World Health Organization

Violence Against Women and HIV/AIDS: Setting the Research Agenda

Meeting Report
Geneva, 23-25 October 2000

Gender and Women's Health
World Health Organisation
Geneva, Switzerland

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WHO would like to acknowledge each of the participants for sharing their vast experiences and valuable work in the area of violence and HIV/AIDS. This report was put together by Claudia García-Moreno and Nadine France who compiled the initial draft of this report, with input from Tim Farley and Jane Cottingham and editorial help from Sally Ann Corcoran.

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Introduction

Violence and the fear of violence are emerging as an important risk factor contributing to the vulnerability to HIV infection for women. The extent to which individuals who are HIV infected, particularly women, are vulnerable to violence is also an issue of concern.

A growing number of studies have documented the high prevalence of intimate partner violence and sexual violence against women worldwide. This violence can contribute to women's increased risk of HIV infection both directly through forced sex and indirectly by constraining women's ability to negotiate the circumstances in which sex takes place and the use of condoms. In addition, sexual abuse during childhood seems to be associated with high-risk behaviours in later stages of life that may also increase the risk of HIV. However, many questions remain as to the extent of this increased risk and the precise interactions between different forms of violence against women (VAW) and HIV/AIDS. Further research is needed to understand exactly how these two areas overlap. The extent to which interventions can effectively address both problems also requires further research and collaboration between those working on VAW and those working on HIV/AIDS.

It was with this in mind that WHO convened an expert consultation "Violence Against Women and HIV/AIDS: Setting the Research Agenda" from 23-25 October 2000, to take stock and learn from existing research. The impetus for the meeting came from discussions with UNAIDS on the development of an HIV/AIDS component for inclusion in the WHO Multi-country Study on Women's Health and Domestic Violence Against Women. It became clear however, that it was necessary and timely to have a more wide-ranging review of what was known, what research was ongoing and what gaps existed on the intersections between violence against women (VAW) and HIV/AIDS. This in order to come up with a comprehensive research agenda on the same. This concern was further strengthened by debates at the International Conference on HIV/AIDS held in Durban, South Africa, which for the first time included a number of presentations on violence against women. The issue of post-exposure prophylaxis (PEP) following rape was one of controversy at Durban, so it was decided to have the third day of the meeting specifically focused on that issue.

This report is divided into three main sections. The first section contains a summary of each presentation. The second section summarizes the discussion and the third details the recommendations and conclusions from the meeting.

The meeting agenda and list of participants are included as Annex 3 and 4.

Objectives

The meeting brought together researchers, activists and policy makers working in the area of violence against women and HIV/AIDS in low and middle-income countries to:

1. Discuss current research activities in the area of violence against women and HIV/AIDS;
2. Identify key research questions (epidemiological, social/behavioural, clinical and intervention related) related to the connections between domestic and sexual violence against women and HIV/AIDS in different regions and among different age and population groups;
3. Identify opportunities to integrate issues of violence into ongoing HIV/AIDS research activity, and vice-versa;
4. Discuss methodological, ethical and safety issues associated with conducting research in relevant areas of violence against women and HIV/AIDS, including provision of post-exposure prophylaxis (PEP) to rape survivors;
5. Make recommendations/proposals for a research agenda to address violence against women and HIV/AIDS.

The meeting was divided into two parts. The first two days consisted of presentations by participants on epidemiological, social/behavioural and intervention research related to violence against women and HIV/AIDS. Four working groups were formed to address the four topics below:

- Partner violence and HIV risk
- Childhood Sexual Abuse (CSA) and HIV/AIDS risk
- Violence in the context of HIV testing and disclosure
- Violence and HIV/AIDS in the context of sex work, trafficking and migration

Participants sought to identify for each of the topics, key research questions, suggest possible study designs and discuss methodological concerns, as well as intervention issues that needed addressing.

The third day of the meeting focused on post-exposure prophylaxis following rape. This also consisted of presentations and discussion. The aim was to:

- Review the available evidence on the effectiveness of PEP following rape and other relevant issues to do with its delivery, adherence, compliance and costs;
- Explore the possibility of conducting research to formally assess effectiveness; and
- Consider the types of facilities and other resources necessary to provide PEP appropriately.

The Reports

1 Overview

Presenter: Dr C. Watts, London School of Hygiene and Tropical Medicine, UK,

Based on: Violence against women: its importance for HIV/AIDS C. García-Moreno, and C. Watts 2000, AIDS , 14 (suppl. 3): S253-S265

Violence against women: Its importance for HIV prevention & care activities

This presentation gave an overview of the links between violence against women (VAW) and HIV/AIDS, highlighting the importance of addressing VAW for HIV/AIDS prevention and care, it focused on some of the more common forms of violence against women internationally (namely domestic violence, sexual violence, and trafficking for sex), and presented available evidence illustrating that world-wide, domestic violence, coerced sex and rape are all common, some of this information is summarized below.

The prevalence of domestic violence, sexual violence and trafficking for sex

Violence against women takes many forms. Domestic violence (physical, sexual, physiological), rape and sexual abuse are worldwide phenomena. Other forms of VAW, such as sex trafficking and harmful traditional practices, may be specific to particular geographic areas (Watts & Zimmerman 2001).

Women all over the world experience ***physical violence from intimate partners.*** For example, 16% of Cambodian women (Nelson and Zimmerman, 1996) are physically abused by their spouse. In an UK study (Mooney 1993), 30% of women were physically assaulted by partner or ex partner. In West Bank and Gaza Strip (Haj-Yahia 1998), 48% of currently partnered women experienced assault by an intimate partner in past 12 months.

Although limited, the existing evidence indicates that many women are ***forced or coerced to have sex.*** Young girls and women are the most vulnerable. Increasing evidence is available of the extent to which girls' first sex is unwanted or forced. In New Zealand, a study (Dickson et al 1998) on 548 women aged 20-22, found 25% of those who had first intercourse before the age 13, reported it was forced. In Canada (Randall & Haskell 1995), 17.8% of women reported sexual abuse (rape or attempted rape) before the age of 16. A study in India reports 26% of 133 postgraduate students were sexually abused by the age 12. In Kingston, Jamaica (Walker et al 1994), 13% of 452 schools girls aged 13-14 reported attempted rape, and an additional 4% reported completed rape.

Although prevalence data on ***forced prostitution and trafficking for sex*** are scarce, it appears to be a growing problem. Women and children are trafficked within, and between countries, particularly in Asia and increasingly in Eastern and Central Europe and North America are large importers, e. g., an estimated 500 000 persons were trafficked into Europe in 1995 (IOM 2001).

Rape in war as a form of Violence Against Women is traditionally an under-reported aspect of military conflict. In the conflict in Bosnia and Herzegovina an estimated 20 000 to 50 000 women were raped (1.2% of the pre-war female population) (Women in Transition. The MONEE Project CEE/CIS/Baltics Regional Monitoring Report, No. 6, 1999, UNICEF). Rapes in war are also documented in Korea in WWII, Bangladesh, Liberia, Uganda and Rwanda (Swiss, 1993).

Violence against women increases their vulnerability to HIV infection

Worldwide, half of all new HIV infections are among 15-24 year olds. Sex ratios of new HIV infections are highly skewed, e.g. in Zambia, 16% of girls vs. 1% of boys. The causes for greater vulnerability of girls to HIV infection are both biological and socio-cultural.

The biological risk of HIV transmission will be affected by the type of sexual exposure, the presence of STDs, exposure to vaginal excretions or blood and the degree of trauma. When sexual intercourse is forced, abrasions and cuts are more likely to appear. In addition, condom use in such situations is unlikely. There is a need for discussion on the reality of a range of sexually coercive behaviours-including statutory rape, attempted rape and rape. ***The role of forced or coerced sex in HIV transmission*** deserves greater attention.

Coercive sex is common within ***intimate partnerships.*** For example, in Zimbabwe, 26% of ever married women are forced to have sex when they do not want - 23% by physical force, 20% were shouted at by partner; 12% where forced when asleep, 6% were threatened (Watts et al 1998). This illustrates the strong link between physical and sexual abuse, with women often being beaten and forced to have sex.

Both the fear of and actual violence affects women's expectations in relationships, ability to negotiate terms and conditions of sexual intercourse, and whether a condom is used. For example, research from the US suggests that women in abusive relationships are less likely to use condoms. Likewise, attempts by women experiencing violence to adopt condom use or access sexually transmitted infection treatment services are likely to lead to abuse.

In addition, increasing evidence indicates the links between a history of ***childhood sexual abuse*** and ***adult risk behaviour.*** In US studies, people reporting childhood rape are more likely to have worked as prostitutes or engaged in other risk behaviours than those who did not experience sexual abuse in childhood (Wingwood M G & DiClemente 1997, Zierler 1991).

Violence may be an important risk factor for HIV infection in ***sex workers*** and women trafficked for sex. Violence influences the movement of women into sex work, the extent to which condom use can be achieved within relationships, and whether women are able to leave sex work. For example, in a survey of 595 prostitutes in Bangladesh, 83% were raped, and 91% were beaten by the police (Jenkins 1998). Likewise, a recent study in the UK has highlighted how prostitutes, in particular, street prostitutes, routinely face severe violence (Church et al 2001).

Violence against HIV positive women

Violence is not only a risk factor for HIV infection. It also is becoming increasingly clear that violence is also a result of the epidemic. A woman disclosing her HIV status may be put at risk of violence and/or abandonment. In US, a study of HIV infected women found that 20.5% reported physical harm since being diagnosed HIV positive. In Kenya, 19% of 324 HIV positive women experienced violence from partner. Just as women are more vulnerable to interpersonal violence than men, it is likely that they are also more vulnerable to violence following disclosure than men are.

Interventions linking VAW and HIV

In thinking through how to respond to the issue of violence against women and HIV infection it is important to build upon existing initiatives. Nascent activities linking VAW and HIV include advocacy for increased investment in topical microbicides, UNHCR guidelines on responding to sexual violence in refugee settings, proposals for development of guidelines on violence and partner notification for VCT, and micro-credit interventions addressing women's economic vulnerability to both violence and HIV.

To date much of the VAW and HIV/AIDS debates and actions have developed separately. As a first step, it is important to ***improve collaboration*** between HIV and VAW groups, exchange experiences and expertise and learn form existing initiatives. Meaningful HIV/AIDS prevention activities for women can only be developed if the extent to which women world-wide are exposed to physical and sexual violence, not only by strangers, but also by men they know and love, is recognized.

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Research is needed to explore the implications of VAW for HIV. The concept of risk has to be examined more broadly - moving from viewing sex only as a mutually desired activity. We need to produce better estimates of the magnitude of sexual violence, to assess factors influencing women's vulnerability to both HIV and violence, and to understand strategies used by women and girls to protect themselves from violence. In conducting such research, we must bear in mind the ethical and safety implications for women who have experienced violence participating in such research.

Existing ***education and counselling programs for women*** should include talking about issues such as gender and HIV, roles and expectations in relationships, risk of physical and sexual violence and violence associated with the disclosure of HIV status. Skills that enable girls and women to recognize and avoid risk situations need to be discussed.

The range of HIV ***prevention activities focused on men*** should be used to discuss issues of power, roles and expectations in relationships, promote increased communication and male responsibility, challenge expectations and decision making in sex, and discuss non-violent means of resolving conflicts. In education and counselling activities, we have to ensure that HIV prevention messages do not appear to condone abusive sex.

In ***Mother to Child Transmission (MTCT) and Voluntary, Counselling and Testing (VCT) interventions,*** the risks of violence associated with HIV testing and disclosure, ethical and safety considerations should be addressed programmatically. Policies on partner notification and HIV testing for women who have been raped need to be put in place. Modules on gender and VAW should be incorporated into VCT counselling training and awareness created about the importance of informed choice about whether to be HIV tested and how to receive results.

Discussions on trafficking for sex needs to be put on the HIV agenda. We have to challenge the supply and demand sides of trafficking and sex tourism, including stronger sanctions for men who buy or sell women and increase information, training and employment opportunities for girls and women in key supply areas. In conclusion, the growing recognition that all forms of violence and sexual coercion contribute in different ways to the transmission of HIV/AIDS needs to be translated into policies and programmes for HIV prevention and care. While this is beginning to happen in a few places, much more is needed. In this regard, the importance of identifying opportunities for collaboration between groups working on violence against women, and those working on HIV/AIDS was stressed.

Research priorities for violence and HIV/AIDS

Presenter: Dr Suzanne Maman, John Hopkins University, USA.

Based on: "The intersections of HIV and violence: directions for future research and interventions" S. Maman, J. Campbell, M. D. Sweat, A. C., Gielen

This paper outlined the overlaps between violence and HIV and then went on to examine what is currently known in terms of research. In doing so, it clearly identified a list of possible research questions.

There are four main areas where violence and HIV overlap:

1. Forced sex may directly increase women's risk for HIV through physical trauma.
2. Violence, and threats of violence, may limit women's ability to negotiate safe sexual behavior.
3. Sexual abuse as a child may lead to increased sexual risk taking as an adolescent/adult.
4. Women who test for HIV and share test results with partners may be at increased risk for violence.

This paper will address each of the four main areas in turn, highlighting what is currently known and outlining pending research questions for each one.

1.1 Forced sex may directly increase women's risk for HIV

What we know:

- HIV-positive women have experienced more sexual coercion than HIV-negative women [1 2 3]
- HIV risk factors are associated with sexual coercion [4, 5, 6, 7, 8, 9, 10]
- Women who are raped are at high risk of a pre-existing sexually transmitted infection (STI) and lower but substantial increased risk of STIs [11, 12]

Pending research questions:

- Is violence and HIV a direct causal relationship or is it related to the underlying context of relationships?
- Are HIV risks different for sexual coercion vs. sexual assault?
- Is the relationship between forced sex & HIV mediated by relationship type?

Intervention research questions:

- Would post-exposure prophylaxis (PEP) with antiretrovirals reduce the risk for HIV infection?
- What post-exposure prophylaxis (PEP) with antiretrovirals would be the most effective/efficient way to administer PEP?

1.2 Violence may limit women's ability to negotiate safe sexual behaviour

What we know:

- Women in violent relationships discuss and use condoms less [13, 14]
- Initiation of condom use, refusal of sex & use of STI services are affected by abuse [15, 16]

Pending research questions:

How does violence limit a woman's ability to:

- Negotiate condom use and does this vary by relationship type?
- Demand mutually monogamous relationships?
- Negotiate other HIV preventive behaviours?

Interventions research questions:

How do we:

- Create enabling environments to negotiate safe sex?
- Promote an ethic of responsibility among men?
- Change male sexual behaviour & conflict resolution strategies?
- Promote open dialogue between partners about HIV?

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1.3 Child sexual abuse may increase risk taking as adolescent/adult

What we know:

- Individuals with history of childhood sexual assault initiate sexual behaviour earlier and engage in more risk behavior [17, 18, 19, 20, 21, 22]

Pending research questions:

The mechanisms are unclear:

- Direct association between childhood abuse & HIV?
- Does childhood sexual abuse lower self-esteem, which then affects self-perceived ability to negotiate safe sex?
- Does childhood sexual abuse create expectations about partnerships that women fulfill in choice of partners?

Intervention research question:

- How can women who have been sexually abused as children be identified and targeted early enough to impact behavior change?

1.4 HIV testing & disclosure of serostatus may increase women's risk for violence

What we know:

- The majority of women who disclose report supportive reactions [23, 24, 25, 26]
- Studies show that some women (10-25%) reported negative outcomes [27, 28, 29]
- A major reason for non-disclosure is fear of partner's reaction [30, 31, 32, 33]

Pending research questions:

- Does disclosure increase risk for violence? (prospective studies)
- Is it the testing or the revelation of HIV-positive serostatus that increases the risk for violence?
- Are negative outcomes more common in violent relations?
- Is the fear of partner's reaction driven by history of violence?

Intervention research questions:

- How can women be supported within VCT to safely share results with partners? Should all women be encouraged to share results with partners?
- How can we advocate against provider-referral notification systems and develop more effective counseling approaches?

Methodological issues for all studies on HIV and violence:

- Clear and consistent outcome measures.
- Conduct more population-based studies.
- Conduct studies with larger sample sizes.
- Combine qualitative and quantitative methods.
- Conduct comparative, cross-cultural studies.

