

**Bangkok Consultation on HIV/AIDS and Gender-Based Violence**  
**International Health and Human Rights Program,**  
**François-Xavier Bagnoud Center for Health and Human Rights**  
**Harvard School of Public Health**  
**June 2 and 3, 2005**

**MEETING REPORT**

**Summary**

This report summarizes the substance of the presentations and discussions that took place at the June 2 and 3, 2005 Consultation for HIV/AIDS and Gender Based Violence (GBV): Linking Advocacy at the Grass-Roots in China, India, Thailand and Vietnam, held at the Royal River Hotel, Bangkok, Thailand.

The two-day meeting was convened to initiate an informed exchange of information, approaches and activities among those working on issues of sexuality, HIV/AIDS and GBV through a human rights framework and to facilitate a receptive climate for effective gender-sensitive violence and services as related to prevention, treatment, care, activism, and advocacy. These exchanges served to organize pilot program development on the parts of teams from India, Vietnam, Thailand, and China, with assistance from the International Health and Human Rights Program (IHHRP) at the François-Xavier Bagnoud Center for Health and Human Rights (FXBC), to address the factors that make individuals vulnerable to both HIV/AIDS and Gender-Based violence over the next two years. A human rights and sexuality framework were agreed to provide a common and effective backdrop for program design and implementation. Additionally, the shared knowledge and experiences of participants working on either HIV/AIDS or GBV issues was seen to be an invaluable resource for all of the teams to learn from each other and identify effective methods of intervention for their particular set of issues, settings, and target populations.

Invited participants gave presentations on existing work examining or addressing the intersections and linkages of gender based violence and HIV/AIDS and how human rights and sexuality frameworks can be integrated into these efforts. Individuals gave presentations on both the HIV/AIDS and GBV situation in their own countries and their proposed pilot program plans. Many issues were raised over the course of the two days, but most importantly the topics of disclosure, cross-cultural differences in expression of and responses to GBV and HIV/AIDS, as well as globalization and the subsequent impact of shifting gender responsibilities on the GBV and HIV/AIDS epidemics were flagged as crucial considerations in program planning and design. Next steps were discussed and it was agreed that efforts would be made to present results of the pilot interventions at the upcoming XVI International AIDS conference to be held in Montreal, CA, July 2006.

This meeting report is divided into three parts. The first part outlines the formal presentations, including the individual team presentations on the situation and initial concepts for their pilot programs. The second part highlights the general themes that emerged from the two days of discussion, including considerations for pilot program design and implementation in the individual country settings. The third part considers administrative and financial matters that were discussed, including funding and next steps.

Presentations and other background documents may be found at [www.hsph.harvard.edu/xfbcenter](http://www.hsph.harvard.edu/xfbcenter) on the International Health and Human Rights Program's page. The agenda and list of participants is attached as Appendix 1 and full descriptions of the pilot programs are attached as Appendix 2.

## **PART I**

### **Introduction/Project Background**

*Presenter: Sofia Gruskin*

Following general introductions of attendees and other housekeeping matters, Sofia Gruskin presented the background to the project and to the framework of the meeting.

She stressed that at the conceptual level, the neglect and violation of human rights, including those related to sexuality, were at the core of vulnerability to both HIV infection and GBV, but they also could highlight the intersection of these two issues. She noted that one of the major problems of doing this work is the reluctance of organizations, in both areas, to work together. This reluctance could be attributed to three main fears - fear of diverting attention away from the important issue (whichever issue the organization is working on), fear of losing resources, especially as they are scarce and difficult to obtain, to the "other" issue, and distrust of the culture of other organizations. These concerns had traditionally made linking work in these areas difficult.

In speaking about the project, she noted that these challenges are at the core of this project's origin. This project idea stemmed in part from the fact that the discussion of the intersections of GBV and HIV/AIDS was happening at the policy level but has yet to be translated into programming, advocacy for programming, or legislation. The lessons learned from the pilot projects should be presented in such a way that they can inform the policy discussions so that the results are translated into future programs and government service provisions in the four countries and beyond.

The main objectives are to translate theoretical and policy discussions between HIV/AIDS and GBV into enhanced programming, provide evidence of the value of using human rights and sexuality for joint programming on HIV/AIDS and GBV, create appropriate materials and tools to help organizations do this sort of work effectively, and foster donor involvement and support. She then discussed the four critical steps to getting this work done through this project: identifying the partner organizations, holding a joint consultation between these organizations, designing, implementing, and monitoring and evaluating pilot interventions, and publishing related materials and tools. She concluded by stressing how important the input of each of the participants was to the successful completion of this project.

