

# Discussion paper



## Linkages between violence against women and HIV in Asia and the Pacific



*Empowered lives.  
Resilient nations.*



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# Foreword

*Violence against women and girls is one of the most pervasive manifestations of gender inequality and is an indicator of the status of women in a society. Violence against women is both a cause and a consequence of HIV infection. Therefore, violence needs to be dealt with as an integral part of multisectoral HIV responses.*

UN Secretary-General, Ban Ki Moon

There is limited research conducted in the Asia-Pacific region exploring the linkages between HIV and violence against women (VAW). While research conducted in sub-Saharan Africa and in hyper-epidemic settings have established that violence against women drives and fuels the HIV epidemic, there has been little analysis done in countries with concentrated epidemics such as those in the Asia-Pacific region, and therefore little is known about how they overlap. Perhaps as a result, policy and programmatic responses on VAW and HIV are not always coordinated and often run in parallel.

This Discussion Paper was commissioned by UNDP and UNAIDS on behalf of the Asia-Pacific Inter-agency Task Team on Women, Girls, Gender Equality, and HIV (IATT), to review and analyse existing qualitative and quantitative research on the relationship between violence against women and girls and HIV in the region. The paper clearly demonstrates that violence is a risk factor for HIV, with women living with HIV more likely to report a history of violence. It also shows that HIV is a risk factor for violence, including from intimate partners. It also demonstrates that key HIV-affected groups of women and girls, particularly sex-workers and female drug users, face disproportionate violence.

These findings will provide the basis for an IATT position on VAW and HIV, which we are confident will help to sharpen policy and programmatic actions to address the inter-linkages. Further, in order to achieve UNAIDS' vision of "Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths." it is imperative that the recommendations of this paper on addressing the overlaps between VAW and HIV in the Asia Pacific region are implemented, starting with translating political commitments into scaled-up action to address the rights and needs of key HIV-affected women and girls.



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# Preface

Gender inequality and violence against women are issues of serious concern for the Asia-Pacific region. As noted by the UN Secretary-General's UNiTE to End Violence Against Women campaign in the Asia and Pacific, "violence against women remains one of the region's most pervasive human rights challenges despite progress towards its elimination."<sup>1</sup> Studies demonstrate that 15 to 65 percent of women in the Asia-Pacific region experience intimate partner violence.<sup>2</sup>

Robust global policy frameworks reiterate the importance of addressing violence against women as an essential component of national HIV responses. The 2011 UN General Assembly Political Declaration on HIV and AIDS saw governments in the Asia-Pacific region "commit to ensuring that national responses to HIV and AIDS meet the specific needs of women and girls, including those living with and affected by HIV, across their lifespan, by strengthening legal, policy, administrative and other measures for the promotion and protection of women's full enjoyment of all human rights."<sup>3</sup> Similarly, the UNAIDS Agenda for Accelerated Action for Women, Girls, Gender Equality and HIV and the UNAIDS 2011–2015 Strategy: Getting to Zero commit the UNAIDS family to "ending the HIV-related stigma, discrimination, gender inequality and violence against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services."<sup>4</sup> Further, the UN Secretary-General's UNiTE to End Violence against Women campaign, the Millennium Declaration, and the Millennium Development Goals (MDGs) all reiterate the commitment of the UN to ending gender-based violence (GBV) and advancing women's rights in all parts of the world, including the Asia-Pacific region.

At an exploratory meeting, the Asia-Pacific Interagency Task Team on Women, Girls, Gender Equality and HIV<sup>5</sup> (IATT–women and girls) noted that limited evidence from the region continues to undermine efforts to address the twin epidemics of HIV and violence against women through effective, evidence-based, programmatic interventions. For these reasons, a discussion paper on violence against women and HIV linkages that considers and draws upon available data and research from the region would mark a starting point for national and regional partners to engage more closely in addressing this issue.

## Methodology

This paper primarily reviews English-language peer-reviewed articles and grey literature on the inter-linkages between HIV and violence against women in Asia and the Pacific. The search item combinations included gender-based violence, violence against women and HIV; sex workers; women who use drugs; women living with HIV; young and adolescent women; migrant women; and lesbian, bisexual, and transgender women. Although, some global literature was reviewed and referenced (especially evaluated programmes to address the linkages), following the mandate of the review, articles and literature from Asia and the Pacific were given priority. The conceptualization and development process included feedback mechanisms at various stages. Feedback was sought through:

- E-discussion on [www.hivapcop.org](http://www.hivapcop.org) to validate the scope of the review and seek input on regional and national research studies and experts for interviews;

1 UNESCAP, 2008, UN Secretary-General's Asia Pacific Unite to End Violence against Women.

2 Ibid.

3 At [www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html](http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html).

4 UNAIDS (2010), "Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV Operational Plan for UNAIDS Action Framework: Addressing women, girls, gender equality and HIV."

5 Key HIV-affected women and girls include: i) women and girls living with HIV; ii) female sex workers; iii) female spouses of male clients of sex workers; iv) women who use drugs; v) female spouses of men who inject drugs; vi) female spouses of men who have sex with men; and vii) women and girls from households affected by HIV/AIDS. See UNAIDS (2011), "People Living with HIV Stigma Index: Asia-Pacific Regional Analysis."

- Interviews with experts in the region, including representatives of networks of women living with HIV, sex workers, women who use drugs, national AIDS machineries, UN bodies, research organizations, and HIV organizations; and
- E-discussion on [www.hivapcop.org](http://www.hivapcop.org) to seek input and recommendations based on preliminary findings of the review.

## Language and terminology

This paper invokes the definition of violence against women framed in the 1993 UN Declaration on the Elimination of Violence against Women (DEVAW).

The Declaration states in **Article 1:**

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 states in **Article 2:**

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

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

The 1993 DEVAW specifically focused on violence against women, although since then the UN family has accepted a broader definition of gender-based violence to include violence against persons based on their gender, including women, men, men who have sex with men, and transgender people.<sup>6</sup> While the overwhelming majority of those who experience gender-based violence are women, men and transgender people can also be targeted for violence. The scope of this review is, however, restricted to violence against women and girls as a cause and consequence of HIV acquisition.

### Note on terminology:

The studies reviewed occasionally use the terms “violence against women” and “gender-based violence” interchangeably. This report, when paraphrasing from a study, uses the term “violence against women” except when specifically referring to violence against men and transgender people. As with internationally agreed definitions, the term “violence against women” includes girls.

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6 UNHCR (2001), “How-to guide: Sexual and gender-based violence programme in Liberia,” at [www.rhrc.org/resources/h2g008.pdf](http://www.rhrc.org/resources/h2g008.pdf).



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# Acronyms

AIDS	Acquired immunodeficiency syndrome
APN+	Asia Pacific Network of People Living with HIV
APNSW	Asia Pacific Network of Sex Workers
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DEVAW	UN Declaration on the Elimination of Violence against Women
GBV	Gender-based violence
GNP+	Global Network of People Living with HIV
HIV	Human immunodeficiency virus infection
IATT	Asia-Pacific Inter-agency Task Team on Women, Girls, Gender Equality, and HIV
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
IOM	International Organization of Migration
MDG(s)	Millennium Development Goal(s)
NSWP	Global Network of Sex Work Project
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother-to-child transmission (of HIV)
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCAP	UN Economic and Social Commission for Asia and the Pacific
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VAW	Violence against women
VCCT	Voluntary and confidential HIV Testing
VCT	Voluntary counselling and treatment
WHO	World Health Organization

# Executive summary, findings and recommendations

The twin epidemics of HIV and violence against women are exacerbated by inadequate services; persistent denial of sexual and reproductive health and rights; laws that are weak or discriminatory towards women and people living with HIV;<sup>7</sup> limited access to justice for women and girls; community standards that validate gender inequality and the subordination of women; women's unpaid care burden, including HIV care burden; and multiple discriminations faced by women and girls because of their class, caste, race, ethnicity, age, sexual orientation, gender identity, and other factors.

Across Asia, the HIV epidemic is predominately concentrated among sex workers and their clients, men who have sex with men, and people who inject drugs.<sup>8</sup> In many countries, the proportion of women among persons living with HIV is increasing as the epidemic matures and HIV spreads to the intimate female partners of men who inject drugs, as well as to the clients of sex workers and their other sexual partners.<sup>9</sup> Epidemiological data shows that in a number of countries the majority of women who cite sexual transmission of HIV as the source of infection report that they contracted the virus from their spouse or long-term partner.<sup>10</sup>

## Violence against women and HIV in Asia and the Pacific: The evidence base

- Violence as a risk factor for HIV: Studies from the region indicate that women living with HIV are more likely to report a history of intimate partner violence than women who are not.<sup>11</sup>
- HIV as a risk factor for violence against women living with HIV: Studies show that (1) actual or the threat of violence is a barrier to HIV disclosure, access to services, and adherence to treatment; and (2) women living with HIV experience violence after disclosure of their HIV status. In addition to intimate partner violence, women living with HIV experience human rights violations within the context of health care settings, including forced sterilizations, forced abortions, forced disclosure of HIV status, and the denial of access to sexual and reproductive health (including family planning) information and services.<sup>12</sup>
- Young women's risk for violence and HIV: The majority of sexually active girls aged 15–19 in developing countries are married, and these married adolescent girls tend to have higher rates of HIV infection than their sexually active, unmarried peers.<sup>13</sup> For women in sex work, age can also heighten both HIV risk and risk for violence.<sup>14</sup>
- Sex work, violence, and HIV: Across Asia and the Pacific, female, male, and transgender sex workers face endemic violence from a range of perpetrators, including intimate partners, clients, street gangs, and

7 Global Commission on HIV and the Law, 2012, Risks, Rights and Health

8 UNAIDS (2012), "Global report: UNAIDS Report on the Global AIDS Epidemic.

9 Ibid.

10 Ibid.

11 Silverman, J. G., Decker, M. R., Saggurti, N., Balaiah, D., Raj, A. (2008), "Intimate partner violence and HIV infection among married Indian women," *JAMA*, 300(6):703–10.

12 GNP+, ICW, IPPF, and UNAIDS (2011), "People Living with HIV Stigma Index: Asia Pacific Regional Analysis 2011; Women of the Asia Pacific Network of People Living with HIV (2012), "Positive and Pregnant: How Dare You? A Study on Access to Reproductive and Maternal Health Care for Women Living with HIV in Asia." In Indonesia, the Indonesian Positive Women's Network is in the process of using the Convention on the Elimination of All Discrimination against Women to challenge forced sterilisations. For more, see [www.opendemocracy.net/5050/baby-rivona-oldri-mukuan/global-mechanism-regional-solution-ending-forced-sterilisation](http://www.opendemocracy.net/5050/baby-rivona-oldri-mukuan/global-mechanism-regional-solution-ending-forced-sterilisation).

13 Bruce, Judith and Shelley Clark (2004), "The implications of early marriage for HIV/AIDS policy," a brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents.

14 Sarkar, K. et al. (2008), "Sex-trafficking, Violence, Negotiating Skill, and HIV Infection in Brothel-based Sex Workers of Eastern India, Adjoining Nepal, Bhutan, and Bangladesh," *Journal of Health, Population and Nutrition*; 26(2):223–231.

police.<sup>15</sup> Studies also show that police harassment and surveillance of sex workers can increase their risk for both violence and HIV. In particular, criminalisation of sex work adversely affects the ability of sex workers to protect themselves from HIV as well as to access justice.

- Drug use, violence, and HIV: Women face gender-specific risks, vulnerabilities, and consequences of their drug use as well as gender-specific barriers to information and access to harm reduction, violence survivor services, and sexual and reproductive health and HIV services.<sup>16</sup> In addition, women who use drugs in the Asia-Pacific region face conditions of marginalization, criminalization, and police surveillance, which places them at heightened risk for violence and HIV.

