of these infections are likely to have occurred through intimate partner transmission, among women in relationships with male partners from key populations or other populations at higher risk of HIV.[19] These findings highlight the need for continued focus on increasing investment in treatment and prevention among key populations and their partners, and innovative interventions (including new testing strategies) to reach "low risk" women who are in fact affected by HIV, as well as women who have engaged in risk behaviors in the past or are partners of men with a history of behaviors which puts them at higher risk of HIV exposure.

GBV in Asia and the Pacific

Findings and analysis from kNOwVAWdata, an initiative of UNFPA Asia Pacific Regional Office (APRO) reveals that there is a growing demand for reliable and comparable prevalence data on violence against women since the adoption of standard indicators for measuring VAW by the UN Statistical Commission in 2011. This has only increased with the adoption by Member States of a specific target to "Eliminate all forms of violence against all women and girls in private and public spheres, including trafficking and sexual and other types of exploitation", under the Sustainable Development Goal 5 of the 2030 Agenda for Sustainable Development (target 5.2) and the associated two indicators on VAW.[20] Violence against women and girls varies widely in the region, as reflected by the proportion of women who reported experience of GBV in their lifetime. It has both very low and very high prevalence rates, ranging from about 14%[21] to more than 67% women.[22] Nevertheless violence against women is an abuse of human rights and remains as a serious problem for all countries in the region.

FIGURE 4:

Proportions of women reporting physical and/or sexual partner violence, among ever-partnered women aged 15-49 in Asia-Pacific region (2000-2015)**[22]

Lifetime   Current (last 12 months)
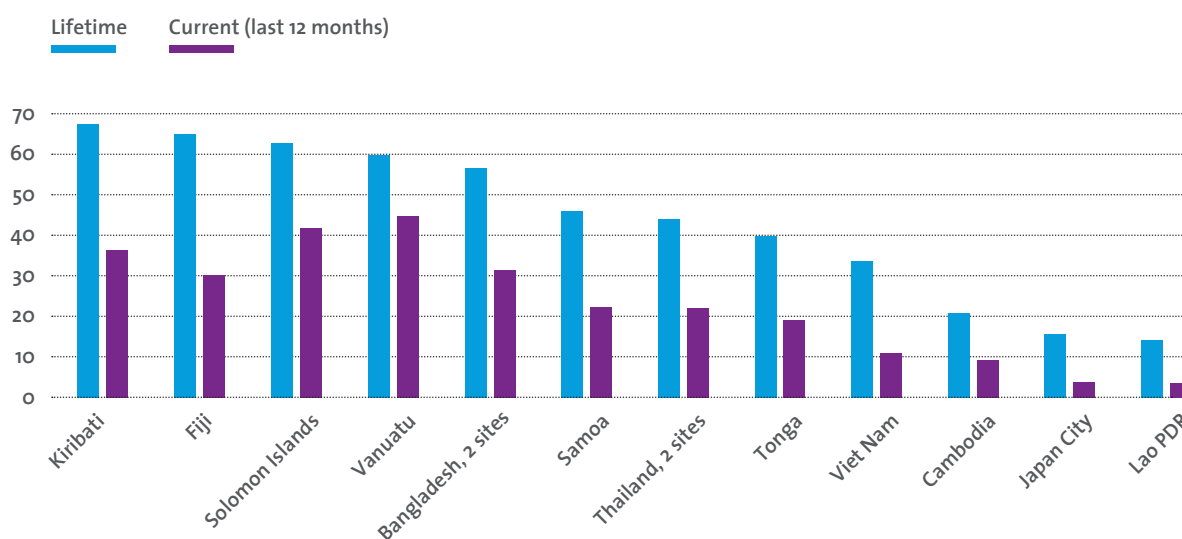
Data in the region: A snapshot

Conservative cultural values, social inequality associated with age and gender, and limited autonomy and access to information, as well as social hierarchies and unequal power-relations make young women particularly vulnerable to GBV.

Recent research, including studies of violence against transgender women in China and Malaysia,[26] and a four country study of violence against male, female and transgender sex workers in Asia identify high levels of GBV against these key populations.[5]

Women who inject drugs face HIV and GBV risks associated with dependence in the context of drug use in intimate partnerships,[27] and in involuntary treatment and detention centers.[28]

A study among women living with HIV in India found that they were more likely to report a history of intimate partner violence than women who are HIV negative.[29]

Migrants, including internal and undocumented migrants, migrant workers, asylum seekers and refugees, face GBV and the related risk of HIV and interruption to treatment associated with moving away from support systems in their country of origin and changed circumstances in their new

home. Regional research and studies in Cambodia, Viet Nam and Lao PDR recognize sex workers and female migrant domestic workers as being at particular risk of GBV associated with their precarious legal status and harmful gender norms attached to domestic work as "women's work."[30]