Test Result to a Sexual Partner or any other Confidant in Dar es Salaam, Tanzania. Presentation at the Conference on global Strategies for Prevention of HIV Transmission for Mothers to Infants, Montreal, Canada.

[33] **Maman, S.; Mbwambo, J.; Hogan, M.; Kilonzo, G.; Sweat, M.** Women's Barriers to HIV Testing and Disclosure: Challenges for Voluntary Counseling and Testing Programs. Forthcoming AIDS Care.

2 Current/completed epidemiological research related to violence against women and HIV/AIDS

HIV and violence: The implications for HIV voluntary counselling and testing (VCT), Dar es Salaam, Tanzania

Presenter: J. Mbwambo, Muhimbili University College of Health Sciences

Jessie Mbwambo, Suzanne Maman, Margaret Hogan, Michael D. Sweat and Gad P. Kilonzo: Women's Barriers to HIV Testing and Disclosure: Challenges for Voluntary Counseling and Testing Programs. Forthcoming AIDS Care.

This Population Council/Horizons Project funded operations research, which was conducted by the Muhimbili University, College of Health Sciences (MUCHS), was designed to explore the intersections between HIV and violence among women at a voluntary HIV counselling and testing (VCT) clinic in Dar es Salaam, Tanzania.

Data collection was done in two phases, the major goals of the first phase were to:

1. Describe the factors that influence men, women and couples' decision to test for HIV-1;
2. Define what violence means in this cultural context;
3. Develop and/or refine instruments and measures for use during the second phase of research.

The second phase was designed to:

1. Determine the prevalence of violence among women;
2. Identify correlates of violence;
3. Compare the histories of violence among HIV-1 positive and HIV-1 negative women;
4. Determine the rate of HIV-1 serostatus disclosure to partners and other social network members;
5. Identify the predictors of HIV-1 serostatus disclosure to sexual partners; and,
6. Measure the association between history of violence and serostatus disclosure.

The major findings that can be distilled from this study are that women described more barriers to HIV testing than men did. Men's decision to test for HIV was one that they usually made on their own without soliciting the consent of a partner. For women, on the contrary, fear of partner's reaction was the major barrier to HIV testing. The decision to test was one that women either fought hard to defend or made on their own without the consent of a partner. If women sought testing without the consent of a partner conflict frequently arose. The major factor driving women to overcome barriers to HIV testing was perception of personal risk for HIV.

The rate of HIV serostatus disclosure to sexual partners, although high in both groups, was significantly higher among HIV-negative women compared to HIV-positive women (83% vs. 69%). Seventeen per cent of HIV-positive women reported that after testing they did not disclose their HIV status to any person. The rate of HIV serostatus disclosure to a sexual partner increased significantly among HIV-positive women who came to be tested as individuals. In

1995, 27% of HIV-positive women reported that they disclosed their serostatus to sexual partners compared to 64% of HIV-positive women in 1999. Factors that may contribute to this change over time include increased awareness and acceptability of HIV and HIV testing in the community, better counselling surrounding disclosure, and more communication between couples about HIV and HIV testing.

Physical abuse as an adult was commonly reported by both HIV-positive and HIV-negative women. Overall, 46.5% of women had at least one verbally abusive partner in their lifetime, 38.5% had at least one physically abusive partner in their lifetime and 16.7% had at least one sexually abusive partner in her lifetime. Despite this background of physical and other violence by partners, the majority of women who disclosed HIV serostatus to primary partners (57.5%) reported that they experienced support and understanding from partners after disclosure. The frequency of negative outcomes reported among all women who disclosed serostatus was minimal; 1.2% reported physical assault by partner, 1.2% reported abandonment and 0.8% reported that the partner forced her to leave the house.

When controlling for other demographic variables, HIV-1 positive women were significantly more likely to report physical violence (OR 2.63; 95% CI 1.23-5.63) and sexual violence (OR2.39; 95% CI 1.21-4.73) than HIV-1 negative women. HIV-positive women also had a significantly larger mean number of physically violent partners in their lifetime (.61vs .37; OR 1.65; 95% CI 1.02-2.67) and a significantly larger mean number of physically violent events with their current partner (10.53 vs. 4.05; OR 1.02; 95% CI 1.00-1.04). The most important predictors of violence with a current partner were HIV status, women's age, women's education <14 years, being married or living with partner, partner's age >30 years, partner's concurrent relationship with other women, and the age gap between partners of 6-15 years. The odds of reporting partner violence was 10 times higher among HIV-positive women under the age of 30 than among HIV-negative women under the age of 30 (OR:9.99; 95% CI: 2.67-37.37).

It is clear from the above findings that the epidemics of HIV and violence cannot be separated and that joint efforts from activists who focus on violence against women and advocates for HIV prevention, will yield better results. Without the relevant structural changes in legislation which include women's human rights issues and specifically address violence against women, the impact of short-term programme efforts designed to reduce the level of violence against women will be limited. It is also imperative that women are empowered through education to be financially autonomous and to have larger representation at all levels of decision-making in the country.

In addition the state needs to have machinery in place (at all places of contact) to intervene when women are subject to violence. Women will not adequately feel the impact of any interventions if these are not comprehensive and multi-sectoral in their implementation. The actions suggested are resource intensive and as such, may not be possible for Tanzania to completely fulfil without external support.

Community-based intervention efforts are needed to reduce the level of HIV and violence against women. These efforts should include programmes to change the norms of male sexual behaviour and conflict resolution. They should aim to change the way violence against women is condoned and focus on differences in power relations between the two sexes. It is important that this is implemented at all levels and age groups. Furthermore, additional population-based research is needed to identify the specific pathways through which violence increases women's risk for HIV.

With reference to HIV/AIDS, there is a need to improve women's access to HIV prevention tools, which they can control, including but not limited to vaginal microbicides and female condoms. In addition, partner notification policies that focus on a client-referral rather than a provider-referral system should be encouraged with a greater focus on disclosure within VCT pre and post-test counselling. More operations research is needed to identify alternative counselling strategies to increase the rate of HIV serostatus disclosure and improve the ongoing psychosocial support available for VCT clients.

VCT should continue to be promoted as an important HIV prevention strategy among individuals and couples. The mixed experiences of the seroconcordant HIV-1 positive couples and the serodiscordant couples in our study illustrates the challenges that VCT programmes have to help infected couples come to terms with their infection, to maintain relationships and to promote condom use among serodiscordant couples to ensure that the negative partner remains uninfected.

Consequences of informing women about HIV seropositivity in an African setting: lessons for the implementation of HIV testing and interventions to reduce mother-to-child HIV transmission (MTCT)

Objective To determine the consequences of informing women of a positive HIV test result in the setting of a perinatal HIV study in Mombassa, Kenya.

Presenter: Philippe Gaillard, WHO

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The following people and organizations are duly acknowledged as without them the study could not have been carried out: Coast Provincial General Hospital, Mombassa, Kenya, Fabian Mwanyumba, Esther Muigai, Kishorchandra Mandaliya, International Centre for Reproductive Health, University of Ghent, Belgium, Patricia Claeys, Marleen Temmerman, Department of Microbiology, University of Nairobi, Kenya, Job Bwayo, the counsellors and midwives and the mothers and infants.

Background

Efficient interventions to reduce Mother-To-Child HIV Transmission (MTCT) such as anti-retroviral therapy or formula feeding are available. These interventions might require the partner to be informed in order to accept and/or to pay for the treatment. Violence against women disclosing their HIV-positive serostatus to their partner has already been reported.

Methodology

Site: Maternity ward in the Coast Provincial General Hospital, Mombassa, Kenya.

Patients were recruited in an intervention study aimed at reducing MTCT doing chlorhexidine vaginal lavages during labour. Recruitment took place the day after delivery after informed consent was obtained.

Inclusion criteria included:
- Living in Mombassa
- ≥ 18 years old
- Informed consent

Exclusion criteria were:
- Serious maternal illness
- Caesarean section
- Perinatal death
- Refusal to participate

Follow-up was carried out six weeks after delivery and consisted of the following:
- Disclosure of HIV tests results
- Post-test counselling
- Discussion about risks and benefit of sharing results with the partner

A further follow-up was then carried out 14 weeks after delivery where a questionnaire on the consequences of knowing HIV tests results was administered. Home visiting was carried out in cases where women did not show-up. However, advantages were provided for participants including free medication for children, infants' immunization during visit and provision of free transport.

Results

Recruitment	
April 97 – April 99	
Deliveries	13 872
Not screened for HIV:	8 088
Living too far	37.3%
Maternal illness/complicated delivery	17.8%
Not recruited for CHL study (2nd stage)	14.9%
<18 years	7.2%
Refused HIV screening	0.3%

Characteristics of women recruited	
Age (mean)	24.2 y
Primigravida	36.1%
Stable relationship	87.6%
Monogamous	85.9%
Christian	87.8%
Secondary level of education	35.3%

Questionnaire 64 days after giving serostatus	
Knew she was HIV positive	0.9%
Suspected she was HIV positive	3.4%
Husband promiscuous	8
Women and/or partner often sick	1
Partner died of AIDS	1

Partner informed (women in a stable relationship)	90 (32.0%)

Partner's reaction	
Understanding and supportive	73.3%
Did not believe results / denial	10.5%
Had no comments	9.3%
Chased his wife away	3 (3.3%)
Violence against his wife	3 (3.3%)

Knowing the HIV serostatus useful	83.3%

chart continues

Will be more careful about health - treat early infections, balance diet	64.6%
Will give better care to their infant	15.6%
Will use family planning	10.6%
Learned how to live being HIV positive	7.1%
Useful to know about own health status	7.1%
Knowing the HIV serostatus not useful	16.7%
More worried of being sick or dying	68.6%
AIDS has no cure	35.3%

Limitations

There were four main limitations with the study:

- The study used interviews and not questionnaire;
- The research setting was not a real life situation;
- The baseline level of violence in the household was unknown; and,
- Loss to follow-up.

Conclusions

- The majority of women accepted to be HIV tested.
- Twenty per cent did not come to get their results.
- The majority of those who did come found it useful to know their HIV status.
- Two thirds of HIV-positive women did not share the results with their partner mainly due to fear of his reaction.
- Risk assessment for partner violence was not enough to avoid it.

Recommendations

- Efficient interventions to reduce MTCT (anti-retroviral therapy, infant feeding) are available. These interventions might require the partner to be informed in order to accept and/or to pay for the treatment.
- Promoting infant health as a responsibility of both the mother and the father could be part of the message to encourage the fathers to be tested for HIV.
- HIV voluntary counselling and testing of couples should be encouraged to avoid violence.
- The possibility of violence against women in cases of disclosure of HIV-positive status to a partner should be part of counselling

Study on the links between marital violence and women's vulnerability to Sexually Transmitted Diseases (STDs), Karnataka State, India

Presenter: Suneeta Krishnan, University of California, USA and Swasthya, India

Research focus Ethnographic and epidemiological research focused on the ways in which socio-political, economic and gender inequalities influence women's vulnerability to STDs in rural South India. In recognition of the social necessity of marriage, the near universality of marriage among women, women's young age at marriage and widespread gender inequalities, this study concentrated on women's vulnerability to STDs within marriage. Specific questions of interest to this discussion included: how prevalent is marital violence against women? What are the relationships between the socio-political and economic resources of women and their households and marital violence? Is marital violence associated with women's vulnerability to STDs?

Setting

The research was conducted between July 1997 and August 1999 in the context of a women's health promotion programme called the Swasthya Community Health Partnership. Swasthya is active in Sringeri Taluk (sub-district), Chickmagalur District in the central plateau region of the southern Indian state of Karnataka. It is a collaboration between a prominent charitable hospital in Sringeri, local women who have been trained as community health workers (CHWs), and an international group of students of public health, nursing and medicine.

Swasthya's programmes focus on 1) generating dialogue between women and health professionals; 2) fostering a sense of solidarity among women; and 3) encouraging empathic and sensitive clinical and public health practices. Activities include individual interactions and group discussions on health issues in homes, work sites, day care centres and schools; 2) provision of primary care and counselling at Swasthya health centres and during home visits; and 3) provision of preventive and curative gynaecologic care in a sensitive and caring environment. The CHWs routinely organize "well woman clinics" that focus on providing private, personal and sensitive health care for women.

Methods

Ethnographic research involved multiple methods including in-depth, open-ended and semi-structured interviews and discussions with women and men as well as observations made during a two-year period of residence in Sringeri. Many insights were gained during the course of Swasthya's day to day activities, particularly during counselling sessions, "well women clinics" and home visits.

Epidemiological research, in the form of a cross-sectional survey, was conducted to investigate aspects of women's vulnerability to STDs within the context of marriage. Respondents were selected from currently married women between the ages of 15 and 50 years and their husbands between the ages of 15 and 60 years residing in villages within a 30Km radius of Sringeri town through a stratified, multistage cluster sampling procedure. Women and men were invited to participate in an interview survey and health screening. Survey and health screening protocols were approved by the Committee for the Protection of Human Subjects at the University of California at Berkeley and the Sri Abhinava Vidyatheertha Swamigal Scientific Research Academy, Sringeri.

The Swasthya CHWs interviewed women and their husbands separately and in a confidential setting. The CHWs were provided basic training in research and interview methods. Information on participants' socio-political and economic background, current health, medical history, access to health services, and perceptions of and practices related to reproductive health (including experiences of marital violence) was collected during the interview.

Participants were invited to take part in a health screening camp (fair) held in either their village or a nearby village on a specified day. Their general health, including blood pressure, blood sugar and haemoglobin levels, was assessed, and blood and urine samples were collected to test for evidence of past or current infections with Hepatitis C viruses, C. trachomatis, N. gonorrhoea, and T. Pallidum. Laboratory samples were collected and tested by a team of researchers from the Post Graduate Institute for Basic Medical Sciences, University of Madras of Chennai.

Outcomes

A number of lessons regarding the planning and implementation of research on "sensitive" issues such as marital violence and STDs emerged including the importance of 1) building broad-based alliances between researchers and the community; 2) taking into account a community's prior experience participating in research; and 3) providing counselling and support services. One of the main method-ological challenges was the measurement of violence. In addition,, several ethical dilemmas arose during the course of the research, which primarily had to do with responding to women's experiences of violence.

Ethnographic research revealed the centrality of gender inequities in shaping women's vulnerability to STDs. Women's perceptions of vulnerability reflected a recognition of the vulnerability of their bodies and the fact that in many instances they had little control over their vulnerability. Violence -beating, sexual coercion, and verbal and psychological abuse -were closely tied to women's sense of vulnerability. Women's experiences of violence were primarily located within the home and within the context of marriage. Women identified husbands' alcohol use and the ensuing violence as critical impediments to negotiating sex and the way in which sex occurs.

Based on the epidemiological study and the specific question 'Have you ever been forced to have sex with your husband when you did not want to?', the prevalence of marital violence was 34.1% (95% CI: 30.3 - 37.9%). Twenty nine per cent of women reported that their husband had hit them (95% CI 25.4 - 32.1%), and 12% reported that their husband

had forced them to have sex when they did not want to (95% CI: 9.1 - 14.4%). Multivariate analyses highlighted the influence of structural (caste/class) and gender inequalities on marital violence. A particularly noteworthy finding was the relationship between women's control over economic resources and reported experiences of violence: women who reported controlling an income were more than twice as likely to have also reported marital violence. The relationship between marital violence and markers of sexually transmitted infections could not be evaluated due to lack of power. cluded: how prevalent is marital violence against women? What are the relationships between the socio-political and economic resources of women and their households and marital violence? Is marital violence associated with women's vulnerability to STDs?

WHO multi-country study on women's health and violence against women in Brazil

Presenter: Ana Flávia Pires Lucas d'Oliveira, University of São Paulo, Brazil

Lilia Blima Schraiber, University of São Paulo, Brazil, Ana Flávia Pires Lucas d'Oliveira, University of São Paulo, Brazil, Ivan França Jr., University of São Paulo, Brazil, Simone Grilo Diniz, Colectivo Feministe Sexualidad y Saúde, São Paulo, Brazil

Study objectives This population-based study aims to:

- Obtain reliable estimates of the prevalence of violence against women in several countries.
- Document the health consequences of domestic violence against women.
- Identify and compare risk and protective factors for domestic violence against women, within and between settings.
- Explore and compare the strategies used by women experiencing domestic violence to reduce or stop it.