## Key recommendations

### **Generate better evidence and increased understanding of the specific needs of women and girls in the context of HIV and ensure prioritized and tailored national AIDS responses that protect and promote the rights of women and girls:**

- Collect and analyse new and existing epidemiological and qualitative data disaggregated by sex, age, and setting on how the epidemic impacts key affected women and girls.
- Use data collected on women and girls in the context of HIV to develop sound interventions and activities for more effective planning of HIV programmes for key affected women and girls, as well as for generating strategic information, for allocating resources and budgets, and for developing national key advocacy messages to be promoted by government at all levels.
- Collect data against the indicator on prevalence of intimate partner violence, including key affected women and girls.
- Equip and support key affected women's groups on how the epidemic affects them in order to monitor programmes to assess their human rights impact and to contribute to national data collection.
- Track expenditure of country-level resources allocated to programmes for key HIV affected women, girls and gender equality, in the national AIDS spending assessments in order that resources and results can be tracked and quality improved.
- Expand the evidence base on what works by evaluating and showcasing interventions that address gender equality, violence against women, and HIV, including evaluating the appropriateness of successful interventions for replication and scale-up.

### **Translate political commitments into scaled-up action and resources for policies and programmes that address the rights and needs of women and girls in the context of HIV, with the support of all relevant partners, at the regional, national, and community level:**

- National AIDS authorities to take actions to incorporate global and regional commitments on the rights of women and girls into their national strategic HIV plans, in consultation with key affected women's organizations, networks of women living with HIV, and national women's mechanisms, and ensure scaled-up action and gender-responsive budgeting at the country level.

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15 For more, see UNFPA, CASAM/APNSW, Partners for Prevention, UNAIDS (2012), *Sex Work and Violence: Understanding Factors for Safety & Protection* – Desk Review of literature from and about the Asia Pacific region.

16 United Nations Office on Drugs and Crime (2004), "Substance abuse treatment and care for women: Case studies and lessons learned"; and Bassel, N., Terlikbaeva, A., Pinkham, S., "HIV and women who use drugs: Double neglect, double risk." *The Lancet* 2010, DOI:10.1016/S0140-6736(10)61026-4[NOTE: our style is to provide the volume, issue, and pages, not the DOI.]; as cited in HIV/AIDS Asia Regional Program (HAARP, 2011), "Understanding and responding to gender issues in substance use in South-East Asia: an analytical review," AUSAID.

- National action plans to reduce violence against women should ensure that HIV-related components are integrated. These and other gender equality plans and services should be monitored to ensure accessibility for key affected women and girls.
- Laws, policies, and practices that discriminate against women and people living with HIV should be reformed in line with internationally agreed human rights standards. In particular, countries should legislate against all forms of violence against women.
- Laws, policies, and practices that undermine the effectiveness of the national AIDS response, such as criminalization of same sex practices, sex work, and drug use, and the possession of condoms and clean needles as evidence for criminal sanction should be reformed in line with international human rights standards.
- State institutions such as health systems and law enforcement machineries should follow a zero tolerance policy regarding stigma, discrimination, rights violations, sexual harassment, and violence – especially directed at women living with HIV, sex workers, women who use drugs, transgender people, and men who have sex with men – and ensure equal access to justice for all.
- Laws and policies that guarantee women’s sexual and reproductive rights and prevent and redress violence against women should be resourced and strengthened to respond to women and girls’ risk of violence and HIV. In particular; policies that hinder access to sexual and reproductive health information and services for adolescent girls and unmarried women should be reviewed and brought in line with international human rights treaties, including the Convention on the Elimination of All Forms of Discrimination against Women.

**Design appropriate programmes to address specific risks and vulnerabilities of key affected women, and ensure all women and girls have universal access to integrated multisectoral services for HIV and sexual and reproductive health, including harm reduction and nutrition services and services addressing and responding to violence against women:**

- Models of integrated services – such as enhanced voluntary counselling and testing (VCT), provision of comprehensive post-rape care, integrated sexual and reproductive health, violence response-VCT, and prevention of mother-to-child transmission (PMTCT)/vertical transmission services – should all be evaluated, costed, scaled-up and replicated. Services should be periodically monitored to ensure accessibility for all women and girls, especially key HIV affected women and girls.
- In accordance with WHO guidelines,<sup>17</sup> develop a minimum service package of emergency post-rape medical treatment, including prevention of HIV infection through post-exposure prophylaxis (PEP), emergency contraception, and presumptive sexually transmitted infection (STI) treatment, and make this available through different levels of health services. The availability of this package should be widely publicised among the general public, relevant institutions, and referral agencies, particularly the police, emphasizing the urgency of accessing PEP within 72 hours to prevent HIV transmission.
  - a. Protocols and referral pathways for linking VAW services, HIV services for adults and children, and such other health care services as maternal and child health, family planning, sexual health, and tuberculosis should be developed.
  - b. Pre- and post-test protocols for voluntary and confidential HIV testing should be amended to include routine screening for partner violence as a potential outcome of a positive test result, with appropriate assistance provided where necessary, in line with WHO recommendations.
- Programmes for sex workers should acknowledge and address the spectrum of violence faced by them and ensure that state institutions are accountable for preventing and redressing violence against sex workers.

<sup>17</sup> WHO (2006), “Addressing Violence Against Women in HIV Testing and Counselling: A Meeting Report”; [www.who.int/gender/documents/VCT\\_addressing\\_violence.pdf](http://www.who.int/gender/documents/VCT_addressing_violence.pdf). See also WHO and UNAIDS (2007), “Guidance on Provider Initiated HIV Testing and Counselling in Health Facilities.”

- Programmes for people who use drugs should respond to the needs and risks of women who use drugs, including their access to integrated and gender-sensitive HIV, harm reduction, sexual and reproductive health, and violence response services.
- Outreach and harm reduction services should be expanded throughout the intravenous drug user – IDU - community to ensure safe injection practices and reduce the potential spread of disease. These services should incorporate access and referral to HIV testing, treatment, and care services; violence response services; and sexual and reproductive health services.
- Health care services need to respond to violence by developing integrated screening and referral protocols, mainstreaming HIV prevention, treatment, care, and support services for women living with HIV.

# Introduction

## The twin health and human rights crises

Women are two to four-times more likely to contract HIV during unprotected vaginal sex than are men because their physiology places them at a higher risk of injuries, and because they are less able to control the circumstances and conditions of sexual intercourse, and because they are more likely than men to be at the receiving end of violent or coercive sexual intercourse.<sup>18</sup> The 2005 report of the UN Special Rapporteur on Violence against Women noted that “the lack of respect for women’s rights both fuels the epidemic and exacerbates its impact.”<sup>19</sup> Simultaneously, gender inequality and violence against women can profoundly affect the health and well-being of women living with HIV, as “violence against a woman can interfere with her ability to access treatment and care, maintain adherence to antiretroviral therapy or feed her infant in the way she would like.”<sup>20</sup>

Violence against women is a human rights crisis in its own right. According to the World Health Organization’s multi-country study on women’s health and violence against women, 13–61 percent of ever partnered women have experienced physical and/or sexual violence by a partner in their lifetime.<sup>21</sup> Young women are at particular risk for violence, with as many as 30 percent of women in some locations reporting that their first sexual experience was coerced or forced,<sup>22</sup> and the younger the women were at the time of sexual initiation, the higher the chance that it was violent.<sup>23</sup> Also, the majority of sexually active girls aged 15–19 in developing countries are married, and these married adolescent girls tend to have higher rates of HIV infection than their sexually active, unmarried peers.<sup>24</sup>

Actual and the threat of violence not only cause physical and psychological harm to women and girls, it also limits their access to and participation in society. Even the threat of violence alone circumscribes women’s freedom of movement and of expression as well as their rights to privacy, security, and health.

## Compounding factors

The twin epidemics of HIV and violence against women are exacerbated by inadequate services; persistent denial of sexual and reproductive health and rights; laws that are weak or discriminatory towards women and people living with HIV;<sup>25</sup> limited access to justice for women and girls; community standards that validate gender inequality and the subordination of women; women’s unpaid care burden, including HIV care burden; and multiple discriminations faced by women and girls because of their class, caste, race, ethnicity, age, sexual orientation, gender identity, and other factors. Moreover, uptake of VCT services, disclosure of HIV status to sexual partners, and breach of confidentiality and partner notification by HIV service providers all have the potential of increasing women’s risk of violence.<sup>26</sup>

18 WHO (1998), “Gender and Health: Technical Paper.”

19 Yakin Ertürk (2005), “Integration of the human rights of women and the gender perspective: The intersections of violence against women and HIV/AIDS,” *Report of the Special Rapporteur on violence against women, its causes and consequences*.

20 WHO (2006), “Sexual and reproductive health of women living with HIV/AIDS: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.”

21 Claudia Garcia-Moreno, Lori Heise, Henrica, A. F. M. Jansen, Mary Ellsberg, Charlotte Watts (2005), “Violence Against Women,” *Science: Policy Forum on Public Health*, vol. 310, 5 November 2005.

22 WHO (2006), “WHO multi-country study on women’s health and domestic violence against women.”

23 Ibid.

24 Bruce, Judith and Shelley Clark (2004), “The implications of early marriage for HIV/AIDS policy,” brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents.

25 Global Commission on HIV and the Law, “Risks, Rights and Health.”

26 WHO noted that evidence indicates that fear of and actual violence have an impact on women’s uptake of HIV testing and counselling services, HIV status disclosure, and access to post-test services. For more, see WHO (2006), “Addressing Violence against Women in Voluntary Testing and Counselling: A Meeting Report.”

In particular, forced abortions and sterilisations of women living with HIV in health systems are blatant violations of their sexual and reproductive rights.<sup>27</sup> The UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment noted that women can face abuse and mistreatment in institutional settings, including “involuntary sterilization; denial of legally available health services such as abortion and post-abortion care; forced abortions and sterilizations; violations of medical secrecy and confidentiality in health-care settings.”<sup>28</sup> The Special Rapporteur also noted that “Forced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment.”<sup>29</sup>

Criminalisation of sex work, same sex practices, drug use, and HIV transmission all have an impact on the efficacy of HIV response. The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health noted that “criminalization of same sex practices, drug use, sex work and HIV transmission are counterproductive to the prevention of HIV transmission.”<sup>30</sup> As examined below, for women in Asia and the Pacific, whether they are living with HIV, are in sex work, or use drugs, criminalisation not only increases their risk for HIV but also increases the likelihood that they will experience some form of violence.

## International human rights framework

A number of international human rights standards that are agreed by governments are directly relevant to women in the context of HIV and violence against women.<sup>31</sup> Among these:

**Vienna Declaration and Programme for Action** (1993) recognises the importance of women’s right to enjoy the highest standard of physical and mental health throughout their lifespan. Article 41 reaffirms a woman’s right to accessible and adequate health care and the widest range of family planning services.<sup>32</sup>

**Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW, 1993), articles 2, 5, 11, 12, and 16, require state parties to take action to protect women from violence of any kind occurring in the family, at the work place, or any other area of life. The CEDAW committee in General Recommendation 19 (1992) noted that gender-based violence impairs or nullifies women’s enjoyment of human rights and is a form of discrimination; and in General Recommendation 24 (1999) noted that in unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices.<sup>33</sup>

27 Global Commission on HIV and the Law. Also, in July 2012 the High Court in Namibia ruled in favour of three women living with HIV who had been forcefully sterilised by the government. The campaign was spearheaded by the Namibia Women’s Health Network, formed and led by women living with HIV. For more, see [www.icw.org/node/421](http://www.icw.org/node/421) and [www.opendemocracy.net/5050/nell-osborne/against-coerced-sterilisation-resounding-victory-in-namibia](http://www.opendemocracy.net/5050/nell-osborne/against-coerced-sterilisation-resounding-victory-in-namibia). In Indonesia, the Indonesian Positive Women’s Network is in the process of using CEDAW to challenge forced sterilisations. For more, see [www.opendemocracy.net/5050/baby-rivona-oldrimukuan/global-mechanism-regional-solution-ending-forced-sterilisation](http://www.opendemocracy.net/5050/baby-rivona-oldrimukuan/global-mechanism-regional-solution-ending-forced-sterilisation).

28 Report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan Mendez, to the UN Human Rights Commission, February 2013; [www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53\\_English.pdf](http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf).