Child marriage is a breach of human rights and a form of violence and HIV risk factor for girls. Forty-five percent of child marriages globally occur in South Asia, where two out of five girls are likely to become child brides.[23] The highest prevalence is found in Bangladesh (66%), followed by India (47%), Nepal (41%) and Afghanistan (39%). In East Asia and the Pacific, the prevalence of child marriage is 18%, where among women aged 20-24 in 2010, an estimated 9.2 million had been married when they were children.[24] Child brides are often forced into early sexual activity and early childbearing, and are vulnerable to HIV and other STIs because older men are more likely to be living with HIV or have other STIs from prior sexual experience.[25]

** Data prepared by UNFPA Asia and the Pacific Regional Office, 2016 based on surveys using methodology of the WHO multi-country study on women's health and domestic violence

People living with HIV, especially women experience high levels of intersecting stigma, discrimination and violence, and are more likely to experience violence once their status is known. The *People Living with HIV Stigma* Index recognizes stigma as a form of violence and that institutional, societal and community stigma fuels self-stigma, causing psychological harm and reducing motivation to seek help and the ability to manage HIV and HIV risk.[31] Households are a major site of violence for women living with HIV with spouses and other household members the most common perpetrators of physical assault. Financial insecurity due to illness and discrimination in employment can make it difficult for people living with HIV, particularly women to leave violent situations and allows perpetrators to use a person's status for manipulation and to inflict psychological pressure. [31]

FIGURE 5:
People living with HIV assaulted in past 12 months, by country [31]
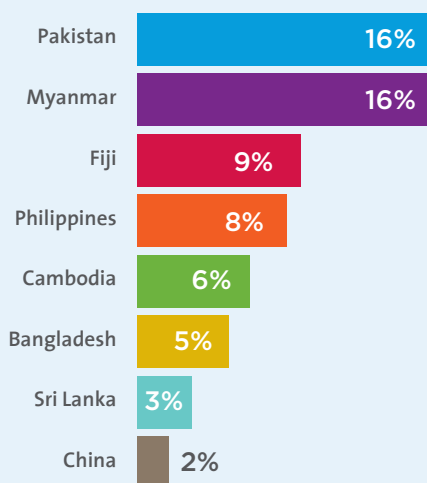
Violence against women and the threat of violence create a barrier to HIV disclosure, access to services and treatment adherence that hinders the HIV response.[31] Women living with HIV report violence after disclosing their HIV status. Analysis of stigma index results in Bangladesh found that gender discrimination was an added burden for women living with HIV. 'Female participants described being thrown out of their in-laws' houses, tortured and having their inherited properties and money taken away even in cases where in-laws knew that the participant had been infected with HIV through her husband.[31]

People living with HIV also experience grave rights violations in healthcare settings including denial of treatment, and emotional, physical and sexual abuse.[15] Coerced abortion and forced and coerced sterilization of women living with HIV (WLHIV) is widely reported. One study covering six-countries in Asia interviewed 573 WLHIV and found that:[32]

- 29% had terminated pregnancies they wanted, many of whom had been coerced – in 21% of cases the decision was made solely by their intimate partner and in 9.2% of cases, by a mother-in-law.

- Almost one-third of respondents were encouraged by health workers to consider sterilization, 82% believed this was because of their HIV status – some did not consent or understand the procedure and others were offered incentives such as free baby formula.

Sex work, violence and HIV

The Right(s) Evidence: Sex work, Violence and HIV in Asia – a Multi-Country Qualitative Study found that male, female and transgender sex workers experience high levels of physical, sexual, economic and emotional violence.[5] This included intimate partner violence, rape and gang rape (male and transgender participants were more likely to experience gang rape than rape by an individual) that directly contributed to risk of sexual transmission of HIV. Participants in the study faced intersecting stigma, for transgressing gender norms, and on the basis of involvement in sex work and HIV status. The violence they experienced was fuelled by an environment of impunity shaped by stigma, police abuse of power and laws against sex work and same sex acts in which perpetrators faced few disincentives and sex workers are afraid to report. The most common perpetrators were police and clients.

Criminalization of key populations in Asia and the Pacific:

- 17 countries criminalize same-sex sexual acts
- 37 countries criminalize some aspect of sex work
- 4 countries criminalize "cross-dressing"
- 11 countries have compulsory detention centers for people who use drugs
- 15 countries impose the death penalty for drug offences

Violence against key populations, including people living with HIV, is fuelled by intersecting stigma, criminalization and discrimination against sex work, drug use and HIV, and on the basis of sex, gender identity and sexual orientation. Stigma and discrimination combine with, and are sometimes supported by discriminatory laws and policies. Many countries in Asia and the Pacific criminalize behaviors by key populations creating fear of arrest or mistreatment and limiting access to services and fundamental freedoms, economic opportunities and avenues for redress by criminalizing the conduct of key populations, providing inadequate protection against GBV and discriminating against women. Non-recognition of gender identity is a contributor to GBV experienced by Transgender Persons.