The multi-country study comprised of formative qualitative research and a survey consisting of home interviews with women between 15 and 49 years of age in a sample which is representative of two regions in each of the countries in the study.The study is being carried out in eight countries (Bangladesh, Brazil, India, Japan, Namibia, Peru, Tanzania, Thailand and Samoa) and coordinated by Claudia Garcia-Moreno, WHO, in a highly populated city and a rural or semi-rural area. In each country, a team with representatives from a university and NGOs was identified.

This presentation described the multi-country study in Brazil. In Brazil, fieldwork was carried out in 1269 households in the city of São Paulo in the first quarter of 2000. Data collection is currently underway in 2160 households in região da mata in Pernambuco, a state in the NorthEast. The questionnaire is extensive and goes through a very detailed set of questions on various aspects of women's health and life experiences. In the formative research that preceded the population-based study, eight focus groups (of both men and women) were identified, from which six in-depth interviews and 40 key informant interviews were conducted.

Research questions

The study seeks to address, among others, the following research questions:

1. Within each of the study populations, the prevalence and frequency of physical abuse of women from the age of 15.
2. The prevalence and frequency within each of the study populations of women reportedly being forced to have sex against their will. At what age(s) has this occurred, and who are the main perpetrators?
3. The prevalence and frequency within each study population that women are physically or sexually abused by a current or former intimate partner, and the extent of violence during pregnancy.
4. The extent that a history of domestic violence can be associated with different indicators of women's physical, mental and reproductive ill-health and the use of health services?
5. Comparing the data within and between different countries, what can we hypothesize about individual, family and community factors contributing to violence against women in families? What are the implications for preventive interventions?
6. Comparing the data within and between different countries, how do women's responses to violence differ between sub-groups and cultures? What are the implications for preventive and supportive interventions?

Outcomes

The study will provide important data on the prevalence, determinants and related risk and protective factors, and health consequences of violence against women from a diverse group of countries. WHO is also committed to several corollary outcomes including (1) the development and testing of new instruments for measuring violence cross-culturally; (2) increased national capacity of researchers and women's NGOs working in this field; and, (3) increased sensitivity to the subject among researchers, policy makers and health service providers.

HIV/AIDS and violence

In relation to HIV/AIDS risk the Study is exploring the following questions:

- Have condoms ever been used to avoid STDs?
- Has the sexual partner ever been asked to use a condom?
- Has the partner ever refused to use a condom to avoid STDs? If yes, how did he show that he disapproved of it?
- Has the respondent ever been tested for HIV? (In Brazil)

The purpose of these questions is to determine if any association exists between violence and condom use, which may indicate a risk factor for HIV infection. The HIV/AIDS programme in the Ministry of Health in Brazil is very interested in this and specifically asked that these questions be included in the study.

Study ethics

- Approval in ethics Committees;
- Informed consent;
- Psychological (emotional support) for fieldwork research teams; and
- Support to the women interviewed through referral to services as needed.

Results

The results of the WHO multi-country study for Brazil are currently being analyzed, so no results were presented. However, it seems that violence may be a risk factor for not using condoms. We also found that a large percentage of women in São Paulo have already been tested for HIV, but cannot yet ascertain if this is related in any way with physical or sexual violence.

Study of prevalence of sexual and domestic violence against women in healthcare services in São Paulo, Brazil

The Brazilian team is also conducting another study to assess the prevalence of sexual and domestic violence against women in women attending healthcare services in São Paulo in order to develop a health care response [1]. The fieldwork for this study will begin in the first quarter of 2001.

Study objectives

General:

- To study the frequency of sexual and domestic violence cases among users of primary healthcare services in the public sector in São Paulo and to know the profile of women in situations of violence in order to develop an appropriate health care response.

Specific:

- To estimate the prevalence of violence against women in users of health care services in São Paulo (between 15 and 49 years of age).
- To identify social, demographic and health characteristics of women experiencing violence.
- To identify differences in the use of services between women who report violence and those who do not.
- To verify the existence of spontaneous reports of violence in medical records.
- To identify the demand for services expressed by women users – those who report violence and those who do not.
- To identify how women express themselves in relation to domestic and sexual violence as well as the possible healthcare needs and interventions they would need or expect.
- To identify how the professionals from these services express themselves with

[1] This refers to protocols for identification of women experiencing violence, including questions that must be asked, medical records to fill in, ethical and safety issues, educational materials, etc.

regard to domestic and sexual violence as a healthcare need and the possible care intervention provided to these women.

The study entails interviews with women users of 23 services, with an instrument to detect the frequency and kinds of violence suffered. It also includes a review of medical records and interviews with professionals. The first phase has already been concluded. This included the selection of participating services followed by a presentation of the problem and training of the professionals in participating services. Participation in the study is voluntary and is dependent on demonstrated interest by employees. One of the interested parties was the Reference Center for AIDS Care in São Paulo which will develop some specific questions for the questionnaire.

The study is a partnership between the University of São Paulo – Department of Preventive Medicine of the School of Medicine of the University of São Paulo – and the Secretary for Health of the State of São Paulo. Through this partnership, the office of the Secretary for Health committed itself to carrying out the required action in its centers at the conclusion of the study. Immediate benefits entail an improvement in the quality of care, in addition to the production of knowledge.

The study will address the same questions on HIV/AIDS as outlined above, in addition to those added by AIDS care providers.

Factors determining differences in rate of spread of HIV in sub-Saharan Africa: Results from a population-based survey in four African cities

*Presenter: Linda Morison, on behalf of the Study Group on Heterogeneity of HIV Epidemics in African Cities**

**Members of the Study Group on Heterogeneity of HIV Epidemics in African Cities: A Buvé (coordinator), M. Laga, E. Van Dyck, W. Janssens, L. Heyndricks (Institute of Tropical Medicine, Belgium); S. Anagonou (Programme National de Lutte contre le SIDA, Benin); M. Laourou (Institut National de Statistiques et d'Analyses Economiques, Benin); L. Kanhonou (Centre de Recherche en Reproduction Humaine et en Démographie, Benin); E. Akam, M. de Loenzien (Institut de Formation et de Recherche Démographiques, Cameroon); S-C Abega (Université Catholique d'Afrique Centrale, Cameroon); L. Zekeng (Programme de Lutte contre le SIDA, Cameroon); J. Chege (The Population Council, Kenya); V. Kimani, J. Olenja (University of Nairobi, Kenya); M. Kahindo (National AIDS/STD Control Programme, Kenya); F. Kaona, R. Musonda, T. Sukwa (Tropical Diseases Research Centre, Zambia); N. Rutenberg (The Population Council, USA); B. Avert, E. Lagarde (INSERM U88, France); B. Ferry, N. Lydié (Centre français sur la population et le développement/Institute de Recherche pour le Développement, France); R. Hayes, L. Morison, H. Weiss, J. Glynn (London School of Hygiene & Tropical Medicine, UK); NJ Robinson (Glaxo Wellcome, UK), M. Caraël (UNAIDS, Switzerland).*

Objectives The objective of this study was to explore whether the differences in the rate of spread of HIV in four urban populations in Africa could be explained by differences in sexual behaviour and/or factors influencing the probability of HIV transmission during sexual intercourse.

Methods

A cross-sectional, population based study was conducted in two towns with a high HIV prevalence (Kisumu in Kenya and Ndola in Zambia) and two towns with a relatively low prevalence (Cotonou in Benin and Yaoundé in Cameroon). In each of these towns approximately 1,000 men and 1,000 women, aged 15-49 years, were randomly selected from the general population. Consenting men and women were interviewed about socio-demographic characteristics and sexual partners, including detailed information of the characteristics of up to 8 nonspousal partners in the last year. Respondents were then tested for HIV, syphilis, HSV-2, gonorrhoea, chlamydial infection and trichomoniasis (the latter for women only). In addition a survey was conducted among a representative sample of 300 sex workers in each town. Questions on clients and regular partners were asked, and specimens were collected to test for HIV and other STIs as for the general population.

Results

The prevalence of HIV infection in men was 3.3% in Cotonou, 4.1% in Yaoundé, 19.8% in Kisumu and 23.2% in Ndola. For women the respective figures were 3.4%, 7.8%, 30.1% and 31.9%. The prevalence of HIV infection among women less than 20 years was 23.9% in Kisumu and 15.5% in Ndola compared to 3.4% and 3.7% in men. Women in the high HIV prevalence sites had their sexual debut earlier than in the other sites. Men and women in Kisumu and Ndola got married earlier than men and women in Cotonou and Yaoundé. High rates of partner change, contacts with sex workers, concurrent partnerships and large age differences between partners were not consistently more common in the high HIV prevalence sites than in the low HIV prevalence sites.

However, several factors that enhance the transmission of HIV during sexual intercourse were more prevalent in Kisumu and Ndola than in Cotonou and Yaoundé, including ulcerative STIs (syphilis and/or HSV-2 infection) and lack of male circumcision. In Cotonou and Yaoundé almost all men were circumcised, whereas in Kisumu 29.6% of men were circumcised and in Ndola 9.8%.

Conclusions

In these four African populations differences in sexual behaviour were outweighed by differences in other factors that influence HIV transmission, in explaining the differences in rate of spread of HIV. This does not mean that interventions aimed at reducing risky sexual behaviour are not important. In all four sites high-risk sexual behaviour patterns were identified. The high prevalence of HIV among young women calls for urgent interventions.

Follow-up studies on why HIV infection rates are so high in young women

The high prevalence of HIV in young women was one of the most striking features of the data collected in the four cities study. Glynn et al (2000) in an analysis of data from Kisumu and Ndola conclude that "despite the tendency for women to have older partners, young men were at least as likely to encounter an HIV infected partner as young women". The high rates of HIV in young women therefore seem likely to be due to an extremely high susceptibility to infection per act of intercourse. There was some evidence of under-reporting of sexual activity in that HIV and STI were found in women denying any sexual activity. However, the authors concluded that this would not invalidate the conclusion. It is not clear to what extent biological factors and "circumstances of first intercourse" might explain these high transmission probabilities in young women. Qualitative data focusing on adolescents was collected in Kisumu as a result of the population surveys described above (Njue, 1999). During in-depth interviews with 54 females aged 15-24 most reported that there had been some degree of coercion during their first sexual encounter, and for most their first sexual experience was not expected. Four reported being forced into sex against their will. One hundred and seven married men and women were also interviewed and 6% said their first sexual encounter took place against their will (but this was not presented separately for men and women). Fifty four per cent of married respondents reported that sexual abuse was a serious problem in the community. Rape was said to be common but would rarely be reported due to fear and stigma. Some men were said to lure young women into their houses on some pretext and then force them into sex. Funding has been obtained for qualitative studies among adolescents in all four cities with a major objective being to examine in more detail the extent to which force/abuse are factors in early sexual activity.

3 Current/completed interventions research related to violence against women and HIV/AIDS

Positive Women: Voices for Choices: study of reproductive choices and decisions of HIV-ositive women in Zimbabwe

Presenter: Ms C. Maposhere, Women and AIDS Support Network (WASN), Zimbabwe

The research project was supported by The International Community of Women Living with HIV/AIDS (ICW) through Women and AIDS Support Network (WASN) and was implemented by eight HIV positive women - Etta Dendere, Dominica Banire, Annatolia Chamuka, Joyce Mwedzi, Nyaradzo Makambanga, Mavis Noyo, Joyce Nyathi and Caroline Maposhere.

The scale of the epidemic and its impact on adults of reproductive age, make issues of reproductive health and rights a primary concern for people living with HIV. Women especially face problems of decision making about having children, of access to services and of maintaining their own health. They also take most of the responsibility for the health of children. There is very little documentation on the situation faced by HIV positive women and this makes advocacy and empowerment programmes very difficult.

Background

In 1995, in response to the concerns of positive women, the International Community of Women Living with HIV/AIDS (ICW) developed a proposal for a research study that would look into the sexual and reproductive health issues of positive women. Positive women carried out the study. The study was proposed to be done in six selected countries namely, Brazil, Thailand, Côte d'Ivoire, United Kingdom, United States of America and Zimbabwe. An international steering group was set up to oversee the project in all six countries. The group decided to stagger the research by carrying out a pilot in one of the countries. Because Zimbabwe had an AIDS Service Organisation that was already looking at HIV/AIDS from a gender perspective - WASN, it was chosen for the pilot. WASN also had a history of successful advocacy activities when the organisation lobbied for the registration of the female condom in Zimbabwe. A national steering group was set up through WASN, to oversee the project activities. Two research consultants were hired - one to coordinate the international activities - Dr Rayah Feldman and the other Ms Caroline Maposhere to implement the national research activities.

Project objective

The overall aim of the project was to carry out a participatory research study that would document the reproductive and sexual health problems of women living with HIV/AIDS in Zimbabwe and then design advocacy programmes based on the identified problems. The study process actively involved women living with HIV.

Methodology

Both qualitative and quantitative methods of data collection were used.

Support groups of HIV positive women were identified through WASN. The support groups were in the following areas: Chirumhanzu- Mvuma District in Midlands, Tshelanyemba- Kezi District in Matebeleland South, Birchnough Bridge- Buhera District in Manicaland and in urban Harare.

HIV positive women from the selected support groups came up with the reproductive health issues that they wanted research to be done on. A questionnaire, which was used to collect data for a demographic survey, was designed on these issues. Ten team leaders were elected by the group members of the support group membership to take the lead role. The ten were trained on how to collect data using Participatory Rural Approach (PRA) methods.

Feedback sessions were held in each of the research areas to discuss the results of the survey. In-depth interviews and focus group discussions were conducted to get the real life stories from the project participants.

Research Results

A total of 209 women were interviewed. The majority of the women (85%) were aged between 36-45 years. Most of them (61%) had some primary education and 37% had secondary school level of education. A large number of the women earned a living through subsistence farming (48%), vending and being formally employed (18%). Most of the women had been married at some time in their life - 36% were married at the time of the survey, 30% widowed, 23% divorced and 11% were single.

Of the interviewed women, 82% knew that they were HIV positive having been tested. Most of the women went for the test after partners or children had become sick or died of AIDS. A large number of them have known their HIV status for 2-5 years. On being asked who else was HIV positive in the family, 31% said their partners while 22% had children who were positive.

More than 50% of the women reported experiencing menstrual changes since knowing about their HIV status. Thirty six per cent of the women reported that they went to health facilities to get treatment for STDs, 14% for respiratory infections, 16% for diarrhoeal diseases and 23% for headaches. Although the majority (90%) of the women used public health care facilities with most of their problems, they reported some barriers in accessing care e.g. user fees, shortages of both drugs and staff and some women did not feel comfortable being attended to by male nurses for STD examinations and deliveries. They also cited incidents of discrimination by health workers especially if one had gone public about their HIV status.

Most questions on the levels of knowledge about the women's body showed that they knew very little about how the body functions. Less then half of the women (33%) talked about sex with their children and more than 20% did not talk about sex with their partners either, but 85% talked to friends.

The women felt that society expects them not to be sexually active because of their HIV status. Condom use in the group was reported to be high - 79% reported condom use for STD prevention. Only seven women reported using herbs to prevent STDs. Seventy per cent indicated that they would like to use female condoms, but could not access them. A small percentage of women (15%) had already heard about microbicides and would like to use them.

Although they reported society did not expect HIV positive women to be sexually active, 35% thought that their relatives expected them to bear children. The majority of the women (85%) know that a breastfeeding mother may transmit the virus to the baby through breastfeeding. A few alternatives were discussed as options for HIV positive women. Eighty-six percent felt that all pregnant women should be tested for HIV, and then be given a lot of information with which to make decisions. Although more than 70% of the women felt that positive women should be given the option to terminate pregnancies, 36% said that they would not do it even if it was possible to perform the procedure at local clinics.

Sixty seven per cent of women reported that their partners almost always initiate and control sex. In 84% of cases, women had instances where they wanted to have sex but their partners were not willing and 64% indicated that they did not have anywhere to go to for help when this happens repeatedly. About 65% indicated that they had pain during sex. Nearly 80% of the women had been forced to have sex by their partners at one time or another, 9 women said it happened all the time and 38% said they were forced when the partner had STDs. Of the women who had been forced to have sex by their partners, only 43% define the incident as rape. About 33% of the women admitted that they have had sex outside

marriage while they were married. Most of them did it to get money. Sex for money was shown to happen even in the marriage.