29 Ibid.

30 The AIDS and Law Exchange, Director of the Lawyers Collective (India) and UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and Mental Health, Anand Grover, 15 December 2009. See also WHO, UNFPA, UNAIDS, NSWP (2012), “Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Worker in Low or Middle Income Countries, Recommendations for a Public Health Approach.”

31 Despite the broad scope of these normative standards on violence against women experienced in a wide range of circumstances and settings, it should be noted that these rarely contain references to violence against women who are engaged in sex work. International women’s rights instruments have restricted themselves to the violence of sex work rather than in sex work. For more, see CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.

32 The Declaration and Programme are available at [www.unhcr.ch/huridocda/huridoca.nsf/\(symbol\)/a.conf.157.23.en](http://www.unhcr.ch/huridocda/huridoca.nsf/(symbol)/a.conf.157.23.en).

33 Available at [www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm](http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm).



**Declaration on the Elimination of Violence against Women** (DEVAW, 1993), in article 4, calls on state parties to condemn violence against women and not invoke any custom, tradition, or religious consideration to avoid their obligation to eliminate violence against women.<sup>34</sup>

**Cairo Programme for Action**, adopted at the International Conference on Population and Development (ICPD, 1994), set out key recommendations to address women's vulnerability to HIV through reproductive health services.<sup>35</sup>

**Beijing Platform for Action**, adopted at the Fourth World Conference on Women (1995), recommended the institution of gender-sensitive initiatives to address HIV, STIs, and sexual and reproductive health.<sup>36</sup>

**Declaration of Commitment "Global Crisis-Global Action,"** adopted by the UN General Assembly Special Session on HIV (2001), noted that gender equality and women's empowerment are fundamental elements to the reduction of women's vulnerability to HIV.<sup>37</sup>

**Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS**, adopted by the UN General Assembly (2011), reaffirmed commitments made in 2006 and committed to a specific target (7) to "eliminate gender inequalities and gender-based abuse and violence."<sup>38</sup>

34 Available at [www.un.org/documents/ga/res/48/a48r104.htm](http://www.un.org/documents/ga/res/48/a48r104.htm).

35 Available at [www.un.org/ecosocdev/geninfo/populatin/icpd.htm](http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm).

36 Available at [www.un.org/womenwatch/daw/beijing/platform/](http://www.un.org/womenwatch/daw/beijing/platform/).

37 Available at [www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html](http://www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html).

38 Available at [daccess-dds-ny.un.org/doc/UNDOC/LTD/N11/367/84/PDF/N1136784.pdf?OpenElement](http://daccess-dds-ny.un.org/doc/UNDOC/LTD/N11/367/84/PDF/N1136784.pdf?OpenElement); see also Asia Pacific Council of AIDS Service Organizations (APCASO) and Asia Pacific Alliance (APA)(2012), "In Focus: Women and Girls and the 2011 Political Declaration on HIV/AIDS."

# Gender inequality and violence against women and HIV

*Violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men.*

— Declaration of the Elimination of Violence against Women, 1993

## Omnipresent threat of violence

According to the UN Secretary-General's 2006 study, *Ending Violence Against Women: From Words to Action*, "violence against women persists in every country in the world as a pervasive violation of human rights and a major impediment to achieving gender equality."<sup>39</sup>

Women experience actual or the threat of violence in different sites (including homes, communities, workplaces, markets, streets, hospitals, and prisons), from a range of perpetrators (including but not limited to their intimate partners, family or community members, strangers, state actors, health care workers, and police and immigration officers). Women experience violence or the threat of violence throughout their life cycles, including during pregnancy.<sup>40</sup>

## Manifestation of and means to maintain women's subordination

According to the UN Secretary-General's 2006 report, violence against women maintains, "control over women's sexuality and reproductive capacity."<sup>41</sup> It is also a means to circumscribe women – and men – to their socially defined gender roles. For instance, gender non-conforming heterosexual men, gay men, or transgender people can also become targets of violence, as they are seen to be transgressing normative masculinity. The same system of gender-based discrimination and violence that targets women also impinges on men who have sex with men and transgender people.

Female sex workers are also at heightened risk for violence because they are seen to transgress normative femininity, whereby control over their sexuality and reproductive capacity or indeed their productive and reproductive labour is not assigned to a single man. In the Asia-Pacific region there is also considerable

39 United Nations (2006), "Ending Violence against Women: From Words to Action," Study of the Secretary-General.

40 Studies show that violence can begin or escalate during pregnancy. See Cook, J., Bewely, S. (2008), "Acknowledging a Persistent Truth: Domestic Violence in Pregnancy," *Journal of the Royal Society of Medicine* (2008) 101: 358–363. The WHO multi-country study found prevalence of physical intimate partner violence in pregnancy ranging from 1 percent in urban Japan to 28 percent in provincial Peru, with prevalence in most sites of 4–12 percent. Similarly, a review of studies from 19 countries found prevalence ranging from 2 percent in settings such as Australia, Denmark, and Cambodia, to 13.5 percent in Uganda, with the majority ranging between 4 and 9 percent. A few facility-based studies in some settings have found even higher prevalence, including one from Egypt with an estimated prevalence of 32 percent and a review of studies from Africa that found a prevalence as high as 40 percent in some settings. For more, see WHO (2012), "Understanding and Addressing Violence against Women Intimate Partner Violence."

41 "Ending Violence against Women," p. 50.

## Violence against women in Asia and the Pacific

- In **Cambodia**, 43.7 percent of surveyed women stated that they had experienced physical violence from their husband [National Institute of Statistics Cambodia Socio-Economic Survey Reports, 2005].
- In the **Philippines**, 20 percent of surveyed women age 15–49 have experienced physical violence since age 15. Almost 18 percent of women who have ever been married have experienced physical or sexual violence by a husband [National Statistics Office, Philippines, and ICF Macro, 2009]
- 41 percent of ever-partnered women in **Bangkok** and 47 percent in **Nakhonsawan** had experienced physical or sexual violence by an intimate partner [WHO, Thailand-Country Factsheet, 2005].
- In **Timor Leste**, approximately 38 percent of women and girls have experienced physical violence since age 15 [National Statistics Directorate, Ministry of Finance, and ICF Macro, 2010].
- In **Viet Nam**, 32 percent of ever-married women reported having experienced physical violence in their life [Viet Nam General Statistics Office, 2010],
- In **Afghanistan**, 87.2 percent of women experienced at least one form of domestic violence, including physical, sexual, or psychological violence, or forced marriage [Global Rights: Partners for Justice, 2008].
- 53 percent of ever-married women in **Dhaka** and 62 percent in **Matlab** had at some point experienced physical or sexual violence [WHO, Bangladesh Country Factsheet, 2005].
- In **Maldives**, approximately 19.5 percent of women who had ever been in a relationship reported experiencing physical and/or sexual violence by an intimate partner [Ministry of Gender and Family, 2007].
- In **Nepal**, 34 percent of women aged 15–49 years have at some point experienced physical violence since age 15 [Nepal Demographic and Health Survey, 2011].
- In **Fiji**, 66 percent of women reported intimate partner violence; 30 percent of these suffered repeated physical abuse; 44 percent reported being hit while pregnant [Secretariat of Pacific Island Countries Community, 2010].
- In **Vanuatu**, 61.7 percent sexually active young women reported forced sex [UNICEF, 2010].
- In **Samoa**, 41 percent of ever-partnered women had experienced physical violence at the hands of an intimate partner [Secretariat of Pacific Island Countries Community, 2007].

## Normative masculinity and femininity

The idea of “normal or compulsory heterosexuality” – or heteronormativity – refers to the explicit or implicit practices and institutions that legitimise and privilege heterosexuality and heterosexual relationships as fundamental and ‘natural’ within society and, moreover, posit that women should be feminine (meaning subservient) and men should be masculine (meaning dominant).

See, for example, Sangeeta Budhiraja, Susan T. Fried, and Alexandra Teixeira, “Spelling it out: From alphabet soup to sexual rights and gender justice,” in Suzanne Bergeron and Amy Lind, eds., *Queering Development*; and Cathy J. Silt, Kirsten and Westbrook, Laurel, “Doing Gender, Doing Heteronormativity: ‘Gender Normals,’ Transgender People, and the Social Maintenance of Heterosexuality” in *Gender & Society* (2009); 23; 440.

evidence of rape and assault of transgender sex workers who present a feminine gender identity.<sup>42</sup> In this context, similarities can be found between violence against specific groups of women and violence against transgender people in that violence is seen as retribution for transgressing fixed gender identity and norms.<sup>43</sup>

## Multiple and intersecting discrimination

No woman is exempt from actual or the threat of violence, yet some women are at greater risk than others.<sup>44</sup> There are power and privilege differentials among different groups of women that determine risk for violence as well as access to justice. The UN Special Rapporteur on violence against women, its causes and consequences, notes in her 2011 report that “the different ways in which women may experience violence, particularly intimate and interpersonal violence, depends on how they are positioned within social, economic and cultural hierarchies that prohibit or further compromise certain women’s ability to enjoy universal human rights. These institutions and structures often promote access for a privileged group of women at the expense of those who are less privileged.”<sup>45</sup>

Women who face multiple and intersecting discriminations on the basis of their class, caste, race, ethnicity, age, sexual orientation, gender identity, and other factors are at heightened risk for violence. In the context of HIV, this includes women who face multiple discriminations, often sanctioned by the state, on the basis of their work (sex workers), addiction (women who inject drugs), and HIV status (women living with HIV).

## Gender inequality fuels HIV

Women have substantially different needs and face both different HIV risks and different risks of violence than do men. This applies in both generalized and concentrated HIV epidemics. Women, as compared to men, also experience differential and often disproportionate impacts of the HIV epidemic. Gender inequality, manifested in women’s and girls’ restricted access to education, health services, assets, resources, and economic opportunities; their diminished participation in decision-making processes; their lack of control over their own sexual and reproductive choices; and their disproportionate care responsibilities all influence women’s and girls’ experience of the HIV epidemic and its response.<sup>46</sup>

In particular, violence or the fear of violence can restrict the ability of women and girls to seek HIV prevention services and to refuse sex or negotiate safe sex. It can also inhibit the ability of women and girls to disclose their status and to access voluntary counselling and treatment services, as well as care and support services.<sup>47</sup>

42 Bhandari, Raju Ram (2010), “Documentation of Human Rights Abuse and Media Report: A Review,” Blue Diamond Society; Chakrapani, V. et al. (2007), “Structural violence against kothi-identified men who have sex with men in Chennai, India: A qualitative investigation,” *AIDS Education and Prevention*, vol. 19, no. 4: 346–364; Mayhew, S. et al. (2009), “Protecting the unprotected: Mixed-method research on drug use, sex work and rights in Pakistan’s fight against HIV/AIDS,” *Sexually Transmitted Infections*, vol. 85(Suppl. 2): 31–36; Nichols, Andrea (2010), “Dance Ponnaya, Dance! Police Abuses Against Transgender Sex Workers in Sri Lanka,” *Feminist Criminology*, vol. 5: 195–222, as cited in CASAM/APNSW, “Partners for Prevention”, UNAIDS, *Sex Work and Violence*

43 Ibid., *Sex Work and Violence*.

44 The Fourth World Conference on Women recognized the particular vulnerability to violence of “women belonging to minority groups, indigenous women, refugee women, women migrants, including women migrant workers, women in poverty living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women, displaced women, repatriated women, women living in poverty and women in situations of armed conflict, foreign occupation, wars of aggression, civil wars, terrorism, including hostage-taking.”

45 For a detailed analysis of multiple and intersecting discrimination and violence against women, please see the 2011 report of the UN Special Rapporteur on violence against women, its causes and consequences, Rashida Manjoo; [www2.ohchr.org/english/bodies/hrcouncil/docs/17session/A-HRC-17-26.pdf](http://www2.ohchr.org/english/bodies/hrcouncil/docs/17session/A-HRC-17-26.pdf).

46 For more information, see UNAIDS, “Agenda for Accelerated Country Action”; UNAIDS and UNDP (2009), “Essential Actions on Gender and AIDS”; and UNIFEM (2009), “Transforming the National AIDS Response: Mainstreaming Gender and Women’s Human Rights into the ‘Three Ones’.”