Discriminatory laws and policies entrench gender inequality, limit decision-making power and autonomy to seek health services and leave violent workplaces and relationships. A recent World Bank study of 173 national economies found that 155 countries have at least one legal barrier to women seeking opportunities and making decisions that men do not face. Laws that limit women's ability to access identity documents, register a business or inherit land have real impacts for women's economic security and independence. Married women often face additional limitations.[33]

FIGURE 6:
Economies where married women cannot perform some actions in the same way as married men*

APPLY FOR A PASSPORT	BE CLASSIFIED HEAD OF HOUSEHOLD	CHOOSE WHERE TO LIVE
Afghanistan, Fiji, Iraq, Myanmar, Pakistan, Philippines	Indonesia, Iran, Iraq, Philippines	Afghanistan, Brunei Darussalam, Iran, Iraq, Malaysia
CONFER CITIZENSHIP TO CHILDREN	GET A JOB WITHOUT PERMISSION	TRAVEL OUTSIDE THE HOME
Brunei Darussalam, Iran, Iraq, Malaysia, Nepal	Iran	Afghanistan, Brunei Darussalam, Iran, Iraq, Malaysia
OBTAIN A NATIONAL IDENTITY CARD	TRAVEL OUTSIDE THE COUNTRY	REGISTER A BUSINESS
Afghanistan	Iran, Iraq	Bhutan, Pakistan

* Table adapted for Asia and the Pacific from World Bank (2015) *Women, Business and the Law 2016*.[33]

Laws in many countries discriminate by providing inadequate protection against GBV. In Sri Lanka, marital rape is only recognized where a couple has judicially separated.[34] Other countries do not recognize marital rape at all. Narrow definitions of rape can also result in inadequate protections. Rape under the Indonesian Penal Code, for example is defined as an offence against women and therefore provides no protection against rape for men.[35]

Punitive laws and social stigma combine to create a climate of impunity for perpetrators of GBV and an ongoing cycle of violence. Reporting of GBV is generally understood to be low, and prosecution of perpetrators is limited,[36] particularly where laws provide inadequate protection against GBV and criminalize key populations or violence against marginalized groups is socially accepted. Where key populations are criminalized, fear of arrest or abuse by law enforcements creates an additional deterrent to reporting experiences of violence.

FIGURE 7:
How gender inequality, stigma, criminalization and punitive laws increase GBV risk and create a cycle of violence**

- Gender inequality, criminalization, punitive laws and social stigma

- Reluctance to report violence to police
- Social stigma and discrimination creates an expectation that police will ignore reports and also a culture of impunity for justice
- Criminalization and police violence lead to fear of arrest and further violence

- Gender inequality and stigma leads to social acceptance of violence including by people who experience violence
- Criminalization and punitive laws expose key populations, women and girls to police and other forms of violence

- Perpetrator impunity and justice not done
Note: In many countries not all aspects of GBV (e.g. same sex relationship or marital rape) are criminalized

- Violence continues
- Perpetrators face no disincentive
- Without successful prosecutions there is no incentive to report
- Social norms that allow violence continue

** Table adapted from Fulu et al (2015).[5]

PREVENTING AND RESPONDING TO GBV AND HIV: WHAT WE KNOW WORKS AND WHAT WE NEED TO KNOW MORE ABOUT

What is gender-transformative programming?

Gender transformative programming is an approach and a goal. Policies and programs should seek to transform gender relations and norms to achieve long-term equality and sustainable, fair and equitable health and development outcomes. Gender transformative programming:

- seeks to address inequalities, change unequal power-relations and transform gender norms

- strengthens social norms, policies and programs that support equality and empowerment