Major issues emerging from the results

- HIV positive women are discriminated against by both health workers and the community;
- Current policies and practices do not deliberately address the specific needs and problems of HIV positive women;
- The majority of HIV positive women as well as the health workers do not have adequate information on parent to child transmission of HIV;
- Some cultural practices violate the reproductive rights of HIV positive women.

Feedback of results to researched communities

The team leaders in all the four areas organized feedback workshops. The women identified people they felt had something to do with solutions to the problems raised in the research and these people were invited to attend the workshops. This was the beginning of local advocacy activities. The results were discussed with women from support groups, their partners, health workers and community leaders. Focus group discussions were held with the various groups on issues arising from the results e.g. forced sex, role of cultural practices, gender power dynamics and aspects of positive living.

Local AIDS Service organizations and health workers were invited to a meeting that was held in Harare in November 1999. At this meeting, the research results were discussed and the participants made commitments to take up some of the problems and look into them. In December and February, a follow up on the commitments made was done.

Positive outcomes from project activities

In one area, one of the team leaders has been selected to be on the Hospital Advisory board to represent the issues of women in general and positive women in particular. This happened after members of the Hospital authorities attended the feedback workshops and heard how much the women wanted representation.

After the discussion that some of the support group members were not accessing medical care because of user fees, one District Health Executive decided that all those support group members that identify themselves, should be treated for free in all government health facilities of their district. At another health facility, outpatient cards for support group members are obtained from one of the team leaders. Payments are usually done when one is obtaining the card so this means that the support group members no longer pay for treatment at this facility.

To address discrimination in health facilities, in addition to representation on the board, a notice was put up to inform anyone that was unhappy with the treatment received to go to the matron. The women noted that all the nurses that had attended the feedback sessions had positively changed their attitude towards them.

In one of the areas, the District Health Executive, after discussion of the research results, decided to set aside a monthly allocation of female condoms to the support group in the area.

At the feedback workshops, some community leaders committed themselves to support widows who decline to be inherited. After the workshop, one chief started the Zunde Ramambo programme to take care of the widows and orphans.

The project process changed the lives of the women in a big way, especially the team leaders. They have written up how the project influenced their lives. Due to publicity through the project, some were selected to take part in the constitution reform process.

Way forward

At this moment of the project, it is important to have the advocacy activities undertaken on in a more sustainable way i.e. by organizations or institutions that will always be with the people. It is good that the project facilitated a process where dialogue was initiated and relationships established so that some changes could start happening at local level but they need to be sustained. Consolidating lessons learnt and replicating the Voices and Choices project in other areas is something for other funding partners to consider.

Integrating gender and gender-based violence interventions and research into both VCT services and a poverty-focused HIV initiative in South Africa

Presenter: Dr. J. Kim, University of the Witwatersrand, South Africa

This presentation described two separate but linked activities, which comprise a multi-level operational research initiative to address HIV/AIDS in South Africa. Both arose as part of the National Department of Health's HIV/TB Pilot Programme, and both attempt to incorporate a gender perspective into interventions which recognize gender-based violence as an important factor fuelling the dynamics of the AIDS epidemic in South Africa.

Incorporating gender and gender-based violence perspectives into a VCT Training Programme in South Africa Beginning in November, 1999, the Health Systems Development Unit HIV/TB Programme began to introduce rapid HIV tests, voluntary counselling and testing (VCT), and basic HIV clinical services into all 5 clinics in the rural subdistrict of Agincourt. Given prior research, it was known that violence against women is a significant problem in these communities, and that nurses themselves often have direct experience of such violence. In response to these findings, a one-week VCT curriculum for healthcare workers was developed, incorporating a strong gender and gender-based violence focus.

In regards to developing the VCT training, key challenges included the following:

- Logistics:
  - how to arrange for nurses to take time away from clinical duties
  - transport from distant clinics to attend training
  - lack of existing clinical records at rural clinics and the need to develop a monitoring system for HIV tests
- Nurses attitudes: stigma, fear, denial regarding HIV
- Confidentiality – especially in rural clinics, where nurses and patients live in the same communities
- Nursing hierarchy – how to empower nurses at all levels to be able to do VCT. Prior experience indicated that junior nurses often faced resistance from senior peers when trying to implement new practices, especially if seniors had not received the same training.

The VCT training curriculum that was developed attempted to address some of these challenges in the following ways:

- A one-week training workshop was held at a centralized location (Agincourt Health Center). While half the nurses attended, the remainder would continue to staff the clinic and provide services. The training was repeated until all nurses had been trained (3 workshops).
- All levels of healthcare staff were trained - from senior matrons to nursing assistants.
- Creative, inter-active, experience-based learning methods were used to breakdown nurses' "professional distance" from the issues at hand: HIV, gender-based violence, and the gender dimensions driving the epidemic.
- A PWA facilitator was instrumental in developing and implementing the training: her disclosure of her HIV status and the way in which nurses could identify with her were invaluable in addressing issues relating to denial of personal risk, stigma and confidentiality issues.

Six months following the training, the VCT program was evaluated. This involved: (1) a review of use of VCT services, (2) in-depth interviews with nurses regarding the impact of VCT on nurses and health services delivery and (3) local PWAs (people living with HIV/AIDS) were recruited from the HIV support group and trained as "mock patients" to evaluate the pre- and post-test counselling from a patient perspective. In one evaluation scenario, the PWA played the role of a woman who is in an abusive relationship, in order to assess how and whether the nurse addressed this issue in the course of counselling.

Results

Use of VCT services: Over 40 healthcare workers from all levels (90% of nursing staff in the sub-district) were trained, and over 350 HIV tests were performed in the first six months following training. More women than men had come for testing (2:1), and approximately two thirds of tests results were positive. Same day results were delivered in all cases (a rapid HIV test had been implemented), and confidential record-keeping for monitoring testing and results had been introduced in all five clinics.

Impact of VCT: The majority of nurses felt very satisfied with the introduction of VCT services in their clinic, and felt that it had not interfered significantly with provision of existing services. Although initial confidence levels had been low, ongoing, on-site support following the training had been critical, and at six months time, most felt confident about their ability to perform VCT. Approximately one-third of nurses did note that they found VCT emotionally stressful however, particularly in relation to wanting to be able to "do more" for those who tested positive. Ninety per cent of nurses interviewed felt that the attitude of healthcare workers to PWAs had become more accepting since the introduction of VCT, and that fear and stigma had diminished. Perhaps reflecting the "personalization" approach to the training, over 90% responded that they had spoken to their spouses about HIV since the training, and almost one third had subsequently had an HIV test themselves.

"Mock patient" evaluation: Two VCT sessions per clinic were evaluated for each of the five clinics, by separate PWA evaluators (one male, one female). The evaluation was useful in detecting specific problems with senior nurses in two clinics. Apart from these cases, VCT services were of a high standard, with 8/10 pre-test sessions and 7/10 post-tests sessions achieving technical scores of over 90%. Nurses seemed confident discussing issues relating to sexuality, HIV prevention and transmission, and privacy and confidentiality were well maintained. Informed consent was obtained in all cases. In relation to the gender violence scenario, nurses' exhibited a non-judgmental and non-directive attitude, and none tried to persuade the client to disclose her positive status to her partner. Instead, follow-up visits for support and counselling were offered in all cases, and in some instances, nurses even offered their home phone numbers in case the client needed to talk further.

Summary of lessons learned:

- VCT using rapid HIV tests can be introduced and implemented at the primary care level in rural South Africa.
- Training approaches that attempt to "personalize" the issues for nurses are an effective way to motivate nurses in both professional and personal spheres.
- Using a PWA as a trainer, and incorporating a gender perspective that reflects the reality of nurses' own lives are both effective means to cross the "personal/professional" boundary.
- Incorporating issues relating to gender based violence and the gender dimensions of the epidemic provides an opportunity to raise awareness about the potential dangers of disclosure for women, and to emphasize the importance of confidentiality, and non-directive counselling.
- PWAs can play an important role in the development, implementation and evaluation of VCT training.

Ongoing challenges: The training is now being rolled out at the provincial level, and it will be a challenge to ensure that the quality of training is maintained, and that government is able to take increasing ownership over the process. Among those already trained, a key challenge will be to maintain good practice over time. Particular challenges will involve negotiating the ongoing power dynamics in clinics, and avoiding "burnout", given the emotional stress identified by the nurses. Increasing the use/demand for VCT services is another challenge and there are early indications that the introduction of HIV support groups and basic clinical care guidelines for PWAs may play an important role in this regards.

Addressing the links between poverty, gender-based violence and HIV/AIDS through an Expanded Microcredit Programme

As the next phase of this project, the HSDU TB/HIV Programme is developing, implementing, and evaluating an operational research initiative which aims to assess and address some of the social and structural roots behind the AIDS epidemic - in particular, poverty and violence against women. The intervention is informed by precisely the observation which both WHO and UNAIDS have begun to highlight at policy levels - that, for many women, the ability to protect themselves from HIV infection is often severely constrained by lack of decision-making power, not just in sexual matters, but in their lives more broadly. Both poverty and violence are shaped by, and further enforce these gender inequalities.

Moreover, both gender-based violence and HIV/AIDS represent profound and inter-linked challenges to the goals of poverty alleviation and sustainable development in Africa. While the ability of microcredit programmes to serve as "enabling strategies" that foster both economic and social gains among vulnerable groups has been well-established, their potential to provide a broader platform for critical health and development activities has not been sufficiently operationalized or evaluated.

This initiative will develop and evaluate an Expanded Microcredit Programme (EMP) by introducing and mainstreaming a participatory gender and HIV education component into core microcredit activities. It will utilize participatory learning and action (PLA) tools in the design and implementation of health promotion activities, in order to elicit and incorporate the priorities and needs of microcredit participants themselves. During monthly loan group meetings, participating women will be brought together to discuss issues of gender relations, reproductive and sexual health decision-making and vulnerability to HIV infection. The intervention is based on the hypothesis that, in combination with the social and economic benefits, the attitudes and skills gained through participation in EMP will support patterns of decision-making that can reduce vulnerability to both gender-based violence and HIV.

The study design represents a community intervention trial and will follow villages in intervention and control sites (all based within a demographic and health surveillance site) over three years. The intervention and study design was presented and methodological and ethical challenges were explored.

Technical challenges: implementation

- Developing a study design and research methodology in partnership with microcredit organization:
  - different ideas of "research";
- implementation of gender/HIV training should not interfere with microcredit program:
  - needs to be developed in partnership with the microcredit NGO;
  - separate staff for implementation and evaluation;
- target group: older women or younger women?
  - older women "traditional" loan candidates but younger women most at risk of HIV;
- working with men, household-level intervention:
  - male migrancy – when and how can men be engaged?
  - microcredit: seen as a household rather than a "women's" intervention; male partners brought on board from the start.

Research challenges

- Choosing intervention and control villages:
  - selection bias: enrolling "eligible" loan participants as comparison group;
  - randomization?
  - matching: using participatory wealth ranking;
- Developing meaningful indicators of change:
  - economic benefits: is microcredit working? Broad SES indicators not sensitive enough;
  - measuring "empowerment": developing locally appropriate indicators: GBV as one indicator
  - capturing changes over time: limitations of "before/after" design - importance of incorporating qualitative methods to capture processes, and meanings of observed change
  - impacts may fluctuate over time (duration of involvement in microcredit) and vary among participants (age). Some evidence to suggest levels of GBV may increase initially as women's roles and status begin to change. Fluidity of "empowerment".

Ethical challenges

- Meeting with local leaders, communities;
- avoid misconceptions: not "giving loans to HIV positive people";
- participation in research voluntary - not linked to loan eligibility;
- HIV testing: confidentiality, coding, linking;
- safety issues: research on violence;
- extending intervention to control site later on;
- sustainability of microcredit operations beyond the research initiative;

An intervention programme of SHAKTI targeted at street-based sex workers in Dhaka City, Bangladesh

Presenter: A. S. M. Enamul Hoque

A.S.M. Enamul Hoque, Smarajit Jana, K.M.N. Gani, Juliana Rozario, Hajera Begum, Rehana Begum, Pinky, Shahanaj Begum, Joya, Bangladesh

Background SHAKTI a project of CARE Bangladesh carried out this HIV prevention intervention programme in 1997. It followed a peer-based approach, involving sex workers in designing, implementing and monitoring targeted intervention programmes from the outset.

A base line situation assessment, including estimation of the size of the street based sex workers in Dhaka City, was carried out between January and March. In March 1997 using capture - recapture methods in size estimation, 4366 street-based female sex workers were found in 70 sites of Dhaka City. Among them 25% were <18 years old, mean age in years was 22.2 (+5.6), 80% were illiterate and 60% were divorced/separated. Forty-two per cent previously worked as maidservants, 33% worked in garment factories, and those remaining worked in hotels, restaurants and brothels. Thirty seven per cent were found to live in slums, 30% lived in streets and parks while the rest lived in surrounding areas of Dhaka City. The average number of clients during the last 24 hours was 3.4 (+3.1) and during the last week were 13.20 (+12.6). Condom use in all sex during past seven days was 2.5% and half of the sex workers never used a condom. Twenty nine per cent of them were suffering from active syphilis. Another study conducted by SHAKTI during November-December 1998, aimed at understanding the client profile, showed that 17.7% were rickshaw pullers, 15.5% were service holders, 15.1% were students, 13.4% were police and 10.9% were businessmen. These groups constitute the top five occupation groups using street-based sex workers.

SHAKTI's activities aimed at promoting behaviour change among sex workers including peer outreach and peer education; support services, particularly STI treatment and access to condoms. Activities also aimed at creating an enabling environment for behaviour change that included the establishment of drop-in centres, working with local power groups and facilitating the formation of self-help groups. The programme provided needs-based training on literacy, human and legal rights, self-defence, savings, credit schemes and training on leadership and organization development. After the development of an organisation by the sex workers themselves, the project stopped free distribution of condoms as the sex workers' organization decided to sell condoms through their members.

Challenges to behaviour change

During the course of the implementation of activities, the project encountered different challenges. Major challenges identified are the low social status and low self-esteem of street-based sex workers. There is ambiguity in the legal status of sex workers in Bangladesh and soliciting in the street is illegal. Due to high mobility, it is difficult to contact sex workers regularly. They frequently leave prostitution and then return to the sex profession later on, and there is continually a large influx of new women (3.5 years-mean duration). Moreover, sex workers frequently face violence from police, thugs and clients. Denial at policy makers' level and resistance from bureaucrats have made the behaviour change programme more difficult to implement.

Study issues

Due to the social status of sex workers and the working conditions on the street, street-based female sex workers are more vulnerable to HIV infection. Where the level of harassment is high, safer sex practices are more difficult to adhere to especially when the law enforcing authorities are involved. Rape, extortion, and beatings, being conducted routinely by the police was identified as one of the major obstacles in implementing an effective HIV-prevention programme among the street workers. Data on harassment have been collected in order to understand violent situations and the impact of violence on sex practices.

Methodology

Methods used in this investigation were both qualitative and quantitative. The project consisted of six drop-in centres located in different locations of Dhaka City. Each drop in centre has facilities such as toilets, bath, laundry and resting spaces. Apart from the clinic, literacy training and alternative skills development training (i.e., training on sewing) programmes are also promoted through these centres. Sex workers from surrounding locations came every day to the drop-in centres to enjoy these facilities. Peer outreach workers conducted group sessions on STD/HIV/AIDS at the centres five days a week. Each sex worker participated at least once in a group session every three months. In every group session, peer outreach workers asked sex workers questions about situations of harassment during the last seven days. These questions included how many of them were harassed (beaten, raped, forced to give money) by police, thugs or clients. The information was then filled out in a structured format. Peer outreach workers were trained on the issue and supervised by project staff. Between January and December 1999, data on harassment was collected from 5150 women in all six drop-in-centres.

In addition, focus group discussions were organized both in the field as well as the drop-in centres on the issue of violence. Trained peer outreach workers acted as moderators and project staff took notes of the discussion.