### **Gender-Based Violence and HIV/AIDS: Selected Review of Literature**

*Presenter: Mindy Jane Roseman*

Mindy Roseman presented a literature review outlining the existing research on the links between HIV/AIDS and GBV. Examining the association of GBV and HIV, studies have found that women with HIV are more likely to have experienced sexual violence by their partners than non-HIV infected women and that women who are in relationships with violent or abusive men are at higher risk of HIV infection.

Looking further into the effects of GBV on HIV, research shows even with sufficient information that fear of violence affects condom use, as women fear they will trigger a violent response from their partner if they try to enforce condom usage. It also affects voluntary counseling and testing (VCT) as fear of violence deters women from seeking testing or going back for results, and men are less likely to reveal their HIV-positive status if they have had sex outside their primary relationship. The highest risk for women is for those in discordant relationships. Conversely, examining the effects of HIV on GBV, studies have found associations, but it has been difficult to prove a causal relationship. That is, women at risk of violence are also at risk for HIV, but it is not yet sufficiently clear why this is so.

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Another area of study has examined physical, sexual, emotional, and economic abuse as factors creating a "multiplied female sexual risk." This includes the effects of gendered norms (including masculinity and taboos), economic constraints placed on women, and the role of substance abuse. Finally, the effects of gender and culture have been considered, but there are complications with generalizations in these areas. Gender norms need to be carefully understood and located in particular contexts – geographical, historical, socio-economic, and individual.

Looking towards the future, she pointed out that studies need to examine the roles of human rights and sexuality in HIV/AIDS and GBV. It is clear that health services might be an entry-point for both in relation to HIV and for women who experience GBV, so perhaps more targeted engagement with providers is a solution. She ended by stating that programs must also determine how to impact the social attitudes and gender norms underlying GBV.

### **Situation Analysis from Each Country**

Representatives from each country team spoke about the background of the dual epidemics in their country and some of the work that has been done in the areas of HIV/AIDS and GBV.

#### **Nguyen Van Anh and Nguyen Thi Van Anh: Vietnam**

The team from Vietnam has done work on sexuality and HIV/AIDS and gender-based violence and found that sexual coercion is a problem particularly because women have a limited voice. Sexual violence is thought to be especially prevalent in the countryside. This also leads to discrimination against migrants when they move to urban areas, in that they are thought to bring diseases and addictions from urban to rural areas. Traditional norms persist and even women believe that men have right to demand anything from their wives. Women do not know how to refuse sex and cannot share their experience with anyone because sexuality is still a very confidential and taboo topic to discuss, even between husband and wife. There also appears to be a low prevalence of men willing to use condoms, and women have little say in this area. Alcoholism and drug abuse are other factors that contribute to sexual violence. Many of the people known to be HIV infected in Vietnam are drug users and this exacerbates stigma and discrimination while contributing to increased risk of violence for family members.

Finally, pregnancy is an important issue in Vietnam as many women do not give birth in hospitals and therefore do not have access to modern services, including preventative mother to child transmission programs. As of yet, there are no programs working on the linkages between HIV and violence in Vietnam; instead women face a double stigma from HIV and violence.

#### **Wang Lixuan, Hou Zhiming and Bri Stuart: China**

The UN estimates that there are 2 million people living with HIV in China. (This number differs significantly from the 2003 government figure of 840,000.) The percentage of female infection has increased from 15.3% to 39.4%. The government is working to improve HIV prevention and care; to this end, it has doubled government responses from 2003 to 2004, including policies to provide treatment and care to all infected people. NGO involvement has also improved efforts to combat the disease.

A study found that 34% of women in China had been hit by their partner. In 2001, the government made violence against women illegal, but currently there is no system of legal redress. 7.9% of rural and 2.7% of urban women had experienced domestic rape. While these are punishable crimes, the law does not specify that marital rape is illegal. Rape and violence against sex workers place this

population at an increased risk of HIV infection. There are six million sex workers in mainland China and a study found that 25% of the sex workers in the Yunan province encountered forced sexual behavior in the last year. Another study found that victims of childhood sexual abuse might later engage in riskier sexual behavior. Students have little knowledge about sexual abuse and many have misguided views about issues surrounding this topic. It is known that lesbian and gay populations in China also suffer from GBV but no studies have been done on affects of GBV on these populations.