- promotes participation, leadership and decision making of women, girls and other marginalized groups
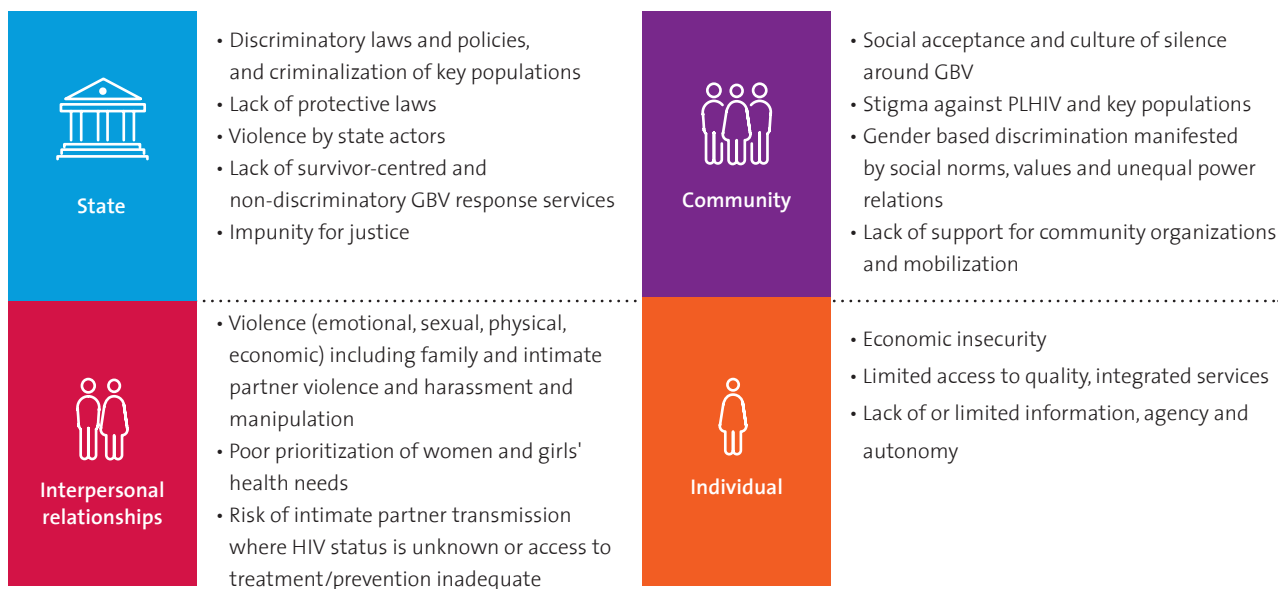
Governments, UN agencies, NGOs, community and civil society need to identify and understand the connections between GBV and HIV – both responses need a comprehensive, multisectoral and gender-transformative approach, that puts key populations and people living with HIV at the centers of decision-making and planning processes.

Ending GBV and AIDS will require increased investment at multiple levels. The social-ecological model is typically used to explain factors that increase risk of violence against women and identify entry-points for intervention.[36] Here it is adapted for GBV and HIV.

Ensuring that interventions at each level support one another requires a coordinated, multisectoral approach. The community, justice, health and education sectors must all be engaged with strong support from states and their legislatures to achieve social and institutional change.

FIGURE 8:
Identifying sites for intervention and risk factors for GBV and HIV

State
- Discriminatory laws and policies, and criminalization of key populations
- Lack of protective laws
- Violence by state actors
- Lack of survivor-centred and non-discriminatory GBV response services
- Impunity for justice

Community
- Social acceptance and culture of silence around GBV
- Stigma against PLHIV and key populations
- Gender based discrimination manifested by social norms, values and unequal power relations
- Lack of support for community organizations and mobilization

Interpersonal relationships
- Violence (emotional, sexual, physical, economic) including family and intimate partner violence and harassment and manipulation
- Poor prioritization of women and girls' health needs
- Risk of intimate partner transmission where HIV status is unknown or access to treatment/prevention inadequate

Individual
- Economic insecurity
- Limited access to quality, integrated services
- Lack of or limited information, agency and autonomy

WHAT DOES A COMPREHENSIVE HIV AND GBV RESPONSE LOOK LIKE?

FIGURE 9:
Conditions and priority actions for effective GBV and HIV response programming

Priority programming:
• Social norm change
• Capacity development of organizations and community leaders advocating for ending GBV
• Access to justice

Priority programming:
• Monitoring impact, review, and reforms of law
• Enabling legal policy framework

Supportive environment
- Social norms that promote gender equality, zero tolerance for GBV, stigma and discrimination.
- Developing capacities of leaders and institutions to end GBV.
- Access to justice including enforcement of protective laws including when perpetrators are state.

Legal policy framework
- Protective laws prohibiting GBV and discrimination in all forms are adopted.
- An enabling legal environment free from laws and policies that criminalize and discriminate key populations, women and girls and create barriers to reporting rights violations and accessing services.

Services and infrastrutures
Access to affordable, high-quality, survivor centred and multi-sectoral, HIV, GBV and sexual and reproductive health prevention and response services, tailored to the needs of young people, women and girls, PLHIV and others from key populations.

Empowerment
Women, girls, people living with HIV and people from other key populations are socially and economically empowered through access to information, strong communities and social protection.

Priority programming:
• Linked and integrated HIV/GBV services and referrals
• Documenting GBV and risk assessment and safety planning
• Social protection support

Priority programming:
• Empowerment of communities and individuals
• Economic empowerment
• Promote leadership and decision-making of women and Key Population

Supportive environment

Social norm change

Harmful gender norms and social stigma must be addressed through action at the individual, community and state levels, through mass media campaigns, training curricula and capacity building and community mobilization, including among men and boys' groups. 'Effective gender strategies transform unequal norms and behaviors, empower women and girls, and engage men and boys as partners and agents of positive social change.[37] This also requires involving those groups that experience high levels of GBV in programs and initiatives on GBV, including sex workers, men who have sex with men and transgender people.