Ethnographic observation by the project staff in parks, street locations, etc., was also included as part of the study.

Ethical issues

In carrying out the investigation informed consent was obtained both individually and from the groups.

Results

Among 5150 women sampled, 61.9% reported harassment either by police, thugs or clients. This has revealed that violence against sex workers in Bangladesh is far greater on the streets than in the brothels. A survey carried out by the national behavioural surveillance team in 1998 in all the nation's brothels showed that less than 5% of sex workers in brothels had been raped or beaten by police. Among the 5150 street-based sex workers sampled, 27.4% had been harassed by police (beaten 15.5%, raped 6.3%, forced to give money 5.6%). Data showed that police maintain high levels of violence against these women. Results from the study to identify client profiles mentioned above, clearly indicate that police represent one of the most frequent clients of street-based sex workers. Local thugs taking advantage of sex workers' low social status and precarious legal status committed the highest levels of violence against street-based sex workers. In the same sample of 5150 women, 28% had been harassed by thugs (beaten 12.4%, raped 7.9%, forced to give money 7.7%).

The nature and types of violence included beating with an object, cut/scraped with a blade/knife, slapped, struck with the fist, burned with a cigarette, forcedly entering hard objects into the vagina, etc. Rape was described as any sex act into which the sex workers are forced against their will. About half of all sexual exchanges with street sex workers in Dhaka were carried out in-groups. These turned into violent acts when sex workers initially contracted for a sex act in exchange of money with two or three clients and later are forced to have sex with five to ten.

The monitoring of data on the sale of condoms within the project area revealed that harassment by the police in the streets reduces the sale of condoms. Condom sales dropped by 60% and 80% during a month when police harassment rose by 58% and 50% respectively.

Conclusions

It is important to empower sex workers both at individual and at community level in order to speed up a process to reduce violence and social harassment. Laws related to the sex profession need to be reformed as certain laws (Metropolitan police act, the suppression of (brothels and) immoral traffic act, 1933) provide enormous power to police enabling them to control the sex trade and movement of sex workers. Other laws (Bengal vagrancy act, 1943) are being misapplied against sex workers. Even fundamental human rights are violated by the misapplication of these laws. Existing laws against prostitution make it easy for the police to harass sex workers.

Efforts are required at national level to decriminalise the sex trade. Effective strategies to reduce police harassment are urgently needed. The ambiguity in the legal status of the sex profession contribute to resistance against safer sex practices. Advocacy at local level has little impact. An effective advocacy strategy is needed as an integral part of any intervention programme targeting marginal populations in general and sex workers in particular.

Safer sex practices can not be ensured unless the level of violence is reduced to a minimum through necessary policy changes at national level.

Presenter:
Dr T. Couette, USA

Overview of research on cross-border trafficking and migration: Towards community-based research, advocacy and interventions

This presentation highlighted research that has been carried out on trafficking and migration issues and reflected on the author's personal experience in this work.

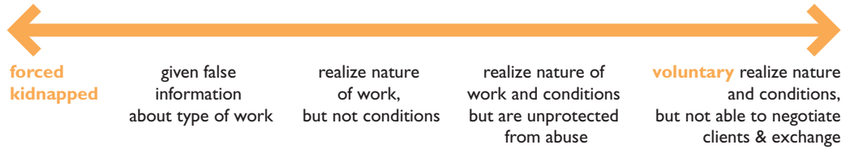
The goals in undertaking research on trafficking were to raise awareness of the issue, challenge misperceptions and identify those involved and responsible. With these goals in mind the specific aims of the research were to

- describe the realities;
- validate the experiences of the women involved in trafficking and migration;
- provide a context from the perspective of those trafficked;
- raise awareness and advocate for appropriate responses.

The following are some of the critical lessons learned:

- Take time to develop partners in the field who can guide the researcher through the entire research process, including the design, tools, implementation, analysis, recommendations, dissemination and advocacy.
- Involve the interpreter throughout the research process as a researcher not just translator, but one to interpret the culture, situation and dynamics.
- Give the interpreter a role in directing the interviews and reviewing notes.
- Study the background and current situation on an on-going basis.
- Conduct observations before beginning formal interviews and continue them throughout the data collection period.
- Prepare interview guidelines that are open-ended, accepting all answers and probe only to understand their responses (referring to the girls or women not telling the truth or "lying" in the interview blinds people to who they are and what is going on).
- Develop a local vocabulary reference and revise the interview guidelines on an on-going basis with the interpreter and partners. All too often the vocabulary being translated misses the nuances (for example the researcher uses "brothel owner" and the girl "uncle" or the researcher referring to a "rescue" and the girl to "arrest").
- Prepare a simple and clear explanation of the research and the girls' voluntary participation assuring those being interviewed they can stop at anytime.
- Be aware that some questions may be too complicated and prepare to revise them on a case-by-case basis (for example: questions on health often assume a knowledge base that doesn't exist).
- Realize that there is low self-esteem among these girls and women who believe that what happened to them is their fault and work to probe beyond their first response (for example, "could you leave the brothel?" "yes" "Did you ever leave?" "No never, because if I did……).
- Allow time for respondents to express themselves and talk about what is important to them even if it is not the information the researchers want.
- Acknowledge the continuum of violence involved. (see figure opposite)
- Safety and confidentiality is an ongoing process:
  - be flexible to the changing dynamics;
  - stop with any sense of risk following others' cues;
  - no photos and consider tape recorders carefully;
  - don't ask name or address of participants;
  - consider carefully with local input if and when to involve government officials;
  - realize the biases of researchers, translators, partners and respondents;
  - thank the participants at the end of the interview and explain again the interview, confidentiality and how it will be used.
- Address the researchers and/or donors capacity and willingness to accept the nuances of the respondent's perspectives and needs. Often, donors backing the research edit the findings and recommendations, taking out that which they consider controversial.

In working with girls, women and their communities, the concept of "trafficking" closed doors as it was often full of stigma, discrimination, loss of face and shame to the family. On the other hand, discussion of migration, and related issues was less threatening and of interest to the entire community.



Research that explored migration required new questions:

- Who are the young girls and women?
- Why are they migrating?
- What are their concerns and aspirations?
- How do they relate to their families and communities and vice-versa in making their decisions, while away and upon return?

Research focusing on migration was aimed at:

- involving more of the community in the research process;
- exploring the broader reasons behind migrating;
- developing intervention strategies at various levels.

The two recent studies of the author have focused on the impact of migration on reproductive health and children and youth. The findings show violence, the fear of violence and strategies for staying safe determined most every decision among migrants and particularly for girls and women.

The lessons learned in conducting migration-focused research challenge the work to:

- Involve migrants as researchers in all stages of the research process.
- Focus on documenting the research process, discussions, decisions while providing technical support and encouragement to explore attitudes, stigmas, double standards and assumptions together.
- Realise language is the greatest obstacle and the benefits of keeping the work in their language through the analysis to ensure their full participation and accuracy of interpretation.
- Keep the final report in the voice of the migrants using the qualitative data (too often qualitative data is summarized and not properly analysed with the words of the respondents lost).
- Follow the translations closely and be sure the final report is published in all of the participant's languages.
- Consider participatory approaches to research for developing community-based action and exploring interventions as research.
- Cross-border exchanges were very useful in broadening analysis.
- Educate donors on the value and responsibilities of participatory approaches to honour the issues, direction and recommendations of the participants.

Work on HIV/AIDS among undocumented migrant populations has been minimal and has not focused on violence although that is such a dominating reality and determines so much of the lives, especially of girls and women. Distributing condoms and HIV/AIDS information does not acknowledge their realities and thus not only does not reach them but can further isolate and discriminate against them.

Key Issues for addressing VAW and HIV/AIDS

- Listen to the community and their realities and perspectives on sexual and reproductive health choices. Then, explore interventions with them.
- Acknowledge that violence, and the fear of violence, determines actual and perceived choices and decisions.
- HIV/AIDS interventions must respond to the community's realities, daily life experiences, beliefs, attitudes and concerns and how they identify HIV/AIDS risks.
- Translate into local languages and provide other venues for information dissemination for those who are not literate.
- Don't restrict girls' and women's choices, but rather work towards increasing their options. All too many interventions focus on preventing migration or "rescuing" girls and women and sending them home. The focus must be towards increasing avenues for pro-tection and providing more opportunities.

Learning to listen and listening to learn is the only way to communicate with vulnerable populations and understand the sensitive and complex issues they face. In this effort to work together, appropriate interventions can be developed.

4 Rape and post-exposure prophylaxis (PEP)

Presenter: Dr D. Smith, Center for Disease Control, USA

HIV postexposure prophylaxis (PEP) and Sexual Assault: A brief Overview

What we know

- sexual assault occurs worldwide, at varying national and local rates;
- it occurs to women more than to children, and to children more than to men;
- HIV infection occurs worldwide, at varying national and local rates;
- antiretroviral PEP can work in needlestick injuries in health care settings;
- antiretroviral PEP can work perinatally; and
- antiretroviral drugs are not equally available or affordable worldwide.

There has been only one case report published about HIV transmission by sexual assault (that meets stringent requirements). In such cases of transmission, it is important to know the following:

- that the assault survivor was HIV negative at the time of the assault
- that the assault survivor seroconverted in a time frame after the assault consistent with data on early HIV infection and the timing of seroconversion
- there have been no intervening exposure events that could have led to HIV transmission, i. e.:
  - sexual abstinence or consistent condom use
  - partner(s) documented HIV-uninfected
  - no needle-sharing injection drug use
  - no needlesticks or other health care worker exposures

Considerations in evaluating PEP for sexual assault as a clinical intervention (for the benefit of an individual patient)

It is important to assess factors that would influence the sexual transmission of HIV, including:

- local environment (e.g., existing sexually transmitted infection);
- integrity of mucosa and skin
- condom use during the assault
- number of assailants
- local prevalence of HIV infection in men
- HIV serostatus of assault survivor (with rapid testing, if available)

One must also consider the potential psychological burden of offering PEP. In some settings, a high proportion of those evaluated for sexual assault are already HIV infected and would be injured by being given this diagnosis during sexual assault care. Among seronegative survivors, the low rate of compliance in all reported clinical situations suggests that survivors may not be willing to accept the possibility of acquiring HIV, or they themselves do not consider transmission a great risk. Very few actually complete drug regimens, which leads to a high cost for potentially preventing a single transmission.

Children are often sexually assaulted on an ongoing basis rather than during a single event. The risk and extent of local trauma is greater in children than in adults. Also, child sexual abuse is commonly unreported and undiagnosed due to active denial and misdiagnosis (as perinatal transmission). In one study done in Zimbabwe from 1998 to 1999, there was a fairly high rate of seroprevalence (in all ages) at the time the children arrived at the sexual abuse clinic, but there was also a high rate of seroconversion that occurred among children who were negative at the time of the assault.

Considerations in evaluating PEP for sexual assault as a public health intervention (for the benefit of overall population health)

A large proportion of those who are sexually assaulted do not report the assault or seek medical care. It is possible that widely publicising the availability of PEP would increase the number of assault survivors that would present for treatment, but this is not yet shown to occur.

In most cases, studies find that assault suspects, although often known to survivors, are not available for HIV testing within a reasonable time frame. The rate of infection in assailants appears not to be significantly higher than one might expect in other high-risk populations. (See Table 1.)

Several studies have been conducted regarding the use of PEP after sexual assault. (See Table 2). In these studies, a small proportion of individuals consented to starting PEP, and a much smaller proportion actually completed the regimen. Several of these programs had specific outreach involve, adherence counsellors, and multiple support services.

Worldwide, individuals have a lifetime of potential exposure to HIV. One could spend a great deal of time and money attempting to identify and treat a single episode that may have little impact on a person's lifetime risk of HIV transmission. UNAIDS estimated that with current rates of prevalence and transmission in South Africa, a 15-year-old boy has about a 65% chance of developing HIV infection at some point in his life; the rate is even higher for women. In this context, being sexually assaulted at some point may contribute very little to the overall risk of acquiring HIV infection.

Regarding impacting the epidemic from a public health perspective, the question remains whether PEP is the best expenditure of resources to improve women's health. In developing countries, the sexual assault treatment arena is underfunded, understaffed, and in need of support and development. There is also a great need to focus on STD treatment, counselling, and assault prevention. Costly antiretroviral therapy following sexual assault may be of limited benefit compared to developing and fully funding these other programs.

A model of potential public health benefit (See Table 3)

Based on a cost-benefit analysis, a very small number of infections would be potentially averted for a very high cost. This holds true even in locations with higher rates of HIV prevalence, as many persons who present for treatment are already infected at the time of assault.

What we need to know to make effective public health and clinical decisions

It is questionable whether it is feasible to study PEP efficacy in cases of sexual assault. Studies must be designed ethically, and factors such as sample size, cost, and timeliness must be taken into account. Since both the occupational efficacy data and animal studies suggest that PEP more than 72 hours after exposure is unlikely to be protective. One possible design is to provide PEP to all assaulted persons presenting for care with 72 hours of the assault and providing no PEP (but all other treatments and services) to those presenting for care after 72 hours. However, even with this perhaps ethical design, extremely large sample sizes would be required.

In addition, research needs include gaining a better understanding in specific locales of:

- how many HIV infections occur as a result of sexual assault.
- seroprevalence rates among sexually assaulted women, men, and children
- the rates of sexual assault on men.
- seroprevalence among assailants.
- comprehension necessary to make an informed choice about PEP during a stressful time.
- rates of disclosure and support received (rape, HIV test result, PEP).
- services necessary to support good adherence to PEP.

Final thoughts

Many modelling exercises give the message that sexual-assault survivors need to be treated even if it is not of proven efficacy and not cost-effective. This idea seems to be developing into an ethical mandate of sorts, regardless of the data. It is troubling to draw a distinction between those who are "innocent" in their exposure (sexually

assaulted women and children) and so "must" be treated regardless of any other considerations and those who are "guilty" or complicit in some way (consenting casual sex partners) and so may not be treated. Treatment is ethically mandated only if the treatment is known to be effective, the proven indication is present, treatment is available and affordable, and the benefits of the treatment outweigh the risks and costs.

The potential benefits of PEP in the sexual assault situation are unproven at this point and may be limited to a very small number of persons. The potential risk to individuals treated may be low because of the short duration of drug treatment, but the potential risks and costs for PEP as a population strategy may be high.

Table 1. Studies of HIV Infection Among Sexual Assailants

Author	Population	HIV Prevalence	
Di Giovanni	Male sex offenders in a Maryland treatment clinic	0%	(0/49)
Larkin	Male sexual assault suspects in Oakland ER	10%	(2/20)
Spaulding	Males charged with sexual assault in RI	0.8%	(11/1,422)

Table 2. Studies of PEP use in Sexual Assault Survivors

Author	MEDS	Started PEP		Completed PEP	
Opio	2 NA ± PI	6/34	18%	0/34	0%
Babl	2 NA + PI	10/?		2/10	20%
Benais	2 NA + PI	100/2,550	0.3%	??	
Weibe	2 NA 71/160	44%	8/71	11%	
Livrozot	2 NA + PI	35/56	63%	<15/35	43%
Myles	2 NA	69/213	32%	<26/69	38%

Table 3. Modelling Potential Benefits of PEP Following Sexual Assault

Assumptions	"Expected"			"Extreme"		
Ratio of sexual assaults reported/not reported	1/10	1/10	1/10	1/35	1/35	1/35
Proportion of sexual assaults reported	0.10	0.10	0.10	0.03	0.03	0.03
Proportion presenting for care <72 hours	0.60	0.60	0.60	0.75	0.75	0.75
Proportion without HIV infection at time of sexual assault	0.80	0.80	0.80	0.65	0.65	0.65
Proportion offered PEP	0.90	0.90	0.90	0.50	0.50	0.50
Proportion starting PEP	0.50	0.60	0.95	0.50	0.60	0.95
Proportion exposed to HIV (assailant HIV infected)	0.20	0.20	0.20	0.40	0.40	0.40
HIV per act transmission rate without PEP	0.015	0.015	0.015	0.030	0.030	0.030
PEP agent(s) used	HAART x28d	Combivir x28d	NVP x2doses	HAART x28d	Combivir x28d	NVP x2doses
Proportion completing prescribed course	0.20	0.30	0.95	0.20	0.30	0.95
PEP efficacy	0.95	0.80	0.50	0.95	0.80	0.50
Rate of fatal drug reactions						
Suicide rate (e.g., among survivors already HIV infected)						

chart continues

Suggested reading

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Low-Beer S., Weber A. E.,

Results						
# Sexual Assaults/yr	700,000	700,000	700,000	2,000,000	2,000,000	2,000,000
# Reported Sexual Assaults/yr	70,000	70,000	70,000	60,000	60,000	60,000
# Presenting for care <72 hours	42,000	42,000	42,000	45,000	45,000	45,000
# Offered PEP	37,800	37,800	37,800	22,500	22,500	22,500
# Starting PEP	18,900	22,680	35,910	11,250	13,500	21,375
# Completing course of PEP	3,780	6,804	34,115	2,250	4,050	20,306
# Initially seronegative	3,024	5,443	27,292	1,463	2,633	13,199
# Exposed to HIV	605	1,089	5,458	585	1,053	5,280
# HIV infections expected to occur	9	16	82	18	32	158
# HIV infections potentially prevented	9	13	41	17	25	79

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Services for raped women

Presenter: Dr W. Taylor, University of Hong Kong, Hong Kong

In order to ensure that the discussion around the provision of PEP to rape survivors would be grounded in the reality of services, this presentation described existing services for raped women in the United States of America.