47 Program on International Health and Human Rights, Harvard School of Public Health (2011), *Gender-Based Violence and HIV*.

## Key messages

A human rights-based approach to reduce and eliminate the gender-specific risks for women in the context of HIV and VAW requires that policies and programmes aimed at both epidemics address their underlying structural causes. This includes a concerted effort to address factors such as male control over women's agency and sexuality; religious and cultural influences that perpetuate gender inequalities; and a lack of justice, accountability, and resources to implement existing policies as well as the resulting sense of impunity. It also requires that all stakeholders in the national AIDS response monitor the human rights impacts of their HIV-related activities and remedy any adverse human rights outcomes, especially among groups that have a heightened risk for violence and HIV. In the context of the Asia-Pacific region, this includes key affected women and girls. Risk of violence and other negative outcomes can be compounded for women sex workers and women who use drugs, especially in settings where their work or addiction is criminalized. Interventions must be gender-sensitive, non-discriminatory, and designed with the meaningful participation of those most affected, with a view to changing the structural factors that underpin the twin epidemics of HIV and VAW. This includes changes to the legal and policy environment to bring them into line with international human rights standards so that they may be a means to prevent violence against women and reduce HIV risk among women and girls.

# The HIV epidemic and its impact on women

## The global epidemic

Globally, women account for 50 percent of people living with HIV, 32–35 percent in Asia and the Pacific, while in sub-Saharan Africa this number escalates to 60 percent.<sup>48</sup> In sub-Saharan Africa and the Caribbean<sup>49</sup> young women's vulnerability to HIV is double that of young men's.<sup>50</sup> Further, 98 percent of women living with HIV live in developing countries, and of the remaining 2 percent in developed countries the majority live in impoverished conditions.<sup>51</sup> Globally, HIV remains the leading cause of death among women of reproductive age, and one-in-five maternal deaths are HIV-related.<sup>52</sup>

## The HIV epidemic in Asia and the Pacific

### Key affected populations in the Asia Pacific region

Across Asia, the HIV epidemic is predominately concentrated in sex workers and their clients, men who have sex with men, and people who inject drugs.<sup>53</sup> Different countries in the region show that certain key populations are at highest risk of HIV. Almost 18 percent of surveyed female sex workers in Myanmar and 15 percent in southern India were living with HIV<sup>54</sup> (Figure 1). In the region, 16 percent of people who inject drugs are living with HIV, although the prevalence is considerably higher in some countries.<sup>55</sup> HIV prevalence among men who have sex with men ranges from 5 to 35 percent.<sup>56</sup> In Papua New Guinea, the epidemic is the largest and the only generalized one in the Pacific, and is primarily characterized by unprotected heterosexual contact.<sup>57</sup>

### Intimate partner transmission of HIV in the Asia-Pacific region<sup>58</sup>

The Asia-Pacific region, which is characterized by mostly concentrated HIV epidemics, has seen the proportion of new infections that women account for rise from 21 percent in 1990 to 35 percent in 2009<sup>59</sup> (Figure 2). In many countries the proportion of women among persons living with HIV is increasing as the epidemic matures and HIV spreads to the intimate female partners of men who inject drugs, as well as of clients of sex workers and their other sexual partners.<sup>60</sup> Epidemiological data shows that in a number of countries the majority of women who cite sexual transmission of HIV as the source of infection report that they contracted the virus from their spouse or long-term partner. For example, 90 percent of women in India report that they were infected within long-term relationships.<sup>61</sup> In India, Cambodia, Myanmar, and Thailand, married women account for a significant proportion of new HIV infections. For example, in Thailand in 2005, 43 percent of new infections were among

48 UNAIDS (2012), *Report on the Global AIDS Epidemic*.

49 The only region outside sub-Saharan Africa where the number of women and girls outnumber men and boys among people living with HIV.

50 Global Commission on HIV and the Law.

51 Ibid.

52 Ibid.

53 UNAIDS (2012), *Report on the Global AIDS Epidemic*.

54 Ramesh, B. M. et al. (2008), "Determinants of HIV prevalence among female sex workers in four south Indian states: Analysis of cross-sectional surveys in twenty-three districts," *AIDS*, 22(Suppl. 5):S35–S44, as cited in UNAIDS, *Report on the Global AIDS Epidemic*.

55 UNAIDS (2010), *Global Report: UNAIDS Report on the Global AIDS Epidemic*.

56 Ibid.

57 Ibid.

58 The term 'HIV transmission in intimate partner relationships' is used to describe the transmission of HIV to women from their long-term male partners who inject drugs, have sex with other men, or are clients of sex workers. UNAIDS (2009), *HIV Transmission in Intimate Partner Relationships in Asia*.

59 UNAIDS, *HIV Transmission in Intimate Partner Relationships in Asia*.

60 Ibid.

61 Ibid.

women.<sup>62</sup> In the Asia-Pacific region a significant proportion of women are at risk of HIV not because of their own behaviour but because of their male partner's behaviour.

The Commission of AIDS in Asia (2008) report estimates that 75 million men regularly buy sex; 16 million men have sex with other men (MSM); and 4 million inject drugs.<sup>63</sup> It is also known that many these men (see, for example, Figure 3) are married or have regular sexual partners.<sup>64</sup> The Commission on AIDS in Asia report estimates that between 10 and 60 percent of men who have sex with men and between 25 and 60 percent of men who inject drugs are married or have regular female sexual partners. In some contexts, men who have sex with men are married to women or maintain heterosexual relationships because they do not necessarily identify themselves as gay or to escape homophobia – especially where same sex relationships and/or behaviours are criminalized.<sup>65</sup>

Predicated on these estimates, the report found that around 50 million women are at risk for HIV from their intimate partners.<sup>66</sup>

Also, low condom usage can increase the risk of HIV for women who are sexual partners of men who buy sex, use drugs, or have sex with men. As shown in Figure 4 below, condom usage among key populations in the region is uneven: reported condom usage at last sex can range from as high as 92 percent among female sex workers in Thailand to 53 percent in PNG. Reported condom usage among men who have sex with men and people who inject drugs remains low in most countries across the region (Figure 4).

## Understanding the HIV epidemic and its impact on women in the Asia-Pacific region: Key gaps and challenges

Data is largely unavailable on whether clients of sex workers and men who have sex with men (who also have sex with women) use condoms with their female sexual partners. If this data were to be uniformly collected it would have important implications for interventions to reduce intimate partner transmission of HIV. For example, one study from Vietnam shows that only 16 to 36 percent of men who inject drugs and also buy sex reported using condoms with their regular partners.<sup>67</sup>

- Data on condom usage, while useful, does not necessarily address the question of women's ability to refuse sex as well as negotiate safe sex arising from unequal power relations between men and women in intimate relationships, including violence.
- It is unclear from the data collected whether female sex workers or female intimate partners have access to and use female condoms.
- Another evidence gap is sex disaggregated data on people who inject drugs, which renders invisible the gender-specific risks and vulnerabilities of women who inject drugs.

Continued on p. 24

62 World Health Organization (2007), "HIV/AIDS in South-East Asia Region.

63 Commission on AIDS in Asia (2008), "Redefining AIDS in Asia: Crafting an Effective Response," as cited in UNAIDS, *HIV Transmission in Intimate Partner Relationships in Asia*.

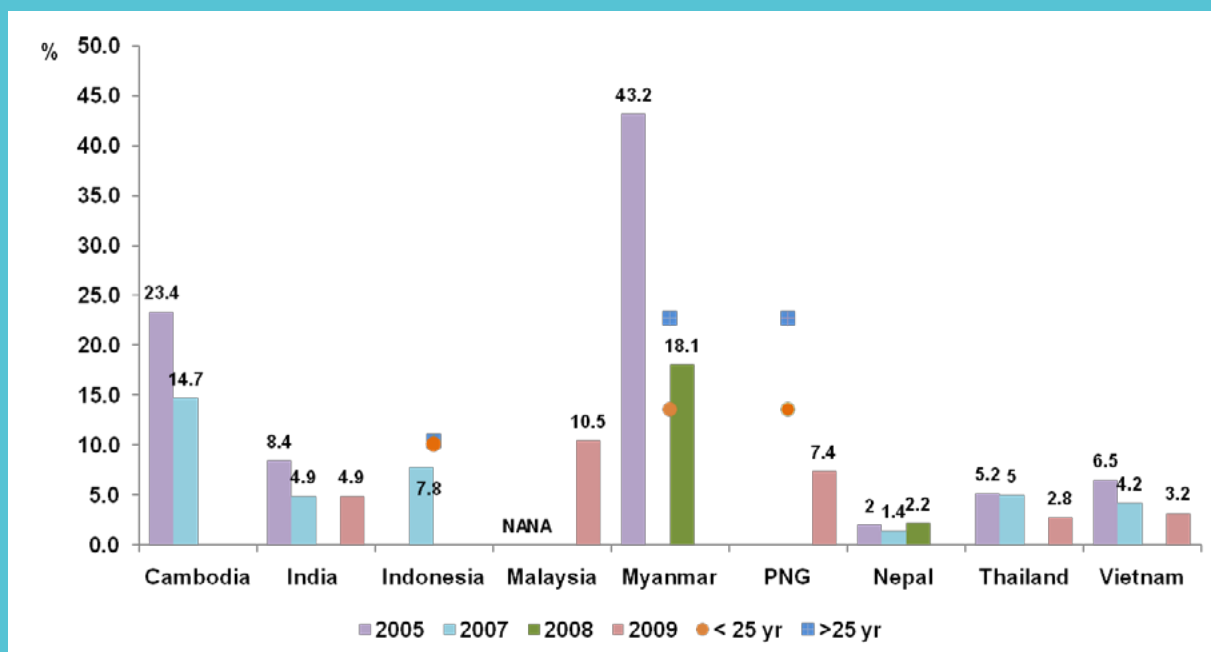
64 UNAIDS, *HIV Transmission in Intimate Partner Relationships in Asia*.

65 Hart, G., Elford, J. (2010), "Sexual risk behaviour of men who have sex with men: Emerging patterns and new challenges," *Current Opinion in Infectious Diseases*, 23(1), p. 39-44; Dowsett, G. W., Grierson, J. W., and McNally, S. P. (2006), "A Review of Knowledge about the Sexual Networks and Behaviours of Men who have Sex with Men in Asia," Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia, Monograph Series Number 59; Beyrer, C. et al. (2011), "The Global HIV Epidemics among Men Who Have Sex with Men (MSM)," (The World Bank); UNAIDS, UNDP (2009), "UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People," as cited in Global HIV-LAW commission report, p 45, footnote 217, 218, as cited in Global Commission on HIV and the Law, 2012, Risks, Rights and Health, UNDP.

66 Commission on AIDS in Asia, "Redefining AIDS in Asia."

67 Ministry of Health, Viet Nam (2006), "Results from the HIV/STI integrated biological and behavioural surveillance (IBBS) in Viet Nam, 2005–2006," as cited in UNAIDS, "HIV Transmission in Intimate Partner Relationships in Asia."

**Figure 1: HIV prevalence among female sex workers, countries where data is available, 2005–2009**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNGASS Country Progress Reports 2006, 2008 & 2010. UNAIDS, UNICEF, WHO and ADB (2013), HIV and AIDS Data Hub for Asia and the Pacific; <http://aidsdatahub.org/>.