Save the Children's Choices curriculum supports boys and girls aged 10-14 including brother/sister pairs to explore alternative masculinities and femininities together through emotion-based training sessions. Early adolescence is a crucial stage in the crystallization of gender attitudes.[38] Evaluation of a pilot in Nepali children's clubs showed statistically significant changes to children's gendered attitudes and behavior relating to discrimination, control and dominance, violence, attitudes to girls' education and acceptance of traditional norms among program participants.[39]

Ending Violence Against Women – It's all of our responsibility provides a practical guide to data in the region and effective programming with a specific focus on addressing causes of violence among men and boys and involving as partners in the response. The publication includes chapters on promoting non-violent masculinities, child abuse, addressing early perpetration of violence by young men and healthy sexuality to address male sexual entitlement. Guidance is included for governments, community organizations and individuals.[22]

Ashodaya Samithi, an Indian network of over 8,000 female, transgender and male sex workers conducts a range of work including activities aimed at reducing the intersecting stigmas, discrimination and violence experienced by sex workers including those living with HIV. These activities include the placement of volunteers from the organization living with HIV in clinics and hospitals to support other People living with HIV (including non-sex workers) and intervene in instances of discrimination by healthcare workers. In some states volunteers provide direct assistance to healthcare workers, entering data and assisting with tasks like cleaning, fighting stigma by demonstrating their value to the wider community.[40] They also mobilize sex workers, conduct peer-outreach and community activities to end acceptance of violence and develop capacities of sex workers to advocate for and take actions to end violence against sex workers. Ashodaya Samithi also mobilizes the broader community including local police and other government officials, local leaders and others to raise awareness on the rights of sex workers and end violence, stigma and discrimination. As a result, violence by the police, goons, boyfriends and clients have been substantially reduced from 2004-2014.[58]

Photo: UN Women

Access to justice

Improved access to justice is essential for key populations, women and girls to claim their rights and advocate effectively on legal issues. Legal literacy training and information should be made available to individuals and community organizations covering rights to health, non-discrimination and protection from violence. Access to quality, affordable legal support services should be expanded and service providers should be sensitized to the particular legal challenges faced by key populations and people who have experienced GBV. Supporting communities to document rights violations and use paralegals to strengthen linkages with the justice system are also effective interventions for building the evidence based on GBV and its impact on individuals and communities for both individual justice and advocacy for reform. Law enforcement officials and the judiciary are crucial allies in ensuring access to justice for all people; they must be trained and sensitized to recognize the rights and understand the challenges faced by women, girls and key populations that make them vulnerable to GBV, including in their interactions with the legal system.

Under the *UN Secretary-General's Campaign to end Violence Against Women (UNiTE),* legal actors, service providers and legal advocates have been trained in a victim/survivor-centered approach to legal services, including 280 grassroots organizations and women leaders in Myanmar.[42]

Stigma and the law: In Thailand, organizations M Plus and ThaiLadyBoyz.net use social networking to address stigma and support men who have sex with men and transgender people who have experienced GBV, provide information on sex workers' rights and free legal counseling.[46] Indonesia's STIGMA Foundation provides people who inject drugs with legal services, combines needle exchange with referral to GBV services and promotes empowerment within the community through advocacy and networking.[46]

Legal policy framework

Enabling legal and policy environments

Laws and policies must be reformed to remove barriers to accessing health services and promote the adoption and enforcement of laws and policies that promote gender equality, criminalize GBV in all its forms and guarantee human rights to freedom from discrimination, from violence and to the highest attainable standard of health. To achieve this, understanding of how laws and policies impact access to services (including through law enforcement practices) and the avenues for reform will need to be increased among legislators, policy-makers and advocates. International human rights mechanisms including reporting requirements under the Convention on the Rights of the Child, Convention on the Elimination of all forms of Discrimination against Women, Convention on Economic, Social and Cultural Rights, Convention Against Torture and the Universal Periodic Review should be leveraged to raise community voices, increase pressure for reform at the domestic level and showcase progress.

The *Blue Diamond Society*, a community-based organization for men who have sex with men and transgender people that works closely with legal institutions and senior lawyers brought a case in the Supreme Court of Nepal that resulted in a finding that criminalization of same sex sexual acts and discrimination against transgender people was unconstitutional.[45]

The Asia-Pacific Forum is partnering with UN agencies and *National Human Rights Institutions* in countries throughout the region. Training has been delivered on sexual orientation and gender identity rights in partnership with UNDP. Representatives from Afghanistan, Bangladesh, India, Maldives, Nepal and Sri Lanka have also participated in a pilot blended-learning course on the rights of women and girls, including sexual and reproductive health rights, delivered in partnership with UNFPA.

Supportive policy and legislation in the region:

In the last five years, at least seven countries in the region have adopted or amended legislation to improve their response to GBV.