It outlined typical types of services provided by the sexual assault nurse examiner/sexual assault response team (SANE/SART) programmes which provide holistic, comprehensive, and sensitive services for women who present themselves for treatment after having been raped. These services include crisis intervention, forensic evidence collection, medical evaluation, and appropriate referral to rape counselling or rape advocacy programs, legal services or other community agencies as appropriate to the victim and situation.

When a person is raped they may interact with and/or utilise the services provided by any or all of the following agencies and programs:

- Law enforcement - It is the responsibility of the police to take the victim's statement; protect the victim from further harm; transport the victim to a SANE/SART program, rape treatment centre or hospital for treatment if for example they respond to the scene of the crime; and initiate and conduct the investigation [1,2].
- Paramedics - Depending on the extent and seriousness of the injuries, the victim may or may not need the services of paramedics. In cases of severe injuries, the paramedics are called to the scene to treat the victim's injuries on site. They then transport the victim to the emergency department for further evaluation, treatment, evidence collection, and referrals [2].
- SANE/SART Programmes - The SANE conducts the forensic interview with other members of the SART (typically members include the SANE, police, and rape advocate/counsellor); the SANE conducts the forensic exam and collects the evidence, provides pregnancy and STD testing and prophylaxis as appropriate and per protocol; the SANE may treat minor injuries or refer for medical evaluation and treatment as necessary; initiate crisis intervention; provide appropriate follow-up instructions and referrals [1,3,4,5].
- Advocacy Programmes [1]
  - Counselling programmes - Rape counselling programs provide counselling services for rape victims The rape counsellor/advocate meets the victim at the treatment program and stays with the victim until she/he is discharged. The role of the counsellor/advocate is to be supportive and comforting to the victim.

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The rape counsellor/advocate may also be available to accompany the victim to court if the case goes to trial.
- Court advocacy programmes - These provide information on a person's legal rights, how to exercise those rights and assist the person through the legal system. Some court advocacy programs have advocates who are available to accompany the victim to court.
- Victim/Witness programmes - In many jurisdictions crime victims are entitled to compensation. However, in order to be eligible for compensation the victim must file a police report and co-operate with the prosecutor's office.

- Criminal Justice System - It is the responsibility of the criminal justice system to prosecute the case providing there is sufficient evidence [1].
- Forensic exam. An uncomplicated forensic exam can take 3-4 hours and consists of the following steps [1, 2, 6 4, 5, 3].
  - Obtaining consent for treatment, photographs, and releasing evidence to police.
  - Crisis Intervention.
  - History and physical exam.
  - Evidence collection (maintaining chain of custody).
  - Photographs.
  - STD testing and prophylaxis.
  - Raise the issues of HIV. Some programs screen as a routine, others do not; some will screen at the patient's request. Patients can also be referred to an HIV clinic for anonymous and confidential testing.
  - Pregnancy testing/prevention.
  - Treatment of injuries.
  - Follow up which includes information on types of tests performed (pregnancy, STD testing), important telephone numbers (program, police, hospital, etc)

  types of medication prescribed, etc.
  - Written referrals are given for counselling programs, follow-up appointments, shelter, legal advocacy programs, victim/witness programs, and other community agencies as appropriate.

There are a number of issues that would need to be considered carefully if PEP was to be integrated into existing services [7, 8, 9, 10]:

- Clients should be informed about their risk, testing, and safe sex options. Currently, it is recommended that patients have a base-line test as soon as possible after the rape, get re-tested in 3 months, 6 months and 1 year.
- Assess the client's risk factors which include the following:
  - sodomy;
  - presence of other STD's;
  - vaginal injuries (tears, lacerations etc);
  - perpetrator is HIV +, an IV drug user or bisexual.
- Recommend PEP if the assailant is known to be HIV+.
- Assess the client's health status for possible side effects, compliance and follow-up.
- Cost-Currently most programs cannot afford PEP as it is expensive. If the program decides to offer PEP then it would be necessary to include this as a budget item. Another option is to have a referral policy with an agency that does testing and has counselling services available for pre and post exposure.
- Research questions that need to be answered include:
  - the number of rape victims that seroconvert;
  - long-term toxicity of PEP;
  - safety of combined antiretroviral therapy;
  - effectiveness of therapy.

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Rape and HIV post-exposure prophylaxis: its relevance and reality in South Africa

Presenter: Dr. J. Kim, University of the Witwatersrand, South Africa

Internationally, there has been growing interest regarding the provision of anti-retroviral therapy (ART) to reduce the risk of HIV transmission following sexual assault.

This interest has evolved in light of scientific evidence that such drugs can be both safe and effective when used following occupational exposures, such as needle stick injuries to healthcare workers [1, 2]. Moreover, strong scientific evidence supporting the impact of ART in the prevention of mother-to-child transmission in both developed and developing country settings [3, 4] have added further argument to the biological plausibility of such therapy in other exposure settings. However, at the present time, there are no conclusive data on the effectiveness of ART in preventing HIV transmission after non-occupational exposures.

Given the lack of research evidence, questions remain as to both the efficacy and effectiveness of providing ART following sexual exposure. In this context, the CDC has recently stated that "because the therapy remains unproven and can pose risks, physicians should consider its use only in individual circumstances when the probability of HIV infection is high, the therapy can be initiated promptly, and adherence to the regimen is likely. It should not be used routinely and should never be considered a form of primary prevention" [5].

Yet in spite of this lack of conclusive evidence or definitive recommendations, several centers have begun to offer post-exposure prophylaxis (PEP) following non-occupational exposures, and to develop their own guidelines and protocols. These efforts have been based both on the existing evidence supporting PEP in the occupational setting, and the biological plausibility that extending PEP to non-occupational settings might confer similar protective effects. Simultaneously, research initiatives are being planned in an effort to address the existing gap in empirical evidence.

Most of these interventions and research initiatives have arisen in the context of the more industrialized countries in Europe and North America. Yet it is estimated that 95% of people infected with HIV, and 95% of the lives claimed by AIDS since the beginning of the epidemic, live in developing countries [6]. Given that the global burden of HIV/AIDS is by far concentrated in developing countries, and that high levels of sexual violence have been reported in many of these high prevalence countries [7, 8] there is an urgent need to understand the implications and potential impacts of such nascent initiatives in the context of developing countries.

This document aimed to explore the issue of rape and PEP from the perspective of South Africa. It did not attempt to present a comprehensive overview of the scientific evidence relating to this issue, but rather, is focused on raising some of the key questions and concerns which are of relevance in less developed countries. It began with a situation analysis describing what is known about the prevalence of both HIV and sexual violence in South Africa and the current state of services for survivors of sexual violence. It then described several initiatives currently underway to provide PEP following sexual assault. In addition to reviewing the literature, 18 key informants were interviewed either in person or telephonically in order to draw from perspectives ranging from survivors of sexual violence, gender violence NGOs, rape care providers, physicians, lawyers, researchers and HIV/AIDS advisors within the National Department of Health.

Finally, drawing on insights gained from the above, key issues relating to both intervention and research initiatives were highlighted, with special attention to their technical, policy and ethical implications.

Technical considerations

An overview of key factors considered to influence the **potential efficacy** of PEP following sexual exposure, and their application in the context of South Africa, were explored. These included:

- the probability that the source contact is HIV-infected;
- the likelihood of transmission by the particular exposure;
- the interval between exposure and initiation of therapy;
- the efficacy of the drug(s) used to prevent infection; and
- the patient's adherence to the drug(s) prescribed.

In regards to an efficacy study of PEP, although the details relating to study methodology and sample size calculations were beyond the scope of this presentation, the large number of study participants who would need to be enrolled and followed-up were raised as a potential concern. However, others pointed out that because of the high prevalence of both HIV and sexual violence, South Africa represented one setting where adequate sample sizes could, at least theoretically, be obtained.

Beyond the question of efficacy, several related research issues were raised, such as:

- What is the baseline risk of HIV transmission following rape, as opposed to consensual intercourse?
- What percentage of those who present for post-rape care are already HIV positive?

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- How are they able to cope with learning of their HIV status at this time, and how best can they be supported?
- When is the best time to perform VCT in the context of PEP? During the initial presentation, or later on?
- What are the potential broader prevention impacts of providing VCT in the context of PEP?
- What are levels of patient adherence to therapy, and does this differ from other PEP settings? (e.g., occupational exposures, low HIV prevalence countries)
- What impact (positive or negative) does PEP have on the provision of other services and sectors relating to post-rape care?

Policy considerations

From a policy standpoint, the need to weigh not only the potential biomedical benefits of providing PEP, but also the potential for associated broader impacts which such a policy might have on ongoing efforts to address both sexual violence and HIV/AIDS was highlighted. For example, while many of those interviewed acknowledged glaring deficiencies within existing systems to address sexual violence, many also expressed the belief that, given the current crises of both sexual violence and HIV/AIDS, reform of such systems should be regarded as a concurrent goal - rather than a precondition - to providing PEP following rape. Therefore, in addition to potentially reducing the immediate risk of HIV transmission following rape, efforts to provide PEP in South Africa should also be viewed as an opportunity to raise the level of skills and awareness among those sectors currently working with survivors of sexual violence – such as the police, judiciary, and health services.

The broader policy environment concerning HIV control efforts in South Africa should be taken into consideration. Many of those interviewed pointed out that PEP research initiatives must be developed in close collaboration with government, in order that research findings be raised and acted upon at policy levels. Concern was voiced that research initiatives sponsored by pharmaceutical companies might generate some degree of scepticism or mistrust due to perceived conflicts in motivations and agendas.

Furthermore, the concern was voiced that a failure to document efficacy of PEP (even if due to technical limitations, such as sample size) could effectively shut down further discourse around PEP, and thus efficacy research should only be embarked upon after careful consideration of its feasibility.

Ethical considerations

PEP should be seen as one part of a comprehensive approach to the care of rape survivors. Thus in addition to the need for adequate research infrastructure, the strengthening and development of service infrastructure (such as 1-stop rape crisis centers), was viewed as a critical consideration to embarking on efficacy studies or related research.

The provision of PEP following rape should extend beyond the narrow conception of rape as a violent assault perpetrated by a stranger, and should be sensitive to the broader dimensions of coerced and forced sex in South Africa. Forensic examination and legal reporting should not be pre-conditions for receiving PEP.

Informed consent, including the lack of current evidence of efficacy, should be a standard component of any PEP protocol. Those who test HIV positive at initial screening should be offered adequate support and access to the current standard of care for HIV-positive patients in South Africa.

Pending further research, policy decisions concerning the provision of PEP should not assume that dual- or triple-drug antiretroviral therapy must be the standard of care in South Africa. Furthermore, PEP trials conducted in South Africa should not evaluate drug regimens, which, for economic or other reasons, stand little chance of being implemented locally. Given the potential difficulties noted with adherence to a 4-week drug regimen, evaluation of shorter drug regimens and alternative, potentially cost-effective drugs (such as Nevirapine) should be considered.

Equal access to PEP services is an important consideration, both in regards to the ability to pay for drugs, and to broader resource and infrastructure constraints in rural settings. Accessibility between, as well as within nations is an important ethical consideration. As with access to ART for prevention of vertical transmission, and for routine management of HIV-positive individuals, there is the real concern that, irrespective of further efficacy research, such inequalities between developed and developing countries may also govern accessibility to PEP.

5 Discussions and recommendations, including key research questions and potential methodological approaches

HIV postexposure prophylaxis (PEP) and Sexual Assault: A brief Overview

Four working groups were formed and participants sought to identify key research questions, suggest possible study designs and discuss ethical and methodological issues. The groups were on:

- Partner violence and HIV risk
- Childhood Sexual Abuse (CSA) and HIV/AIDS risk
- Violence in the context of HIV testing and disclosure
- Violence and HIV/AIDS in the context of sex work, trafficking and migration.

This section attempts to capture the discussion and summarizes the outcomes and recommendations of the four working groups for post-exposure prophylaxis. Key research questions and priorities are identified and methodological considerations addressed in each of the areas.

General recommendations and methodological issues

- Better estimates of the magnitude of sexual violence are needed. This requires methodological work on how to conceptualise and measure sexual coercion, assault, etc. How can the spectrum of coercion be described so that when the questions are asked in surveys they can be asked in an appropriate way (i.e. how best to elicit types of things women and men say and do to each other).
- Research should look not just at presence of violence and HIV/AIDS but at how frequency and severity of this violence relate to HIV/AIDS.
- There is a need to develop a short list of questions on VAW, particularly forced sex that could be integrated into planned studies on HIV/AIDS. There is also a need for questions on HIV to insert into surveys about forced sex/sexual violence.
- Research should involve different types of population (including men, by education, income, relationship types) and in different socio-legal contexts as this also influences risk of HIV transmission. There is also a need for more cross/cultural studies (must define measures clearly; understand which questions are best asked qualitatively/ quantitative; which questions are amenable to ecological vs. individual investigation).
- Recommendations need to be practical and sensitive to resource availability so as to reach national AIDS programme managers,

clinicians and policy makers and to be meaningful for resource-poor areas.
- Research results should be disseminated to affected communities as well as professional communities, and linked to public health and social action.
- Research should build on ethical and safety issues already identified for research on domestic VAW (see *Putting Women First: ethical and safety guidelines for research on domestic violence against women. WHO, 2001*)
- Men and their relationship to violence as a legitimate form of expression of control over women needs to be researched as a cause of violence.
- Studies of violence after HIV/AIDS have not always taken into account violence victimization before diagnosis. This has implications for many related issues, such as how living with violence may affect how a woman is able to attend to her own HIV-related needs.

Interventions and interventions research
- Need to understand the impact of interventions challenging inequalities, e.g. do interventions addressing women's low status, lack of economic power, etc. affect partner relationships and communication, sex trafficking, as well as prevention of HIV and other STIs?
- How to integrate screening and management of violence issues into ongoing HIV and other RH activities.
- Funding for intervention research should ensure a strong formative research component as well as an evaluation component.
- Participatory research is important in intervention development, and researchers and funders need to be willing to follow through with the outcomes and priorities as identified by the participants/communities themselves.

5.1 Partner violence and HIV risk [1]

The group developed a tool for understanding the interlinkages between VAW and HIV/AIDS, looking at resilience and risk factors for HIV transmission and violence (see Annex 1). They also located key research questions within this.

Key research questions
- Is the relationship between violence and HIV risk causative or associative? How much violence can be attributed to HIV and how much is a continuation of ongoing violence?
- What are the different forms of sex (and coercion/abuse) and their relative risk for
- HIV acquisition in relationships? (i.e. anal sex in marriage)
- What are the resilience factors in relationships (e. g. where there is no violence, or where women are able to leave violent relations).
- Studies in more representative samples are needed on how and why fear of the partner's reaction is a barrier to testing.
- How does violence limit a women's abilities to treat STIs (seeking health care, disclosing STI to partner, encouraging treatment in partner).