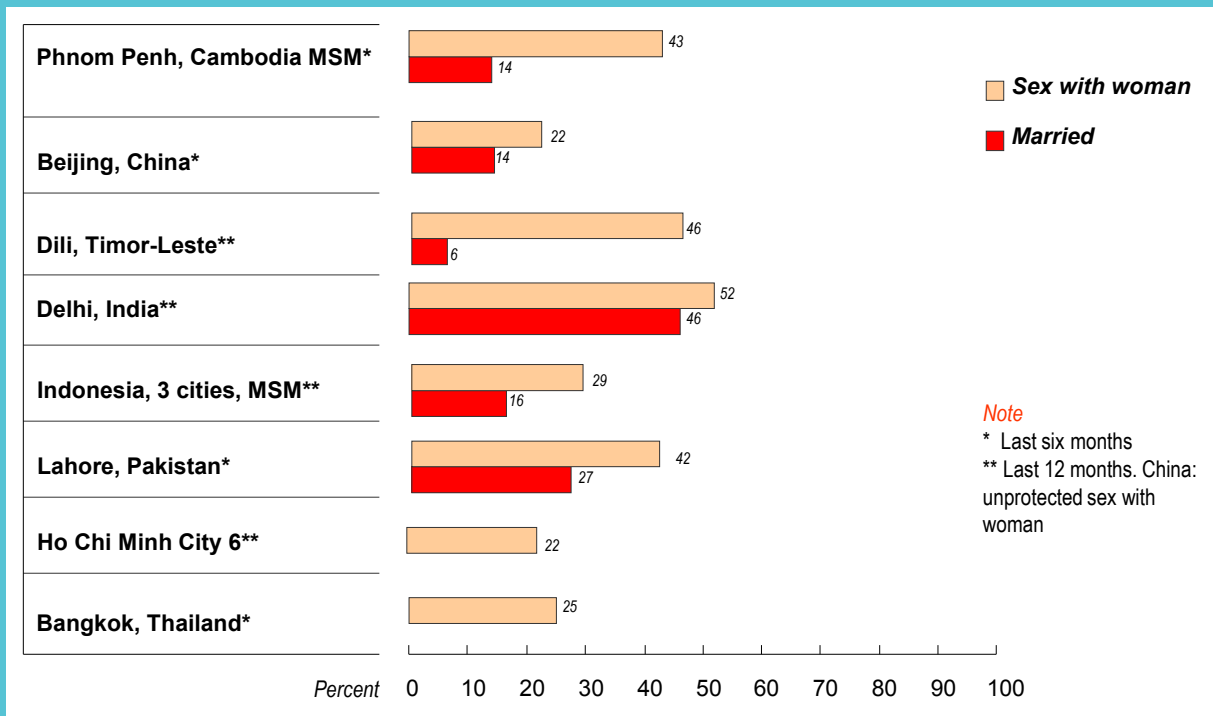
**Figure 2: Proportion of women among estimated number of adults ( $\geq 15$  years) living with HIV, 2010**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on WHO, UNAIDS, & UNICEF. (2011). Global HIV/AIDS Response: Epidemic Update and Health Sector Progress Towards Universal Access. UNAIDS, UNICEF, WHO and ADB (2013), HIV and AIDS Data Hub for Asia and the Pacific; <http://aidsdatahub.org/>.

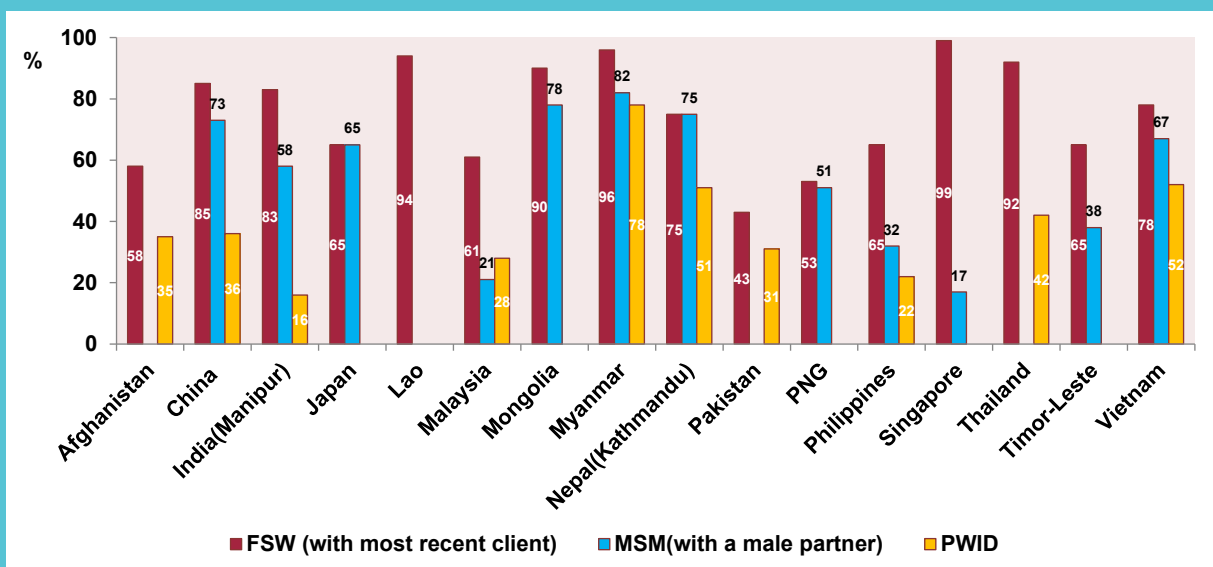


**Figure 3: Percentage of active MSMs who are married or reported recent sex with women among selected countries in Asia, 2002-2004**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Data from national behavioural surveillance and Naz Foundation International and Vision 2002; Choi, Liu et al 2003; Colby 2003; Girault, Saidel et al 2004; van Griensven, Thanprasertsuk et al 2004; Pisani and Dili STI survey team 2004a cited in Monitoring the AIDS Pandemic Network. (2004). AIDS in Asia: Face the Facts - A Comprehensive Analysis of the AIDS Epidemic in Asia 2004. UNAIDS, UNICEF, WHO and ADB (2013), HIV and AIDS Data Hub for Asia and the Pacific; <http://aidsdatahub.org/>.

**Figure 4: Percentage of condom use at last sex among key populations at higher risk, 2008-2009**



Source: Prepared by [www.aidsdatahub.org](http://www.aidsdatahub.org) based on UNGASS Country Progress Reports 2008 & 2010. UNAIDS, UNICEF, WHO and ADB (2013), HIV and AIDS Data Hub for Asia and the Pacific; <http://aidsdatahub.org/>.

These gaps are significant. As the 2010 Global Report notes, the HIV epidemic in the region is concentrated among women sex workers, men who have sex with men, and people who use drugs. And the 2008 report of the Commission on AIDS in Asia notes that the trend of increasing HIV transmission from men with high-risk behaviours to their intimate female partners continues in many countries in the region. Violence against women has implications for sex workers, women who use drugs, and women who are married to or are in intimate partner relationships with men who buy sex, inject drugs, and/or have sex with men. These trends, historical and emerging, warrant greater investment in sex disaggregated data collection, building new evidence and knowledge that identifies and assesses the gender-specific risks and vulnerabilities faced by women and girls in the Asia Pacific region.

# Violence against women and HIV: The evidence base

## Mapping the research

A recent global review of literature examining the inter-linkages between violence against women and HIV<sup>68</sup> found that close to half of the studies were based in the United States and a third in Africa. Fewer than 10 percent of the studies were conducted in Asia and the Pacific. However, India is an outlier, accounting for the third highest number of studies after the United States and South Africa. Most of the studies from Asia and the Pacific have been conducted with married women or women sex workers as the primary focus. In India, the majority of studies conducted focused on married women survivors of violence and their vulnerability to HIV transmission from their husbands.

Globally, there is an evidence base to establish, conceptually and empirically, linkages between violence against women and HIV and the potential causal pathways, including:

- Unprotected coerced sex, increasing women's risk for HIV;
- Violence or the threat of violence restricting their ability to negotiate safe sex;
- Child sexual abuse increasing likelihood of sexual risk-taking, thereby increasing risk for HIV;
- HIV as a risk factor for violence, i.e., women who are HIV-positive being at a greater risk for violence and the threat of or actual violence interfering with their ability to access or adhere to treatment;
- Violence against women and HIV as mutual risk factors combining with other factors – such as alcohol or substance abuse, conflict, or emergencies – reinforcing the relationship between the two.<sup>69</sup>

## Mapping the research in Asia and the Pacific

Of the literature on the linkages between violence against women and HIV in the region, a little over 85 percent were empirical research studies published in peer-reviewed journals, 10 percent were reports written by non-governmental organizations (NGOs), and 5 percent were produced by UN agencies. Of these, 60 percent are on sex workers in which female sex workers as respondents account for 80 percent; 15 percent are on married women; and 10 percent are on women who use drugs. India accounts for 35 percent of the literature, which focus evenly on married women and female sex workers; China accounts for 15 percent of the literature, of which 70 percent are focused on female sex workers and the rest on women who use drugs; and the remaining are divided among such countries as Sri Lanka, Pakistan, Nepal, Burma, Thailand, Cambodia, and Fiji as well as some global-led reports with a special focus on developing countries. Over 90 percent of this literature is on female, male, and transgender sex workers, with 80 percent on female sex workers.

## Violence as a risk factor for HIV in Asia and the Pacific

Studies from the region indicate that women living with HIV are more likely to report a history of intimate partner violence than women who are not.<sup>70</sup> For instance, a 2008 study in rural and urban India found that

68 Program on International Health and Human Rights, *Gender Based Violence and HIV*. The review included peer-reviewed articles on the intersection of gender-based violence and HIV published between 2000 and 2010. A significant majority of the articles reviewed were empirical studies that investigate the link between gender-based violence and HIV. The review used a broader gender-based violence framework, and included violence against boys, men, MSM, and transgender people.

69 Ibid.

70 Silverman et al., "Intimate partner violence."

women living with HIV were more likely to report forced sex and domestic violence.<sup>71</sup> Another 2009 study with husband-wife dyads in India showed that abusive husbands were more likely to acquire HIV than non-abusive husbands, and that the HIV risk for women in violent relationships increased seven-fold.<sup>72</sup> A 2007 study in Bangladesh of married men found that more than one in three husbands reported physically and/or sexually abusing their wives in the preceding year. Men perpetrating such violence were more likely to report both premarital and extramarital sex partners; those reporting physical violence were also more likely to report STI symptoms or diagnosis in the preceding year.<sup>73</sup>

Empirical studies from other parts of the world have established other dimensions of the linkages between violence against women and HIV. First, there is a strong link between actual or threat of violence and sexual risk-taking, including unprotected sex and multiple sex partners.<sup>74</sup> Second, actual or the threat of violence affects women's ability to negotiate condom usage.<sup>75</sup> And third, there is a link between intimate partner violence and unequal gender relations and HIV.<sup>76</sup> It is telling that the type of empirical research outlined above is lacking within Asia and the Pacific and, as such, highlights the urgent need for an improved evidence base for policy makers and programme planners.

## HIV as a risk factor for violence against women

There have been some attempts to understand HIV as a risk factor for violence in the Asia-Pacific region, though these are studies mostly based in India. These studies have tended to follow two lines of inquiry: one, actual or the threat of violence being a barrier to HIV disclosure, access to services, and adherence to treatment; and two, women living with HIV experiencing violence after disclosure of their HIV status.

A cross-sectional study conducted in 2007 explored the prevalence of domestic violence among women visiting a VCT facility in India. Of the participants, 67 percent reported that they were HIV-positive. Of these, 42 percent reported experiencing some form of violence, and 18 percent reported that the cause of violence was their HIV status.<sup>77</sup> A 2004 multi-country WHO review of barriers to and outcomes of HIV disclosure for women

71 Gupta, R. N., Wyatt, G. E., Swaminathan, S. et al. (2008), "Correlates of relationship, psychological, and sexual behavioral factors for HIV risk among Indian women," *Cultur Divers Ethnic Minor Psychol*;14(3):256-65, as cited in Program on International Health and Human Rights, *Gender Based Violence and HIV*.

72 Decker, M. R., Seage, G. R. 3rd, Hemenway, D. et al. (2009), "Intimate partner violence functions as both a risk marker and risk factor for women's HIV infection: Findings from Indian husband-wife dyads. *J Acquir Immune Defic Syndr* ;51(5):593-600, 65, as cited in Program on International Health and Human Rights, *Gender Based Violence and HIV*.