• Lao PDR, Afghanistan and China have adopted new laws on GBV; Myanmar is in the drafting process.[36]

• The new Constitution of Nepal 2015 incorporates rights relating to violence against women, reproductive health, women's political participation and access to health and education as well as provisions prohibiting child marriage, exploitation and human trafficking. It also includes protection against discrimination on grounds of sexual orientation and rights of access to state process and public services for gender and sexual minorities.[41]

• In 2015, ASEAN Heads of State adopted a Regional Plan of Action on Elimination of Violence Against Women.[42]

• Thailand introduced its first Gender Equality Act in 2015, providing new protections against discrimination, including for LGBT people.[43]

• The Cambodian Prakas on Working Conditions, Occupational Safety and Health Rules of Entertainment Service Enterprises, Establishments and Companies is a proclamation by the Cambodian Minister of Labour and Vocational Training to clarify the obligations of entertainment workers (a Cambodian term used for sex workers) and their employers under the national Labor Law. The Prakas includes a prohibition on workplace violence and indecent assault, as well as occupation health and safety training.[44]

Services and infrastructure

Linked and integrated HIV/GBV services

Health services, including testing need to be safe, confidential, high quality and affordable. Access and uptake of HIV, sexual and reproductive health and GBV prevention and response services can be improved through improved referral processes in locations with existing but separate services. Community-led service design and delivery should be supported and healthcare providers sensitized to ensure services are youth-friendly and free from stigma and discrimination. In 2015, UN Women, UNFPA, UNDP, UNODC and WHO developed the Essential Services Package for Women and Girls Subjected to Violence. The package covers justice and policing, social services, coordination and governance, as well as a specific module on health that includes a detailed framework, guidance and tools and resources. [47] WHO has also published specific clinical and policy guidelines for responding to intimate partner violence and sexual violence against women,[48] which covers guidance to clinic staff on identification and care for intimate partner violence, clinical care for sexual assault, training, policy and programmatic approaches to delivering services and mandatory reporting of intimate partner violence be leveraged to raise community voices, increase pressure for reform at the domestic level and showcase progress.

Improving the health care response to gender-based violence project in Vietnam: The *AIDSTAR-One* project trained healthcare providers to apply a GBV screening tool routinely to all female patients. Women who had experienced violence were referred to counseling services, which collected evidence for potential prosecutions and provided HIV and STI information and referrals to free prevention and treatment services. Community outreach training was provided to mass organizations and clubs were created for survivors and GBV prevention volunteers. Survivors' clubs provide therapeutic activities and opportunities to learn protective strategies such as developing safety plans. The model has now been endorsed by the Ministry of Health and screening processes mandated for all Vietnamese hospitals.[49]

Working under the *UN Trust Fund, the Association of Positive Women Indonesia (IPPI)* addressed the absence of integrated services for HIV/AIDS and gender-based violence survivors in Jakarta and Medan by strengthening referral systems and bolstering support networks through the establishment of multisectoral collaborations within the health sector and by building the capacity of HIV/AIDS actors to incorporate violence against women prevention and services into their work.

Empowerment

Empowered communities and individuals

Strong communities are critical to the HIV and GBV responses. Women and girls and members of key populations must be empowered to overcome self-stigma, protect their own health, collectivize and mobilize around their rights as part of the HIV and GBV responses. Community organizations and community leaders should be supported to advocate effectively and participate in decision making processes related to national strategy development, program and policy design and implementation, and human rights reporting processes.

Supporting Gender Equality in the Context of HIV/AIDS program in Papua New Guinea: The programme delivered a capacity-building within the National AIDS Council Secretariat (NACS) incorporating one-on-one mentoring of the NACS Gender and Special Interests Officer and creation of a Gender Equality Core Working Group trained as institutional focal points on gender equality and human rights. UN Women and UNDP then partnered with a faith-based community organization and network of people living with HIV to identify women living with HIV to participate in leadership training. Gender equality is now embedded in the NACS institutional structure, including through a Gender Equality Action Plan, gender-responsive budgeting and increased partnership with WLHIV networks. A tailored version of the program was also delivered in Cambodia, resulting in maintreaming of gender equality into the national HIV planning processs and representation of WLHIV in national decision-making mechanisms.[50]

Comprehensive sexuality education, as outlined in the joint UN International Technical Guidance on Sexuality Education, is most effective when there is emphasis on gender. A 2015 Population Council study found that sexuality and HIV education programs that address gender and power in intimate relationships are five times more likely to be effective than programs that do not. *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education* provides a rationale, content, and sample activities for placing gender and rights at the center of sexuality and HIV curricula—both as stand-alone modules and integrated with topics such as relationships, puberty, and condom use.[51]

The *SASA*! is a community mobilization approach developed by Raising Voices for preventing violence against women and HIV in East and Southern Africa. It is designed to address a core driver of violence against women and HIV: the imbalance of power between women and men, girls and boys. Using a four-phase approach, SASA! introduces the interconnected of GBV and HIV, facilitates awareness about how communities accept men's use of power over women, fueling the dual epidemics of GBV and HIV, helps community members identify ways to support women, men, and activists directly affected by or involved in these interconnectedness issues and supports community members to explore different ways to take action. SASA! Approach has had a rigorous impact evaluation and has shown community-level changes related to VAW and HIV. While this is a program is being applied in the East and Southern and the Horn of Africa, its approach has strong potential for adaptation in this region.[52]