Research questions related to interventions
- What can help people effectively talk about condom use? And how can support systems for women who want to negotiate safe sex be created?
- What are men's attitudes toward condom use with different types of partners?
- What interventions can be carried out with men who learn they are HIV positive to decrease sexual violence?
- What can be done structurally to reduce violence? (These approaches should be context-specific and creative, e.g., legal interventions to address issue of teachers having sex with students in South Africa).
- What are the best ways in different cultures to get the message about violence out?
- How can the perception that women are sources of infection for STI/HIV be changed?
- How can people living with HIV be more effectively involved in intervention efforts?
- How can women who have been abused be more involved in interventions?
- How do we intervene early enough to change norms in adolescent sexuality?
- What are the differences between men and women in terms of how they frame risk and vulnerability?

5.2 Adolescents and forced sex

This emerged as a key issue needing further investigation. Forced first sex has been identified as a high risk factor for HIV and there is growing evidence that first sex may often be forced or coerced. Age at first sex is also related to factors affecting HIV transmission; early first sex leads to early pregnancy and longer risk and exposure to HIV. There is a need for more research (qualitative and quantitative) on sexual debut and early sexual experiences, in particular the degree to which force, coercion and power differentials are involved.

Key research questions
- What are the contexts and precursors of initiation into sexual life?
- How can early sexual behaviour be delayed?
- What proportion of first sex is unwanted/unexpected/economically motivated/forced through social expectation/force?
- How do early sexual experiences affect HIV risk and sexual life course?
- What are adolescents willing to put up with in order to have status in relationships? What are risk factors for teenagers' sexual abuse?
- Within a context of consensual sexual relations does fear of violence contribute to young girls' risk for HIV?

5.3 Childhood Sexual Abuse (CSA)

Key research questions
- How can interventions be developed in settings where children are at high risk for sexually transmitted HIV infection, such as regions with a high prevalence of orphans and other unsupervised children living on the streets?
- How do strategies of resistance to abuse lead to increased HIV risk?
- Does CSA predict HIV risk behaviour across cultures and socio-economic position?
- How do long-term coping/compensatory strategies (e.g. drugs/sexual "acting out") lead to increased risk? Does CSA have an independent (biological) effect on HIV risk in adulthood? (beyond mediating risk behaviour). Is the risk due to the abuse, per se, or the context of the abuse (is it confounded by household characteristics, or characteristics of the perpetrator for example)?
- To what extent do characteristics of the abuse experience (e.g. relationship to perpetrator; penetration; support post-trauma) predict severity of outcomes?
- To what extent do variations in cultural attitudes towards abuse (that sanction, deny, condemn (perpetrators), or stigmatize (victims)), imply different interventions?
- And to what extent do normative contexts shape biological responses to trauma?
- How does the life course of child victims who do not engage in risk behaviours differ from those who do? What can be identified that prevents long-term adverse sequelae?

The definition of CSA included child maltreatment and forced sex in the context of sexual initiation. Although data are lacking on long-term risk-related sequelae of early sexual abuse across different countries and different cultures, it was felt that intervention research - beginning with formative stages - is important for primary prevention of the abuse itself. Thus, in places where forced sex of children and teenagers is regarded as "normal" (i.e. part of "cultural/gendered" patterns of behaviour), or at any rate ignored, how to influence these patterns was discussed.

Interventions research

The focus of research recommendations in relation to prevention and management of childhood sexual victimization was on populations most at risk for early sexual abuse. Intervention research was proposed among the following populations:
- Children and teens living in high prevalence areas where sexual initiation tends to be coercive and this coercion is socially justified or ignored for example, in parts of South Africa, India.
- Orphaned and unsupervised children who live mostly on the streets and/or in foster homes and turn to sex for their own survival, such as has been observed in India, Thailand.
- HIV-positive women and men (and adolescents) who have experienced coercive sex as children and young teens. These interventions emphasize secondary prevention of early abuse sequelae, including HIV-related morbidity, by treating the emotional damage due to the abuse.
- NGOs and other community agencies that include a mission to support children and women who have been raped or in other ways experienced sexual victimization. Whether HIV-positive or not, evidence is consistent that these early abuse experiences can lead to high risk coping strategies, and we do not know what kinds of recovery strategies may prevent HIV-risk related behaviour.

[1] The area of partner violence and HIV risk is broad in scope and can include violence from a sexual partner in any number of different relationships from adolescence to adulthood. For that reason, there may be some overlap with the other priority areas which are more focused.

For populations 1 and 2, there was a discussion on the optimal utilization of existing anti-violence infrastructures and the creation of new ones where non-existent. Part of the formative work would include conducting qualitative research to learn about the availability of anti-violence services and the feasibility of developing these services where they are lacking.

A second formative stage design proposed, is group interviewing of girls and adolescents with respect to forced sexual experiences: their occurrence; effects on girl's self-esteem and sense of bodily control and integrity; context of this (sexual) experience and characteristics of male perpetrators. The need to offer separate discussions with boys who have been victimized was also raised.

A third formative stage design is to conduct group interviews with adolescent boys to learn of their belief systems regarding coercive sex against women.

Through qualitative research it should be possible to learn the strategies that victims and children/teens at-risk for victimization have used or considered to protect themselves and what service provisions to develop for violence prevention. Need to consider what research strategies are needed to understand the benefits and risks of disclosure of coercive sex (will the children be able to articulate these issues?) and what other sources of information are available that will provide valid information on the psychosocial rewards and costs of coercive sex against young people.

For quantitative analysis studies that follow cohorts of previously untreated women and children with respect to abuse trauma could introduce a randomized trial of interventions intended to directly address recovery in a context of HIV prevention in addition to the routine counselling programme; whereas another group would receive whatever the usual counselling programme is. Following teenage and adult women, in particular, over a few years to evaluate efficacy of different kinds of psycho-educational, spiritual, and economic interventions, is a priority area for research. In most places in the world, there are more women and children who have experienced sexual trauma than who have HIV infection. This is a large group to target for both HIV prevention as well as prevention of revictimization.

5.4 Voluntary Counselling and Testing and Disclosure of HIV serostatus

The discussion identified that women who suddenly get beaten as a result of disclosure are probably an exception. It is more likely that a woman who is beaten in this context is living in a violent relationship already. In this case HIV and violence may co-exist and not be causally related. The following points on testing and disclosure were highlighted:

- It is important that both the benefits and risk resulting from disclosure are discussed and that confidentiality is maintained, especially where counsellors (nurses, doctors) live in same community.
- The gender dimensions of disclosure should be a consideration in all research studies. If it is the husband who makes the decision to go for testing for himself and/or his wife, then he is the one who will be informed. Interventions need to consider gender inequalities and how to address power dynamics. They should also address misconceptions, e.g. that whoever is tested first is the one who infected the other.
- To really understand the effects of disclosure studies, a longer follow-up is needed. For instance, it is possible that the threat of violence may increase as a women becomes sick. Women who are counselled not to disclose may experience long-term changes in the relationship with their spouse, especially as their health status changes.

Key research questions

- To what extent do women control disclosure in different settings such as: voluntary counselling and testing (VCT), clinical or mother-to-child-transmission (MTCT) settings?
- How can women be helped to assess the risks and benefits of disclosure and to whom they should disclose?
- What disclosure strategies can be used to minimize adverse effects? For example, develop and test risk assessment tools to assess for violence from significant others, partners, extended family? There is a clear need to measure experiences with and attitudes towards disclosure.
- What additional counselling/follow-up is needed after post-test counselling? For example, in rapid HIV tests where a woman might be visiting only once and a proposed strategy for disclosure is found not to work, how can further support be facilitated?

- If the majority of partners are supportive after their wives disclose positive HIV status, what then are the resilience factors? What enables the majority of women to have supportive partners and how can this be integrated into the VCT process?
- What are the cultural, ethical, legal, and social implications of disclosure and VAW?

In relation to counselling and training for counselling the following issues were identified as needing further work:

- What training is needed to assure quality counselling? How do we assess the quality of counselling in different cultural settings? Do models developed in the West work in other settings?
- What are the predominant provider attitudes about disclosure and what is the impact of this on training physicians, nurses, NGOs etc? Is there a need for gender specific guidelines in some settings?
- How can a violence awareness component be included in counselling?
- What best practices exist for disclosure and for violence prevention?
- What are the special needs of couple counselling? How can we reduce violence when test results are disclosed to couples simultaneously; how can this be dealt with when one is positive and the other is not? Compare how many women and men come back for results. There is a need to do research on the responses of men who find out they are HIV+ and how they react (i.e. regarding issues of fidelity. Does he think the woman infected him?
- How can we educate men to reduce violence following disclosure?
- What are the implications of the sites where testing is taking place? (for example in Africa, men began believing that pregnant women are a source of HIV, which affects risk perception and the ways men react).

General recommendations for VCT

- Develop and test risk assessment tools to assess for violence from significant others, partners and extended family to be used in VCT settings.
- Evaluate existing pre and post HIV test counselling (training and protocols) for quality, including attention to risk of violence (for example see quality assessment protocol for HIV counselling developed by J. Kim). Based on evaluation, modify accordingly.
- Develop guidelines on how to manage disclosure of HIV status (where to disclose, how, to whom) so as to minimize adverse effects. (These are necessary not only for physicians, but also laboratory technicians, counsellors and others.)
- Develop a study to measure experiences and attitudes of women and providers towards HIV disclosure. A possible study design was presented (see Annex 2).

Methodological issues

Issues related to disclosure of HIV serostatus may be best examined using an approach combining qualitative and quantitative research methods. Qualitative research, including focus group discussions and in-depth interviews, involving clients of VCT services (women and men; HIV positive and negative), who may be recruited through community organizations, support groups, hospitals, antenatal clinics or VCT clinics, and health care professionals participating in VCT may be used to explore the circumstances under which disclosure occurs, the dynamics of decision-making related to disclosure and the consequences of disclosure. Based on these results, a cross-sectional survey may be conducted to further explore gender differences in disclosure experiences and disclosure practices. Qualitative research may also be used to help interpret the results of quantitative studies. The goals of the above research are to 1) develop VCT training protocols for health care professionals, including a violence screening tool; 2) modify existing VCT protocols to include a violence screening tool and to ensure gender-sensitivity; and to 3) evaluate VCT training and practice. Evaluation of the VCT violence-screening tool is necessary, and may be conducted at multiple sites with high HIV test volumes in a relatively culturally homogenous locale. Issues to focus on are:

- Whether screening tests are possible/feasible?
- Whether there are differences between settings where rapid testing is and is not available.
- Strategies to follow up clients who do not return for test results/counselling.
- Whether violence screening should be done at post versus pre-test counselling?

Finally, the screening tool needs to be validated for sensitivity in the context of:

- Physical violence
- Sexual violence
- Fear of violent actions

5.5 Trafficking, migration and sex work

The discussion highlighted that:

- Health providers are sometimes not aware of the specific context relating to trafficking – and may, for example, give HIV status of a woman to a brothel owner and not to the women concerned.
- Police are significant perpetrators of violence in cases of sex work.
- Donor-driven agendas sometimes take precedence over actual findings – donors need to be educated to broaden the intervention focus. For instance working with youth in interventions not directly linked with HIV will have an impact on HIV.

Key research questions

- What research methodologies/approaches/safety and ethical considerations are most effective in working with trafficked persons and undocumented migrants?
- Why are girls and women immigrating and taking risks and to what extent does violence contribute to the movement of women and girls into sex work/migration/trafficking/street life?
- What do trafficked and migrant girls and women want in relation to: reproductive health, safety, security, and legal rights? What are the psychological and mental health concerns of violence among trafficked girls and women? What health/reproductive health/HIV/AIDS strategies have worked with trafficked persons, sex workers and migrants, especially with illiterate populations? What are the types of violence and their effects on safer sex practices?
- How does the impact of violence in the lives of girls and young women make them vulnerable to migration and trafficking?
- What are the realities and concerns of girls and young people migrating to domestic service and factories?
- What are the realities, concerns and needs of women who have left sex work and can they be involved in community work on issues of migration, sex work and health?
- Who is profiting from sex work, migration and trafficking? Who are the clients?
- What are the protection issues and safest ways to reach trafficked persons?
- What are the points of access/opportunities to reach trafficked persons and migrants?
- What are the implications of decriminalising prostitution? How have existing laws affected trafficking and migration?
- How can violence be addressed in the context of trafficking and migration? How can girls and women be empowered from their own perspectives?
- What have been the effects of "rehabilitation" programmes? What are protection issues?
- What health information do migrant women need that is relevant in the context of their lives?
- What services and information are available to migrants? Trafficked persons?
- How can we offer more relevant and applicable safe practice information?

Recommendations from discussion

- Review of interventions to identify what has worked and lessons learned in different settings: establishment-based, street-based, casual sex, trafficked women, clients.
- Intervention methodologies – ways to access and to obtain the perspectives of sex workers/trafficked girls and migrants.
- Strategic approach to planning interventions on sex work/trafficking and migration – guidelines and tools must take account of context (legal/regulations/cultural); the same is true for interventions and research strategies.
- Consolidated review of legal frameworks and their impact: lessons learned, applications, and implementation. (No consensus on this).

5.6 Rape and Post-Exposure Prophylaxis (PEP)

Objectives

The objective of the consultation on PEP was to review the available evidence on the effectiveness of PEP following rape, and other relevant issues to do with its delivery, adherence and compliance and costs, and to explore the possibility for conducting research to formally assess effectiveness, and consider the types of facilities and other resources necessary to provide PEP appropriately.

A discussion was held on the same day with the Scientific and Ethical Review Group (SERG) on the ethical issues that may arise in conducting research on PEP. SERG's advice was specifically sought on the ethics of conducting a placebo controlled trial.

Background papers were commissioned on the current state of knowledge on the effectiveness of PEP for preventing HIV infection following rape, on the incidence and context of rape in South Africa, and services for raped women.

Background

There are no data available on the effectiveness of PEP following sexual exposure. Only a single study has been conducted on the effectiveness of prophylaxis with Zidovudine (ZDV) for preventing HIV infection among health care workers exposed to the virus through needle stick injuries. In this case-control study, a one-month course of ZDV was shown to reduce the risk of seroconversion by 80%. Treatment compliance, even among occupationally exposed health care workers, was low. This single study is the basis for recommendations for occupational exposure to HIV, and detailed algorithms have been developed to assess the likelihood that the source was infected with HIV and the degree of contamination and extent of injury suffered. Such algorithms are designed to facilitate clinical decision making according to the likelihood of seroconversion. Regimens based on combination ARV regimens are also used in certain circumstances, in particular when the source may be infected with a certain strain of HIV known to be drug resistant.

The results from this single study have been used as the basis for assuming that PEP will also be effective in preventing HIV infection from sexual exposure, and for assuming that other ARV regimens are also effective. There is however, no direct evidence that the ARVs actually are effective in these situations. There are also differences related to transmission routes as different immune mechanisms are involved in response to mucosal versus parental exposures.

In some developed countries, namely Canada, the USA (some states) and France, victims of rape are beginning to be offered PEP as part of rape care services, although this is not yet official policy or standard practice. This is being done using similar algorithms assessing the extent of exposure and the likelihood that the source was infected with HIV. In some developing countries, like South Africa and Brazil, it appears PEP is being provided in an ad hoc manner and mainly by private providers. Expanding such care to rape victims in developing countries raises many complex issues, and can become highly politicized, as is the case in South Africa.