73 Silverman, J. G., Decker, M. R., Kapur, N. A., Gupta J., Raj, A. (2007), "Violence against wives, sexual risk and sexually transmitted infection among Bangladeshi men, *Sex Transm Infect*; 83(3):211-5. [

74 A 2006 study in the U.S. found a positive correlation between the level of 'survival sex' and high-risk behaviour. Survival sex refers to situations where sex is exchanged for food, shelter, or protection by persons who would not consider themselves to be linked with formal sex work; for more see UNFPA, HIV/AIDS, "Gender and Sex Work," at [www.unfpa.org/hiv/docs/factsheet\\_genderwork.pdf](http://www.unfpa.org/hiv/docs/factsheet_genderwork.pdf). Survival sex was also correlated with violence or fear of violence, relationship loss, and lost shelter. For more, see Whyte J., IV (2006), "Sexual assertiveness in low-income African American Women: Unwanted sex, survival, and HIV risk," *Journal of Community Health Nursing*;23(4):35-44, as cited in Program on International Health and Human Rights, *Gender Based Violence and HIV*.

75 For instance, in a 2008 study of 39 women in Puerto Rico, respondents reported the fear of violence as one of the barriers to practicing safe sex; for more, see Abreu, S., Sala, A. C., Candelaria, E. M., Norman, L. R. (2008), "Understanding the barriers that reduce the effectiveness of HIV/AIDS prevention strategies for Puerto Rican women living in low-income households in Ponce, Puerto Rico: A Qualitative Study," *Journal of Immigration Minor Health*, as cited in Program on International Health and Human Rights, *Gender Based Violence and HIV*. A 2004 study on African-American and Hispanic women in the U.S. also showed that women in violent relationships were more likely than other women to use female-controlled prevention methods, such as female condoms and vaginal spermicidal gels, rather than male condoms. For more, see Saul, J., Moore, J., Murphy, S. T., Miller, L. C. (2004), "Relationship violence and women's reactions to male- and female-controlled HIV prevention methods." *AIDS Behavior*;8(2):207-14, as cited in Program on International Health and Human Rights, *Gender Based Violence and HIV*.

76 Seminal research conducted in South Africa on intimate partner violence, relationship power inequity, and young women's risk for HIV concluded that "13.9% of incident HIV infections could be avoided if gender equity in heterosexual relationships was enhanced so that no women were in relationships with low power. Similarly, for violence, 11.9% of new HIV infections could be prevented if women did not experience more than one episode of physical or sexual partner violence." For more, see Jewkes, R., Dunkle, K., Nduna, M., Shai, N. (2010), "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study," *The Lancet*; 376: 41-48.

77 Chandrasekaran, V., Krupp, K., George, R., Madhivanan, P. et al. (2007), "Determinants of domestic violence among women attending an Human Immunodeficiency Virus voluntary counseling and testing center in Bangalore, India." *Indian Journal of Medical Sciences*;61(5):253-62.

found that between 3.5 and 14.6 percent of women living with HIV reported experiencing violence from their intimate partner following disclosure of their HIV status.<sup>78</sup>

The 2011 People Living with HIV Stigma Index reports that women are more likely to face harassment, threats, and physical assault than men, and it recommended more research on people living with HIV's risk of domestic violence.<sup>79</sup> However, despite these attempts to better understand HIV as a risk factor for violence against women living with HIV, overall there is a lack of clarity when it comes to establishing causality between HIV status and the experience of violence. While studies from the region indicate that women living with HIV are more likely to report violence, it is unclear whether disclosure of their HIV status marks the onset of violence or whether it triggers another episode of abuse within a history of intimate partner violence.<sup>80</sup> In the context of the link between seropositivity and domestic violence, the 2007 cross-sectional study in India concluded that "the cross-sectional nature of the research makes it impossible to determine the temporality of the variables."<sup>81</sup> In light of these ongoing challenges, civil society organizations, including women's rights groups, HIV-positive women's networks, and other HIV/AIDS organizations, have all highlighted the need to examine the association between HIV disclosure and violence as part of the national research agenda. Data from other regions would suggest that the causality runs both ways, though this needs to be further investigated.

In addition to intimate partner violence, women living with HIV as well as women sex workers and women who use drugs are also at risk of human rights violations within the public sphere. Human rights violations experienced by women and girls within the context of healthcare settings are being increasingly documented throughout the region. This includes forced sterilizations, forced abortions, forced disclosure of HIV status, and the denial of access to sexual and reproductive health (including family planning) information and services.<sup>82</sup> The 2011 Stigma Index noted that between 2 percent (in China) and 29 percent (in Thailand) of the women respondents had been coerced into sterilization, and that between 7 percent (in Fiji) and 20 percent (in Thailand) reported health providers making access to antiretroviral treatment conditional on contraceptive usage.<sup>83</sup> A 2012 study reported that women living with HIV in Asia face a range of sexual and reproductive rights violations in health facilities. These include discouraging women living with HIV from getting pregnant; denial or delay of medical care during childbirth; as well as coerced sterilization: "Of the women surveyed, 30.1% said they were asked or encouraged to consider sterilisation, of these 37.7% said they did not have the option to decline. Women in Cambodia, India, and Indonesia recorded the highest rate of being asked to undergo sterilisation (over 35%). Indonesian women recorded the highest proportion who were given the option to decline the procedure (39 of 44 women) whereas Cambodian women recorded the least choice to decline sterilisation (34 of 70 women)."<sup>84</sup>

## Young women's risk of violence and HIV

Young women are at particular risk for violence, with as many as 30 percent of women in some locations reporting that their first sexual experience was coerced or forced,<sup>85</sup> and the younger the women were at the time of sexual initiation, the higher the chance that it was violent.<sup>86</sup> Also, the majority of sexually active girls aged 15–19 in developing countries are married, and these married adolescent girls tend to have higher rates

78 Medley, A., Garcia-Moreno, C., McGill, S., Mamann S. (2004), "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.

79 GNP+ et al, "People Living with HIV Stigma Index Asia Pacific Regional Analysis."

80 Program on International Health and Human Rights, *Gender Based Violence and HIV*.

81 Chandrasekaran et al., "Determinants of domestic violence."

82 Global Commission on HIV and the Law. Also, in July 2012 the High Court in Namibia ruled in favour of three women living with HIV who had been forcefully sterilised by the government. The campaign was spearheaded by The Namibia Women's Health Network (NWHN), formed and led by women living with HIV. For more, see [www.icw.org/node/421](http://www.icw.org/node/421), and [www.opendemocracy.net/5050/nell-osborne/against-coerced-sterilisation-resounding-victory-in-namibia](http://www.opendemocracy.net/5050/nell-osborne/against-coerced-sterilisation-resounding-victory-in-namibia). In Indonesia the Indonesian Positive Women's network is in the process of using CEDAW to challenge forced sterilisations. For more, see [www.opendemocracy.net/5050/baby-rivona-oldri-mukuan/global-mechanism-regional-solution-ending-forced-sterilisation](http://www.opendemocracy.net/5050/baby-rivona-oldri-mukuan/global-mechanism-regional-solution-ending-forced-sterilisation).

83 GNP+ et al, "People Living with HIV Stigma."

84 Women of the Asia Pacific Network of People Living with HIV, "Positive and Pregnant."

85 WHO (2006), "Multi-country study on women's health and domestic violence against women."

86 Ibid.

of HIV infection than their sexually active, unmarried peers.<sup>87</sup> For women in sex work, age can also heighten both HIV risk and risk for violence. For example, a 2008 study found that seroprevalence of HIV was the highest (24 percent) among sex workers aged 20 or younger.<sup>88</sup>

## Sex work, violence and HIV

Across Asia and the Pacific, female, male, and transgender sex workers face endemic violence from a range of perpetrators, and in various sites.<sup>89</sup> At least three studies from the region have found that street-based sex workers are at greater risk for violence because they work in public spaces and are socially and physically isolated from colleagues than those in brothels and entertainment and massage parlours.<sup>90</sup>

Studies from the region have shown that female sex workers also experience intimate partner violence. In India, up to 35 percent of female sex workers surveyed faced intimate partner violence<sup>91</sup>; in Pakistan, a study dated 2009 reported that up to 66 percent of female sex workers faced physical violence and 34 percent faced sexual violence from their intimate partners<sup>92</sup>; in China, a 2012 study found that 55 percent of female sex workers surveyed reported emotional violence, 20 percent reported physical violence, and 16 percent reported sexual violence.<sup>93</sup>

In China, a 2008 study reported that 70 percent of surveyed sex workers had experienced some form of violence from clients<sup>94</sup>; in India, 56 percent reported that clients were the main perpetrators of violence.<sup>95</sup> Research conducted by NGOs in Cambodia in 2005 and 2006 found that female and transgender sex workers are at particular risk of violence from gang members. The 2006 study<sup>96</sup> reported that 38.3 percent of freelance transgender sex workers were beaten by clients in the past year and 48.5 percent were raped by at least a single client in the past year. Similarly, 43.9 percent of freelance female sex workers were beaten by clients in the past year and 57.1 percent were raped by at least a single client in the past year. A 2005 study<sup>97</sup> reported that 54 percent of female beer promotion workers (considered “indirect” sex workers) reported physical abuse, and 38 percent reported coercion into sexual acts in the workplace.

Studies conducted by or in collaboration with sex worker organizations in the region have found high levels of sexual and physical violence perpetrated by the police against sex workers. A 2006 study from Cambodia

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- 87 Bruce, Judith and Shelley Clark (2004), “The implications of early marriage for HIV/AIDS policy,” brief based on background paper prepared for the WHO/UNFPA/Population Council Technical Consultation on Married Adolescents.
- 88 Sarkar, K., et al. (2008), “Sex-trafficking, Violence, Negotiating Skill, and HIV Infection in Brothel-based Sex Workers of Eastern India, Adjoining Nepal, Bhutan, and Bangladesh,” *J Health Popul Nutr*;26(2):223-231
- 89 For more, see UNFPA, CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 90 Dandona, R. et al. (2005), High risk of HIV in non-brothel based female sex workers in India, *BMC Public Health*, vol. 5; El-Bassel, et al. (2001), “Correlates of partner violence among female street based sex workers: Substance abuse, history of childhood abuse, and HIV risks,” *AIDS Patient Care*, vol. 15: 41–51; Barnard, M. A. (1993), “Violence and vulnerability: Conditions of work for street working prostitutes,” *Sociology of Health and Illness*, vol. 15: 683–705, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 91 Shahmanesh, Maryam, Patel, V., Mabey, D., Cowan, F. (2008), “Effectiveness of interventions for the prevention of HIV and other sexually transmitted infections in female sex workers in resource poor setting: A systematic review,” *Tropical Medicine and International Health*, vol. 13 no. 5: 1–21, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 92 Hawkes, Sarah et al. (2009), “HIV and other sexually transmitted infections among men, transgenders and women selling sex in two cities in Pakistan: A cross-sectional prevalence survey,” *Sexually Transmitted Infections*, vol. 85;Suppl. 2:8–16, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 93 Chen Zhang, Xiaoming Li, Yan Hong, Yiyun Chen, Wei Liu, Yuejiao Zhou, “Partner Violence and HIV Risk Among Female Sex Workers in China,” as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 94 Choi, Susanne Y. P., K. L. Chen, and Z. Q. Jiang (2008), “Client-Perpetuated Violence and Condom Failure Among Female Sex Workers in Southwestern China,” *Sexually Transmitted Diseases*, Vol. 35, no. 2: 141–146, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 95 Beattie, Tara S. H. et al. (2010), “Violence against female sex workers in Karnataka state, south India: Impact on health, and reductions in violence following an intervention program,” *BMC Public Health*, vol. 10: 476-577, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 96 Jenkins, Carol, The Cambodian Prostitutes’ Union, Women’s Network for Unity, and Candice Sainsbury (2006), “Violence and Exposure to HIV among Sex Workers in Phnom Penh, Cambodia” (Washington, DC: The Policy Project), as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.
- 97 CARE Cambodia (2005), “A Report on the Situation of Beer Promotion Women in the Workplace, Cambodia: Results of a Harassment and Abuse Survey.”



shows that freelance, transgender, and brothel-based female sex workers report physical and sexual violence, with the highest incidents reported by women in brothel-based sex work (75 percent physical and 57 percent sexual violence). The same study reported that 95 percent of those interviewed feared they had been exposed to HIV during sexual assaults.<sup>98</sup>