Under the UN Trust Fund, the Rainbow Sky Foundation Thailand is implementing a proven Community Life Competence model to empower communities in four provinces to address human rights, violence, stigma and discrimination. The program is community-led and aims to develop a mechanism to monitor and record rights violations against lesbian and transgender women.[46]

The *Change-Makers: A young activist's toolkit for Ending Violence against Women and Girls* is a regionally-focused, youth-friendly toolkit for peer educators to facilitate discussions on gender equality, violence against women healthy relationships and positive activism.[53]

Economic empowerment

Economic independence is key to agency – financial insecurity affects people's ability to leave violent situations, access health services, treatment and commodities for HIV prevention, and to negotiate safe sex and working conditions. Time spent unable to work due to illness and injuries caused by GBV increase vulnerabilty and employment security. Economic empowerment initiatives, greater access to education and improved social protection, (including through universal health coverage) are essential to improving access to services and opportunities for women and girls, key populations and people in families affected by HIV.

The USHA Multipurpose Cooperative Society is a sex worker-run financial institution based in India aimed at enabling sex workers to become financially secure, establish workers' rights and ensure education and career development opportunities for sex workers' children. It provides loans, daily collection accounts, links to life insurance, support for self-employment schemes and runs social marketing campaigns to raise funds community members.[45]

Universal Health Coverage – 'an affordable dream' – Governments in the region, including in middle-income countries, are increasingly recognizing the potential to deliver universal health coverage. Thailand, Indonesia, the Indian state of Kerala now provide universal health coverage with substantial progress being made in Bangladesh and other Indian states (Himachal Pradesh and Tamil Nadu).[55] Thailand's "30 Baht" (approx. $USD 1) universal healthcare scheme includes undocumented migrants and an exemption for patients classed as too poor to make the payment, currently around 1/4 of the country's population.[54]
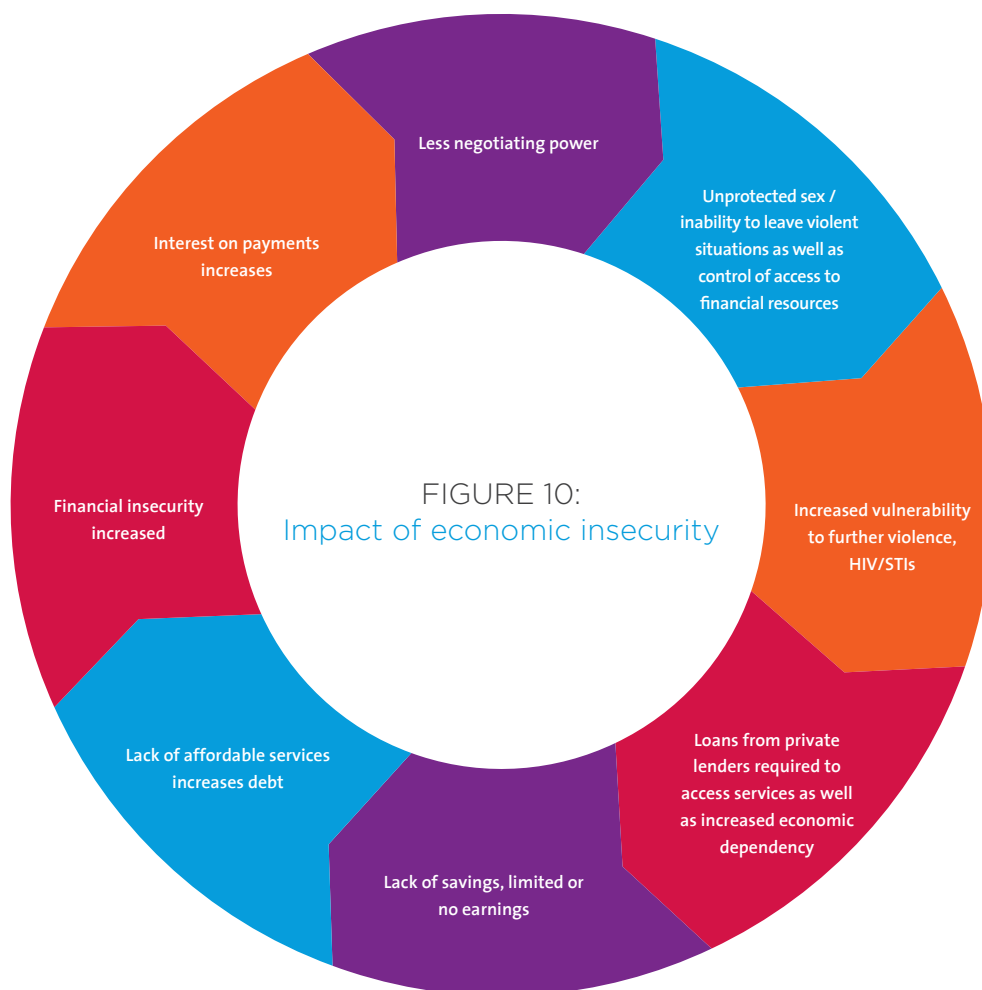