Key Issues arising from presentations and discussion

- Physicians in South Africa and a few other countries are already providing PEP to rape survivors in ad hoc ways; there are no mechanisms to monitor usage, compliance or effectiveness of PEP.
- A range of ARV regimens are used, with little guidance on reasons for choosing between regimens.
- In the absence of guidelines for sexual exposure to HIV, the well-publicised occupational exposure guidelines are used, even though the risk of transmission is different and experts do not believe that these guidelines are necessarily applicable in the same way for sexual exposure.
- The likelihood of seroconversion following consensual sexual exposure is estimated to be about 3 per 1000 cases (data from discordant couples). It is assumed that non-consensual sexual exposure will carry a higher risk of seroconversion, and gang rapes higher still, though there are no data to substantiate this assumption.
- Uptake of PEP and treatment compliance is reported to be low in developed countries following occupational exposure, even where risk of seroconversion is high and efficacy has been demonstrated. The assumption is that these may be similarly low in rape victims, although it is difficult to generalise uptake and compliance to completely different situations and locations.
- PEP registries have been established in a number of developed countries, e. g., USA, France and other European countries - but at present the number of cases is low, except for France where they have large numbers. The problem is the lack of coordination across registries in terms of data collection instruments and methodologies. Resources to share successful strategies and training could be useful. Results obtained from such registries may be difficult to generalise to other settings.
- Economics and lack of data on effectiveness of PEP for rape victims do not favour this as a priority public health intervention that would have a major impact on the HIV epidemic. HIV-prevention resources targeted to risk reduction for the 30 or more years of sexual exposure to HIV may have greater impact than resources targeted at an

isolated rape or non-consensual sexual exposure to HIV with an assailant not known to the victim, or a non-regular partner.
- PEP would need to be part of basic high quality services for rape victims, together with STD and pregnancy prevention.
- There are concerns that PEP may be perceived as an alternative to safe sex precautions, which may undermine condom promotion and other safe sex campaigns.

Ethical concerns

- While rape victims in some developed countries (and UN field staff) have access to PEP following rape, victims in developing countries have limited or no access.
- Should PEP be offered to all rape victims, or just those known to be HIV negative? The period immediately following rape is not necessarily optimal for HIV pre- and post-test counselling and can be perceived as a further assault on the victim.
- Should PEP be provided to rape victims, even in the absence of well-functioning services for rape victims? Is this an essential requirement or an unnecessary barrier to PEP access?

Research issues

- Since ARV regimens are not registered for this indication, PEP can only be provided as part of a research project in many countries.
- Is research on effectiveness necessary, given the existing indirect evidence from occupational exposure and prevention of mother-to-child transmission?
- Randomised placebo-controlled study would give clear answer on efficacy, at considerable expense. Sample size would be very large (it would require 5.000 to 10.000 HIV-negative victims raped by suspected or known HIV-infected assailants; comparison of the effectiveness of different ARV regimens would require even larger sample size).
- This would be similar for a study assessing effectiveness according to different levels of compliance.
- Observational studies have problems of bias and may be difficult to adjust for.
- Children who have been raped would be particularly suitable for research (likely to be first exposure to HIV, may have higher rates of seroconversion than adults), but ethical concerns related to consent are particularly difficult. While studies designed to recruit only minors may be difficult and unacceptable, child victims should not be excluded from a research protocol.
- Criteria for choosing sites would be a high incidence of rape and a high HIV prevalence, good/adequate services for rape victims and good research infrastructure and follow-up facilities. An obvious choice is South Africa plus another location in the Africa region, but it would be important to involve at least two non-African sites (Asia and Latin America) to facilitate generalisation.
- Rapid HIV testing would be necessary (two independent tests performed simultaneously) to ensure that only those testing negative receive intervention.
- The minimal duration of follow-up in order to establish efficacy would need to be determined.

Possible study designs

- Historical – establish rape services including counselling, forensic test, etc while collecting baseline data. Then after a period of time introduce PEP as an additional service.
- Placebo-controlled trial not considered ethical by SERG in view of indirect evidence of potential effectiveness. It would be difficult to withhold PEP if requested and difficult to randomise after fully informed consent.
- Women coming in after 72 hours who will not get PEP could be the control arm.
- Cluster – where one set of sites get improved services for rape victims plus PEP, other sites get improved services but no PEP.
  - Difficulties of "contamination" and adverse publicity, particularly in highly controversial areas.
  - Some members of SERG felt that ethics of cluster-randomised trials are no different from ethics of individually randomised trial.
- Observational data through systematic compilation of PEP usage, HIV status and seroconversion rates through registry may be the only viable option with which to proceed.

Policy issues

- It is difficult to develop policy for PEP without evidence.
- HIV is helping to bring rape up on the political agenda, and has highlighted the need to improve services for women who have been raped.

Recommendations for Post-exposure Prophylaxis (PEP)

- WHO should develop a reference document of what issues need to be considered in the development of national policies on the provision of PEP to rape survivors. This should be a document to help governments and policy-makers make informed decisions about provision of PEP. It should be based on a review of existing evidence and of existing guidelines such as those produced by CDC and others and include:
  - review of existing evidence on PEP (effectiveness, costs, adherence, side effects, etc.);
  - issues concerning programmatic complexities of providing rape services and PEP relevance for different settings (e.g. low vs. high prevalence settings).
- Support the establishment of more PEP registries in developing countries.
- Consider strengthening existing registries, encouraging dialogue between existing registries to ensure maximum use of resources and consistent data collection, encourage twinning of developed and developing country PEP registries with possibility of bilateral funding.
- Consider the need to provide technical assistance in communities providing PEP (e.g. 24 hour hotline like the occupational needlestick hotlines in the US), perhaps linked with registry projects - to provide referral information and assistance with providing the service.
- Support further exploration of the feasibility of a study of the effectiveness of PEP as outlined above (historical design). Support research to develop counselling interventions appropriate for the sexual assault setting (e.g. to assist with HIV testing, provide informed consent, etc.).

6 Recommendations to WHO

- Develop guidance on how to integrate research on violence questions into ongoing HIV and other reproductive health studies (e.g. list of questions, probes, factors that increase disclosure) and how to integrate key HIV risk behaviour and outcome measures into violence-related studies.
- Review and distill lessons from existing HIV interventions that have attempted to integrate violence concerns and what lessons have been learned. For example, Soul City in South Africa, South African Men's Family Planning programme, Stepping Stones, VCT Tanzania, training sex workers on self-defence; SHAKTI Project, CARE Bangladesh, street-based sex workers intervention programme.
- Develop guidelines for maintaining confidentiality when providing care and for partner notification and disclosure of HIV status in the context of violence (where to disclose, how, to whom) so as to minimize adverse effects. (These are necessary not only for physicians, but also laboratory technicians, counsellors and others.)
- Develop and test risk assessment tools to assess for violence from significant others (partners, extended family) that can be used in VCT.
- Review different legal frameworks around sex work (decriminalization, criminalising the purchase of sex, criminalising sex profiteering) and its implications for HIV programming, and sex worker safety and well being.
- Review of interventions to identify what has worked and lessons learned in different settings for sex work: establishment-based, street-based, casual sex, trafficked women, clients.
- Develop a source/resource book of participatory exercises that addresses the basics on gender, violence and power for use by community and peer education HIV programmes.
- Explore the feasibility of a study on the effectiveness of PEP.
- Support:
  - innovative intervention research that addresses common underlying factors that contribute both to violence and HIV, i.e. alcohol use, economic empowerment, changing social roles for men, erosion of social capital;
  - research that addresses some of the key issues identified at the meeting, particularly on: sexual debut and early sexual experiences, in particular the degree to which force, coercion and power differentials are involved;
  - issues of child sexual abuse (CSA) including looking at long-term risk-related sequelae across different countries and cultures and possible protective factors.
- Develop a reference document of what issues need to be considered in the development of national policies on the provision of PEP to rape survivors. This should be a document to help governments and policy-makers make informed decisions about provision of PEP. It should be based on a review of existing evidence and of existing guidelines such as those produced by CDC and others and include:
  - review of existing evidence on PEP (effectiveness, costs, adherence, side;
  - issues concerning programmatic complexities of providing rape services and relevance of PEP for different settings (e.g. low vs. high prevalence settings).

Annexes

Annexe A

Tool for understanding resilience and risk factors for HIV transmission and violence

This framework is meant to identify key **intersecting points** where violence against women (be it physical abuse, threats of violence, coercion) may influence the ability of women to protect themselves from HIV infection via the **conventional/available strategies:** abstinence (here expanded to include the ability to choose not only when, but how, and with whom sex happens), monogamy, condom use, and other HIV-related health-seeking behaviours (such as STD treatment, or VCT). It is meant to help focus attention on key issues for research, as well as provoke considerations regarding study methodology, and opportunities for intervention. In all cases, greater understanding of both resilience and risk factors (enabling and disabling factors) is sought. Also understanding the perspectives of both males and females may suggest strategies and areas upon which to focus interventions.

Questions

		Ability to choose when, where, how, with whom	'Be faithful'	Condoms	Other (i. e health-seeking behaviour)
Life stage of girl/ woman	Age, class, whether sex worker, student, married, etc.	A			
Type of relation-ship involved	With spouse, boyfriend, peer, whether other factors: age disparity, authority figure (e.g. teacher)		B	C	D
Types of violence which may contribute and the ways women perceive it	Physical Sexual Psychological Economic			E	
Male perspective on the issue	Attitudes, responses, enabling or obstructing factors				

Examples of research questions which may arise

A: Adolescent girls and age of sexual initiation: to what extent does violence or coercion limit a young girl's ability to choose when she first becomes sexually active?

B: Monogamy and type of relationship: To what extent does violence limit a woman's ability to ask about her partners other sexual partners, and to implement monogamy as a means of HIV protection? How might this vary, for example, between a married or single woman?

C: Type of partnership and condom use – How does violence impact on the ability to negotiate for condom use, for example in peer relationships vs. those where the male partner is much older?

D: Does violence or fear of violence influence a woman's ability to seek STD treatment or VCT services? How might this vary between an unmarried adolescent or an older married woman?

E: Male perspectives and condom use: Resilience factors. In sero-discordant couples, what are the differences between instances where the condom use is successfully negotiated, and when it is not.

Annexe B

Possible research study on disclosure of serostatus

a) Cross-sectional surveys

Men and women

Clients (pos.> neg.)	providers
Ever had HIV status disclosed for them?	• Ever disclosed for someone?
- by whom	• In what circumstances would they disclose?
- to whom	• Attitudes about disclosure.
- violence	

- Among known HIV + clients (NGO, support group, hospital, antenatal clinic…)
- Among test negative population (VCT, antenatal…)
- Among providers in some locale

b) Qualitative research after surveys to interpret results

- Modify existing protocols (gender) based on data from 1 + 2
- Develop training protocol
- Evaluate training (use Julia's model)

  - understand content?
  - demonstrate skills?

In several counselling settings with high volume (one locale)

VCT	Follow-up
Screening tool	disclosure experience
	violence experience
	pros/cons of testing
	pros/cons of disclosure

Replicate for cultural / situational specifics

Locate best practices

Issues

- Are screening tests possible/feasible?
- Difference between settings where rapid testing is available.
- Concerns about follow-up of non-returners
- ECSI concerns – especially regarding confidentiality
- Should screening be done at post or pretest counselling?
- Should pilot elements of the research about which there are procedural or content concerns
- Screening tool needs to be validated for sensitivity
  - Physical actions
  - Sexual actions
  - Fear of violent actions
  - Need for care (= sought)

Annexe C

World Health Organization Meeting Agenda

Monday, 23 October - Issues and current research activity

9.00 – 9:30	Opening sesion
	Welcome remarks Introduction of participants Purpose and objectives of the consultation *Dr. C. García-Moreno*
10.00 – 10:30	Overview of the links between VAW and HIV/AIDS *Dr. C. Watts*
10:30 – 11:00	Coffee Break
11:00 – 13:00	Presentations of current/completed epidemiological research related to violence against women and HIV/AIDS (15 mins each)
	• HIV and violence: The implications of HIV voluntary counselling and testing (VCT), Dar es Salaam, Tanzania. *Dr J. Mwambo*
	• Consequences of announcing HIV seropositivy to women in an African setting: lessons for the implementation of HIV testing and interventions to reduce mother-to-child HIV transmission (MTCT) *Dr P. Gaillard*
	Discussion (20 mins)
	• Study on harassment and HIV prevention of street-based female sex works in Dhaka, Bangladesh. *Dr A. Hoque*
	• WHO multi-country study on women's health and violence against women in Brazil *Dr A. F. Lucas d'Oliveira*
	• Study on HIV/AIDS in four African cities. *Dr L. Morison*
	Discussion (25 mins)
13:00 – 14:00	Lunch
14:00 – 15:45	Presentations on current / completed interventions research related to violence against women and HIV/AIDS (15 min each)
	• Voices for Choices: study of reproductive choices and decisions of HIV-positive women in Zimbabwe. *Dr C. Maposhere*
	• Overview of research and interventions on poverty and violence against women as root causes fo HIV and integrating violence into VCT in South Africa. *Dr J. Kim*
	Discussion (15 mins)
	• Overview of research on cross border trafficking in women and reproductive health needs of migrants in Asia. *Dr T. Couette*
	• Study on the links between marital violence and women's vulnerability to STDs, Karnataka State, India. *Dr S. Krishnan*
	Discussion (15 mins)
15:45 – 16:15	Coffee Break
16:15 – 17:30	Working groups session 1: Brainstorm and identify key research questions to address the links between violence and HIV/AIDS
	Introduction/explanation. *Dr. C. García-Moreno*

chart continues

Tuesday, 24 October – Identification of key research questions

9:00 – 10:30	Presentation of group work and discussion
10:30 – 11:00	Coffee Break
11:00 – 12:30	Working Group session 2: Based on research issues, identified, suggest appropriate study designs, including methodological and ethical issues, and identify opportunities for integrating research questions into existing initiatives
12:30 – 13:30	Lunch
13:30 – 15:00	Working groups continued
15:00 – 15:30	Coffee Break
15:30 – 16:45	Presentation of group work and discussion
16:45 – 17:30	Moving the research agenda forward: suggestions for action. *Dr C. García-Moreno*

Wednesday, 25 October – Research issues around provision of post-exposure prohhylaxis (PEP) to rape survivors

09:00 – 09:20	Introduction. *Dr T. Farley*
09:20 – 09:40	PEP state of the art: Summary of current knowledge on PEP efficacy, use, costs and compliance. *Dr D. Smith*
09:40 – 10:05	Services for raped women. *Dr W. Taylor*
10:05 – 10:30	Discussion
10:30 – 11:00	Coffee Break
11:00 – 11:15	Context of rape in South Africa: prevalence, availability, use and quality of rape services. *Dr J. Kim*
11:15 – 12:45	Brainstorming and discussion to identify key research questions, types of studies feasible, scientific and ethical issues. *Dr T. Farley - Chair*
12:45 – 13:00	Closing remarks – Dr C. García-Moreno and Dr T. Farley
	End of meeting

Annexe D

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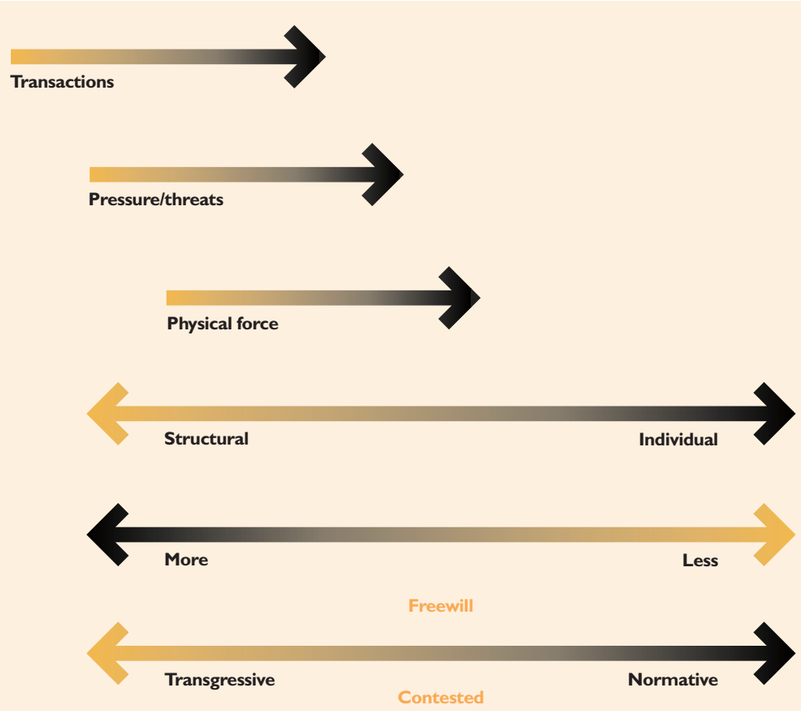
Annexe F

Coercion Continuum Framework[1]

[1] L. Heise



- incest
- rape of another man's wife

Date rape

forced sex in marriage

- rape of prostitute
- rape in war

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