Several other studies from the region have established an association between police surveillance, harassment, and violence and increased HIV risk for sex workers. A 2011 study in India reported that sex workers who have experienced a police raid are three-times more likely to report an STI and four-times more likely to report client violence.<sup>99</sup> In Fiji, a 2009 study revealed that police surveillance and the threat of criminal sanction affects the ability of sex workers to safely negotiate prices and condom usage with clients.<sup>100</sup>

The inability of sex workers to enforce condom usage is a consequence of actual or the threat of violence, regardless of who the perpetrator is. In India, a 2010 study conducted with a cohort of 11,000 sex workers shows that those who report violence are less likely to have access to HIV-prevention information and enforce condom usage, and twice as likely to be infected with STIs than those who do not.<sup>101</sup> A similar finding was reported in a 2010 study conducted in Thailand where sex workers who had experienced violence were found to be twice as likely to report condom failure.<sup>102</sup>

There is emerging evidence from the region regarding sex workers' risk for violence when placed under involuntary detention.<sup>103</sup> Although few studies have investigated the combined risks for violence and HIV in detention centres, a 2010 study in China demonstrated that median syphilis prevalence in incarcerated sex workers was twelve-times higher than sex workers who were not incarcerated.<sup>104</sup>

Globally, sex workers are eight-times more likely to be HIV-positive than other adults. In developing countries, sex workers are fourteen-times more likely to be HIV-positive than women of reproductive age.<sup>105</sup> All countries of the region criminalize some aspect of sex work, with the only exceptions being New Zealand and the Australian state of New South Wales.<sup>106</sup> The threat of criminal sanction pushes sex workers underground, in turn reducing their power to negotiate condom usage as well as their ability to access health, including HIV-related, services. Possession of condoms itself can be used as evidence of sex work, inviting criminal prosecution in a number of countries in the region.<sup>107</sup> Moreover, criminalization affects the access of sex workers to justice and affords impunity to police, clients, and other actors, thereby compounding the risk of violence faced by sex workers as well as their HIV-risk.

98 Jenkins, et al., "Violence and Exposure to HIV among Sex Workers in Phnom Penh."

99 Erausquin, Jennifer Toller, Elizabeth Reed, and Kim M. Blankenship (2011), Police-Related Experiences and HIV Risk Among Female Sex Workers in Andhra Pradesh, India, *Journal of Infectious Diseases*, vol. 204 (Suppl. 5):1223–1228, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.

100 McMillan, Karen and Heather Worth (2009), "Risky Business: Sex work and HIV prevention in Fiji, Sydney" (International HIV Research Group, University of New South Wales), as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.

101 For more see, Beattie et al., "Violence against female sex workers in Karnataka state, south India"; and Swain, Suvakanta N. et al. (2011), "Experience of violence and adverse reproductive health outcomes, HIV risks among mobile female sex workers in India," *BMC Public Health* vol. 11: 357–367, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.

102 Decker, Michele et al. (2010), "Violence victimisation, sexual risk and sexually transmitted infection symptoms among female sex workers in Thailand," *Sexually Transmitted Infections*, vol. 86: 236–240, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.

103 CASAM/APNSW, Partners for Prevention, UNAIDS, 2012, *Sex Work and Violence*.

104 Tucker, Joseph, Xin Ren, and Flora Sapio (2010), "Incarcerated sex workers and HIV prevention in China: Social suffering and social justice countermeasures," *Social Science & Medicine*, vol. 70 no. 1: 121–129, as cited in CASAM/APNSW, Partners for Prevention, UNAIDS, *Sex Work and Violence*.

105 Baral, S., Beyrer, C. et al. (2012), "Burden of HIV among female sex workers in low-income and middle-income countries: A systematic review and meta-analysis," *The Lancet*, DOI:10.1016/S1473-3099(12).

106 UNDP (2012), "Sex Work and the Law in Asia and the Pacific."

107 For more, see The China Sex Worker Organization Network (2011), "Report on the Impact of China's 2010 'Strike Hard Campaign': A Crackdown on Sex Work"; Alexander, P. (2001), "Contextual risk versus risk behavior: The impact of the legal, social and economic context of sex work on individual risk taking," *Research for Sex Work*, 4:3–5; WHO (2005), Violence Against Women and HIV/AIDS: Critical Intersections, Violence against Sex Workers and HIV Prevention, Information Bulletin Series, No. 3; and Human Rights Watch (2003), "Fanning the Flames, How Human Rights Abuses are Fueling the AIDS Epidemic in Kazakhstan," June 2003, vol.15, no. 4. See also Asia Calling (2010), "Burmese Sex Workers Avoid Arrest with Bribes and not Carrying Condoms," at [www.asiacalling.org/km/special-reports/sex-workers-stories-from-across-asia/1919-burmesesex-workers-avoid-arrest-with-bribes-and-not-carrying-condoms](http://www.asiacalling.org/km/special-reports/sex-workers-stories-from-across-asia/1919-burmesesex-workers-avoid-arrest-with-bribes-and-not-carrying-condoms), NC Harm Reduction Coalition, 2012, Arrested for Carrying Condoms? Daily Kosas

## Drug use, violence, and HIV

The estimated number of women who use drugs is increasing globally.<sup>108</sup> In South-East Asia, women constitute approximately 10 percent of people who use drugs, with significant variations among countries. For example, in certain provinces within China, women comprise between 17 to 40 percent of all people who use drugs.<sup>109</sup> Women face gender-specific risks, vulnerabilities, and consequences of their drug use as well as gender-specific barriers to information and access to harm reduction, violence survivor services, and sexual and reproductive health and HIV services.<sup>110</sup>

Gendered analysis of drug use shows that a “large proportion of women are introduced to drug use in sexual relationships and are more likely than men to share injecting equipment, in particular with their sexual partners.”<sup>111</sup> A 2008 study from China reported that more than 90 percent of women who inject drugs share equipment, particularly with their sexual partners.<sup>112</sup> Women are often injected by others, and when this is their sexual partner “they are likely to use the needle after their partner, compounding their HIV risk.”<sup>113</sup> Further, gender power inequalities between women and men, and specifically women’s dependence on their partners for drug use, as well as the threat of or actual violence restricts their ability to insist on clean needles, negotiate condom usage, and access harm reduction and HIV-related services. Studies<sup>114</sup> also show that women who use drugs are more likely to transact sex to finance their and/or their partner’s drug habit, leaving them at greater risk for HIV. The control that some men who use drugs exercise over the drug use and habits of their female sexual partners can also result in the inability of female drug users to manage their drug use, including when to abstain or access treatment.<sup>115</sup>

Women who use drugs in the Asia-Pacific region face conditions of marginalization, criminalization, and police surveillance, which places them at heightened risk for violence and HIV. In many countries, possession of drugs or injecting equipment can lead to criminal sanctions, including imprisonment and involuntary detention in treatment centres – sites where there is a woeful lack of gender-sensitive services and where women are at particular risk for violence.<sup>116</sup> A 2002 study in Sri Lanka points to women being at particular risk for rape, sexual exploitation, and sexual harassment during drug searches by law enforcement officials.<sup>117</sup> Where the possession of drugs is criminalized, women are unable to report police violence and harassment for fear of retribution. Even when perpetrators are not the police, studies from the region have indicated that women who use drugs are reluctant to report violence.<sup>118</sup>

108 Pinkham, S., Malinowska-Sempruch, K. (2007), “Women, harm reduction, and HIV” (New York: Open Society Institute, International Harm Reduction Development Program), as cited in HAARP, “Understanding and responding to gender issues in substance use in South-East Asia.”

109 Ibid.

110 United Nations Office on Drugs and Crime (2004), “Substance abuse treatment and care for women: Case studies and lessons learned”; and Bassel et al., “HIV and women who use drugs.”

111 Hankins, C. (2007), “Sex, drugs, and gender: High time for lived experience to inform action,” *International Journal of Drug Policy*, 19:95–96; as cited in HAARP, “Understanding and responding to gender issues in substance use in South-East Asia.”

112 Zhang, W. Y., Wu, J. Y. (2008), “The characteristics of sexual behaviour, sexually transmitted diseases and HIV/AIDS of female intravenous drug users,” *China Journal of STD/AIDS Prevention and Control*, 8:368–370; as cited in HAARP, “Understanding and responding to gender issues in substance use in South-East Asia.”

113 Ibid., HAARP.

114 Hankins, “Sex, drugs, and gender”; Gu, J., Wang, R., Chen, H. et al. (2009), “Prevalence of needle sharing, commercial sex behaviors and associated factors in Chinese male and female injecting drug user populations,” *AIDS Care*, 21:31–41; as cited in HAARP, “Understanding and responding to gender issues in substance use in South-East Asia.”

115 Family Health International (2007), Participant manual: Treatment and care for HIV-positive injecting drug users – module 1 – Drug use in Asia, FHI; and Hankins, “Sex, drugs, and gender.”

116 Wolfe, D., Saucier, R. (2010), “In rehabilitation’s name: Ending institutionalized cruelty and degrading treatment of people who use drugs,” *International Journal of Drug Policy*; as cited in HAARP, “Understanding and responding to gender issues in substance use in South-East Asia.”

117 Miller, J. (2002), “Violence and coercion in Sri Lanka’s commercial sex industry: Intersections of gender, sexuality, culture, and the law,” *Violence Against Women*, 8:1044–1073; as cited in HAARP, “Understanding and responding to gender issues in substance use in South-East Asia.”

118 Ibid., HAARP.



## Violence against women and HIV: The evidence base in Asia and the Pacific – key gaps and challenges

Research on diverse and complex associations of violence against women and HIV is limited, as is research examining the risks of women who face multiple discriminations.

- This review did not find empirical research on women's risk to violence and HIV in conflict, post-conflict, and humanitarian settings.
- This review found only one empirical study on young female sex workers and their risk to violence and HIV.
- This review found one policy paper on links between early marriage and girls' risk to violence and HIV.
- This review found no empirical studies on the specific risks and vulnerabilities of lesbian and bisexual, women with disabilities, women in serodiscordant relationships, one empirical study on migrant and undocumented migrant women, and three empirical studies on incarcerated female sex workers prisoners.
- This review did not find any empirical study on the interplay between unequal power in heterosexual relationship, violence, and HIV similar to the South African study on relationship power inequity.<sup>119</sup>
- Studies on key affected women and girls are mostly focused on sex workers. However, even these do not investigate the workers' combined risk for violence and HIV. These studies often limit their inquiry to sexual health risks rather than address a range of other risks that health workers face that may have an impact on their health, rights, and well-being. Only two studies (from China) investigate workers' risk for violence and HIV in detention and rehabilitation centres or the systemic violence that sex workers face and its impact on their access to services and entitlements
- This review found only two studies of gender-specific risks and vulnerabilities of women who use drugs, including, their fear of disclosure, risk for violence, gate-keeping by others, and sexual and reproductive needs and rights.

# Response to violence against women and HIV

Despite numerous international policy standards addressing the intersection of gender inequality, violence against women, and HIV, there continues to be a lack of attention to resourcing integrated services and gender-transformative HIV programmes. Commitments made by governments in promoting gender equality and the empowerment of women and girls are not backed-up with appropriate resources and support to address the intersecting risks faced by women and girls to HIV and violence.<sup>120</sup> Where interventions to address gender inequality are being implemented, they are frequently 'added on', rather than firmly anchored within national AIDS programmes.<sup>121</sup>

## What works for women

As noted in the WHO-UNAIDS report,

“Long-term interventions that address structural factors, gender inequalities and harmful gender norms are essential if one is to reduce VAW and HIV... At the same time, there is also a need to move forward urgently to achieve shorter-term gains such as enhanced voluntary counselling and testing services and the provision of comprehensive post-rape care that addresses the psychological and physical health needs of sexual-violence survivors. A menu of actions addressing both long-term and short-term needs related to violence and HIV has the potential to have an impact upon not only MDG 6 (HIV), but all the health-related MDGs, including the reduction of maternal mortality and achievement of universal access to reproductive health and rights. In addition, this approach is at the heart of MDG 3 (gender equality and empowerment of women) and MDG1 (reducing poverty).”<sup>122</sup>

Violence against women and women's risk to HIV are rooted in gender inequality and unequal power relations. Therefore, interventions that are designed to respond to underlying causes and transform unequal power relations do work in terms of reducing HIV vulnerabilities of women and girls.<sup>123</sup>

Interventions that empower women, challenge gender norms, build collective power, and support collective action are achieving results; these strategies have been successfully adapted for different groups of women, whether they are married, living with HIV, or in sex work. Sex workers' collectives have been particularly successful in this region.