FIGURE 10:
Impact of economic insecurity

Less negotiating power

Unprotected sex / inability to leave violent situations as well as control of access to financial resources

Increased vulnerability to further violence, HIV/STIs

Loans from private lenders required to access services as well as increased economic dependency

Lack of savings, limited or no earnings

Lack of affordable services increases debt

Financial insecurity increased

Interest on payments increases

Photo: UN Women

REDUCING HIV AND GBV RISK IN HUMANITARIAN CONTEXTS

During humanitarian situations such as conflicts or natural disasters, the risk of violence, exploitation and abuse is heightened, particularly for women and girls. At the same time, national systems and community and social support networks weaken, an environment of impunity often mean that perpetrators are not held to account and pre-existing gender inequalities are exacerbated. Women and adolescent girls are often at particular risk of sexual violence, exploitation and abuse, forced or early marriage, and denial of resources. Men and boys may also be survivors.

Integrating Gender Based Violence Interventions in Humanitarian Action for the Health sector

Health services are often the first – and sometimes the only – point of contact for survivors seeking assistance for GBV. Health providers at the frontlines in emergencies can play a central role in identifying protection concerns. It is critical that they are equipped to offer non-discriminatory quality health services for survivors, taking into consideration the specific needs of people living with and affected by HIV, as part of a multi-sector response to GBV in emergencies. Adequate health services are not only vital to ensuring life-saving care for women and girls and others at-risk including people living with HIV or at higher risk of HIV, they are also a key building block for any setting seeking to overcome the devastation of humanitarian emergency.

Key resources to guide effective GBV responses in emergencies are:

- *The Minimum Initial Service Package* (MISP), UNFPA is a series of crucial actions required to respond to sexual and reproductive health, including GBV, needs at the onset of every humanitarian crisis.[55]

- The *IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian* provides practice guidance for addressing GBV across sectors including health, protection, food security, camp management, and shelter.[56]

- *The Minimum Standards for Prevention and Response to GBV in Emergencies*, UNFPA which include standards on healthcare, mental and psychosocial support, safety and security and socio-economic empowerment.[57]

LOOKING FORWARD: WORKING TOWARD GENDER EQUALITY AND THE END OF AIDS

Eliminating GBV and ending AIDS by 2030 will require renewed commitment from donors and governments to partner with NGOs, advocates, communities and civil society, and strengthen implementation of the response. To deliver the accelerated response needed, we must improve the way we work by:

Mainstreaming linked HIV and GBV responses – including through national and local policies and action plans that address the crossover between these issues, and the underlying power and gender discrimination that drives both issues.

Adopting a gender transformative approach – to change social norm and transform gender relations that promote sustained equality between people of all genders and end GBV. Working with men and boys helps accelerate progress in preventing and ending violence against women and girls.

Empowering women and girls and members of Key Populations – is central to achieving gender equality, women's empowerment and their enjoyment of human rights. This requires ensuring women's and Key Population participation and decision-making powers – in the home and relationships, as well as in public life and politics. It also means supporting community mobilization, increasing awareness raising about their rights and strengthening solidarity and support system to speak out against violence including to access justice.

Responding to shifting dynamics within the HIV epidemics and developing interventions tailored to national and local contexts – The high proportion of women considered "low risk" who are now living with HIV in countries and locations with mature and declining epidemics demands that we continue work to increase investment in key populations and urgently step-up work to design innovative interventions for "low risk" women who are affected by HIV.

Developing capacity to design and deliver integrated and evidence-based HIV and GBV responses – Organizations and communities working on the HIV response must be assisted to improve their knowledge of GBV and gender inequality and organizations working on gender equality must learn to recognize and address issues for key populations and people living with HIV.

Forging new partnerships and strengthening existing bonds – within the UN system, with governments, donors, advocates, NGOs, civil society and community to increase collaboration and learn from one another including to better understand the trends in gender transformative programming, and rates, trends, and factors related to violence against women and girls, transgender persons, migrant workers, drug users and others in detention and closed settings (e.g. police detention, prisons) and in healthcare settings and the cost of discrimination and violence on their health and well-being.

Strengthening the evidence base and building new evidence – We must deepen the foundations of our work through research to collect gender-disaggregated data and fill gaps in our knowledge. This also includes understanding and disseminating evidence on the effective programming approaches to change harmful gender norms and practices and the impact on ending violence and achieving better HIV and health outcomes for women and girls and transgender people.

Applying what we know works – Scale up effective programming and support continuity through sustainable investment. Improved documentation of existing programs and lessons learned is also crucial.

Innovating to increase investment for GBV and HIV programming – Resource mobilization can be improved through new and strengthened relationships with donors, including in the private sector; capacity building in-country to develop and embed gender-responsive budgets in national strategies; and by leveraging synergies to increase efficiency through integrated planning and programming.

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