Along with interventions that challenge structural determinants of women's risk to violence and HIV, services that reduce and mitigate harm are also needed. Principles of equality and non-discrimination must be integrated, so that the most marginalized and hard to reach groups, such as sex workers, women living with HIV, and women who use drugs, are prioritized and historical discrimination is not reproduced and reinforced.

## Examples of programmatic innovations and promising practices from the region

At the global level, WHO, UNAIDS Open Society Initiative, and the United States Agency for International Development (USAID) have led a concerted effort in recent years to collate evaluated interventions that integrate

120 UNIFEM, “Transforming the National AIDS Response.”

121 UNDP Roadmap (forthcoming publications).

122 Ibid.

123 Ibid.

HIV, gender equality, and violence against women.<sup>124</sup> These evaluations have focused on gender-sensitive HIV interventions that are transforming gender norms;<sup>125</sup> reducing gender and economic inequalities;<sup>126</sup> providing integrated and comprehensive post-rape care<sup>127</sup>; and addressing violence against women in the context of HIV testing.<sup>128</sup> While many of these globally-led evaluations have focused on programmatic interventions taking place in sub-Saharan Africa, there is an increasing number of innovative programmes being evaluated and documented in the Asia-Pacific region. These include programmatic interventions to address violence against sex workers, initiatives to challenge harmful masculinities and gender norms, and programmes aimed at reducing gender and economic inequalities faced by married women.

Interventions such as the Avahan,<sup>129</sup> Sonagachi,<sup>130</sup> and SANGRAM<sup>131</sup> projects in India and Pratirodh<sup>132</sup> in Bangladesh all use multiple strategies to buttress the ability of sex workers to protect themselves from violence and HIV. In response to endemic violence faced by sex workers, Avahan initiated interventions to develop consciousness around gender and sex work; supported collective identity and action; and set up crisis management systems, including medical and legal counselling. Sonagachi established a sex worker-led collective that has changed the legislative and policy environment as well as set up services for sex workers.

SANGRAM has several collective empowerment groups for marginalized groups, including female sex workers, MSM, and transgender people. VAMP is a registered sex workers' collective with 5,000 informal members and 127 staff. It is a rights-based organization led by women that tackles harmful gender norms and gender inequalities, including violence against sex workers and their access to resources and rights.<sup>133</sup> Pratirodh, builds skills around finances, advocacy, networking, and solidarity through support groups. Strategies are based on learning and reflection on power inequities that are at the root of the discrimination, exclusion, and denial of rights that sex workers face.<sup>134</sup>

Avahan has reported a reduction of police violence and an increase in sex workers reporting non-police violence.<sup>135</sup> Through the Sonagachi project, sex workers themselves have reduced HIV rates, condom use

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- 124 A global web-based resource that showcases evaluated interventions that address gender equality and violence against women to reduce women's risk for HIV ([www.whatworksforwomen.org/](http://www.whatworksforwomen.org/)); and WHO, UNAIDS (2010), *Addressing Violence against Women and HIV: What Works.*"
- 125 Stepping Stones seeks to improve sexual health by fostering gender equitable relationships between men and women through peer group sessions. Evaluation of Stepping Stones in South Africa shows that there was a significant decrease in reported intimate partner violence (27 percent after 12 months and 38 percent after 24 months) as well as in the male participants' engagement in transactional sex and alcohol abuse. Although the evaluation did not show a reduction in HIV incidence, there was a 33 percent decline in HSV-2 infections in men and women. SASA! locates women's risk for violence and HIV in the power imbalance between men and women and aims to address both by reorganizing power. Strategies include consciousness building of women's "power within"; recognizing men's "power over" women as a cause for HIV and VAW; supporting men's and women's "power with" others for collective action, and; supporting action and "power to" affect change. See WHO, UNAIDS, "Addressing Violence against Women and HIV"
- 126 IMAGE simultaneously targeted poverty and economic inequalities and gender inequalities. It offered microfinance loans administered by the Small Enterprise Foundation to older women in the intervention communities, and paired the loans with a year-long participatory gender-training programme, *Sisters for Life*. Similarly, evaluation of the IMAGE project shows a 55 percent reduction in reported intimate partner violence among direct participants, but not a significant reduction in HIV incidence. However, when IMAGE was compared to micro-finance projects minus gender training and collective action components, it showed positive results among the participants on improving "personal empowerment, reduced HIV risk behaviour, reduced tolerance for IPV and increased skills in collective action." See WHO, UNAIDS, "Addressing Violence against Women and HIV."
- 127 Liverpool VCT developed and piloted post-rape care services in district hospitals in Kenya, which have been scaled-up to be integrated in HIV services delivered through public health facilities. The comprehensive package includes long-term psychosocial care, HIV pre- and post-test counselling, PEP-adherence counselling, and preparation for interface with the criminal justice system. See WHO, UNAIDS, "Addressing Violence against Women and HIV."
- 128 As a response to risks of violence and other negative outcomes of disclosure for women testing in antenatal VCT clinics, the South Africa HIV/AIDS Post-test Support Study developed an enhanced care model, including administering screening questions on violence to all women, counselling on whether and when to disclose, legal counselling, and legal aid. See WHO, UNAIDS, "Addressing Violence against Women and HIV."
- 129 For more, see [www.gatesfoundation.org/avahan](http://www.gatesfoundation.org/avahan) and [www.whatworksforwomen.org/](http://www.whatworksforwomen.org/).
- 130 For more, see [www.whatworksforwomen.org/](http://www.whatworksforwomen.org/).
- 131 For more information, see USAID (2011), AIDSTAR Case Study Series, SANGRAM's collectives, Gender MARPs Sangram, India, [www.whatworksforwomen.org/](http://www.whatworksforwomen.org/).
- 132 WHO, UNAIDS, 2010, *Addressing Violence against Women and HIV: What Works*, WHO
- 133 USAID, AIDSTAR Case Study Series.
- 134 WHO and UNAIDS, "Addressing Violence against Women and HIV."
- 135 Ibid.

## RHANI Wives

**RHANI Wives** focuses on gender empowerment, including economic empowerment, HIV/STI risk reduction, and healthy relationships and relationship communication. It is being adapted to the Indian context on the basis of formative research and local input and developed as a six-week multilevel intervention.

## Yaari Dosti

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

Source: <http://www.whatworksforwomen.org/>

## Durbar

**Durbar** is a sex worker-led organization with 65,000 sex workers in the state of West Bengal. Durbar has assumed direct responsibility for running the health projects for sex workers, and includes literacy classes that question social norms and use critical thinking. Members have successfully organized against maltreatment from brothels and pimps, against violence by the police and others, against forcible AIDS surveillance, and against eviction of sex workers from brothels and red light areas, achieving greater power for sex workers. Durbar also has a savings and credit cooperative. Prior to the formation of Durbar, sex workers reported a lack of control over their own lives and a sense of powerlessness. Durbar claimed prostitution as legitimate work, viewing it as “a legitimate and necessary occupation” within the context of a wider economy.

in project areas has increased to up to 85 percent, and the prevalence of HIV infection among sex workers decreased to 4 percent (compared with rates of 50 percent as reported in other sex work districts of India).<sup>136</sup> VAMP has increased access to justice and other state services for sex workers, and anecdotal evidence suggests that there has been a reduction in police violence.<sup>137</sup> Pratirodh, has 105 committees of trained sex workers who identify cases of violence and provide survivors with counselling and referrals to other services.<sup>138</sup>

Program H – originally developed in Brazil and subsequently implemented in India and Viet Nam – is a community-education and social-marketing campaign to promote gender-equitable attitudes and action among young men. Evaluation shows participants reported less aggressive interactions; increased ability to openly discuss sexuality; increased recognition of women as having sexual rights and sexual agency; increased worry about their own health needs; increased seeking of HIV testing; delayed initiation of sexual activity with their current partner; and increased use of (male) condoms at last sexual intercourse.<sup>139</sup>

## Resourcing gender equality in national AIDS plans: gaps and opportunities

The UNAIDS Global Epidemic Report (2010) notes that, although women are included in HIV strategies of many countries, budgetary allocations are insufficient:

“Governments in 80% of countries (137 of 171) reported that they include women as a specific component of a multi-sectoral HIV strategy, but the rate of inclusion of women differs by geographical regions. The number of countries with a specific budget for HIV activities related to women is considerably lower: 46% (79 of the 171) reporting countries.

**Outside sub-Saharan Africa, UNGASS reports are silent on violence against women and girls.** UNGASS reports for several countries **in sub-Saharan Africa outline the increased HIV vulnerability of women due to violence and sexual coercion** and highlight the link with armed conflict, including sexual violence against women in refugee camps. Other countries underline that violence against sex workers affects their capacity to insist on the use of condoms. Reporting on gender-based violence is not even” (emphasis added).

While it is encouraging that countries are reporting on ‘women’ as a specific category, it is unclear what kinds of strategies countries are adopting and which groups of women are prioritized, or whether these strategies are gender-transformative and rights-based. Moreover, the fact that a majority of countries do not allocate a budget weakens the efficacy of their plans to address gender inequality and violence against women as part of their national AIDS action plan. Furthermore, along with including women-specific activities, national plans need to integrate gender equality outcomes across HIV interventions in order to be effective.

## Responding to violence against women and girls and HIV in Asia and the Pacific: Key gaps and challenges

- Evaluated interventions that address gender equality, violence against women, and HIV are overwhelmingly focused on responding to HIV and VAW risks of female sex workers.
- Interventions for sex workers that integrate gender equality, human rights, and violence against women are showing positive HIV outcomes, and also gender equality outcomes. However, these are limited to a few countries in the region, which presents opportunities for shared learning, adaptation, and scale-up in other parts of the region.

136 UNDP and UNAIDS (2012), “Understanding and Acting on Critical Enablers and Development Synergies for Strategic Investments.”

137 USAID, AIDSTAR Case Study Series.

138 WHO and UNAIDS, “Addressing Violence against Women and HIV.”

139 Ibid.

- Voluntary counselling and testing services and the provision of comprehensive post-rape care services and other integrated services where they exist have not been evaluated or showcased.
- Most of the evaluated interventions are designed and implemented by civil society organizations or sex worker networks, pointing to the lack of integrated services delivered by the state. Where partnerships between civil society and government exist, these should be evaluated and scaled-up, as they can hold the key to improved health and gender equality outcomes and increased integration of services.
- There is limited evidence of integrated PMTCT/VCT-VAW services being available to women living with HIV who report intimate partner violence.
- There is limited evidence of gender-sensitive harm reduction and integrated HIV-VAW- sexual reproductive health rights services for women who use drugs.

There is growing recognition within the international community that human rights-based and gender-transformative interventions must replace exclusively bio-medical ones because violence against women both violates and is inextricably linked to women's access to other rights.<sup>140</sup> Where women-specific interventions are being implemented in the region, these programmes mostly focus on the practical needs of women (e.g., access to services and information, etc.) as opposed to addressing the underlying structural factors that affect women and girls' HIV and violence risk.<sup>141</sup> In particular, a concerted effort is required on the part of State parties to review their legal and policy frameworks to ensure that these are supportive of gender equality and the empowerment of women and girls, including in the context of HIV and violence; and, where needed, to align national laws and policies with international human rights standards. At the same time, civil society organizations, including women's rights groups and HIV organizations, need greater support from UN agencies and donors to undertake upstream policy advocacy.<sup>142</sup>

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140 Program on International Health and Human Rights, *Gender Based Violence and HIV*.

141 Ibid.

142 Ibid.

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