Looking at GBV and HIV/AIDS in China, the Futures Group and Oxfam have researched intersections in China and several organizations are now promoting awareness of the intersections between GBV and HIV/AIDS. Some HIV/AIDS programs have incorporated gender issues into their program design and function. Additionally, there are grassroots organizations forming now, especially by women living with HIV/AIDS. There is much concern around the areas of coercive sexual violence, rape, and childhood sexual abuse.

### **Geeta Sodhi and Gouri Choudhury: India**

In India, experience is needed to highlight the linkages between GBV and HIV/AIDS. Factors that affect the lack of negotiation for protection and women's lack of control over their bodies and lives undercut both GBV and HIV/AIDS. Additionally, male infidelity and sexual violence are culturally accepted behaviors. There are similar responses to victims of both GBV and HIV, in terms of rejection and lack of support from family members and society. Stigma is an important issue surrounding both, and it means that information is most often kept private and results in a lack of disclosure of either issue. Women are blamed for their HIV status and GBV, as the accepted view is that a woman must have done something wrong to deserve these outcomes.

A study among unmarried boys and girls in Delhi found that there were vulnerability factors that cut across both sexes and that negative outcomes over time could be associated with early sexual exploitation. Another study showed that even when women were sensitized to issues of HIV/AIDS, they still feared they would be abused if they suggested condom use. This knowledge led to an increase in women's groups who discussed how to improve this negotiation process and mechanisms.

Sexual activity is increasingly starting at younger ages in India, despite the conservative culture. Studies have found that STDs are far more common than in previous years, but organizations dealing with HIV as well as those dealing with GBV have little experience working in these areas. Anecdotally it appears that increasing numbers of people have family members affected by HIV, indicating that it is a larger problem than previously realized. Even in the remote villages of Uttar Pradesh, a workshop on women's reproductive health found that out of 20 women, nine had direct knowledge of the impact of HIV/AIDS, either through their husband or other family members. This shows the importance of programs addressing not only urban high-risk areas but rural, migrant-affected populations in India.

### **Sunee Talawat: Thailand**

The HIV epidemic in Thailand originally spread through men who have sex with men (MSM), injecting drug users (IDU), and sex-workers; but HIV/AIDS is now understood to exist in the general population. The spread of the epidemic can be associated with gender differences, as sexual power lies with men in Thailand. A study a number of years ago, found that HIV positive women could not make independent decisions about pregnancy, as hospitals encouraged women to get abortions, and there were few MTCT programs. These conditions have changed now with the increased availability of ARVs for pregnant mothers to reduce mother to child transmission. However, women still have limited decision-making ability about their reproductive and sexual health.

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Thailand has started the “Wife and Child First” program as an intervention to empower positive women by educating them about their choices and encouraging them to speak out about their status. This has led to a discovery that many positive women experience violence in their relationships. Many report having experienced coerced sex and they feel that sex is their duty to their partner. They feel that they belong to their husbands and must give in. They fear that if they do not follow their husbands’ wishes, they will find other women and abandon them. There are many such issues associated with disclosure that make HIV-positive women fearful of disclosing their status. There is also the concern that the man will leave, or that after the husband's death the woman will not find a new husband. Additionally, domestic violence and incest are on the rise because of social shifts. As more and more women are working outside of the home and more fathers are at home because of increased unemployment there has been an increase in incest. Alcohol abuse has also increased. Groups are working to create a campaign to target alcohol abuse as a cause and risk factor of unprotected sex and violence.

### **Current Programs and Initiatives Linking GBV and HIV Work**

#### **Strategic Interventions: Intersections between Gender-Based Violence & HIV/AIDS**

*Presenter: Bernedette Muthien*

Bernedette Muthien presented on strategic interventions addressing HIV/AIDS and GBV in South Africa and the associated strengths and weaknesses of these programs. She noted that there are many splits and cleavages in how people work together on HIV and violence. This is a result of how internalized organizational and individual values and behaviors influences work in this area.

An important area of research in South Africa concerns infant and child rape. The prevalence of “the virgin myth”, in which men believe that raping virgins and children will cure them of HIV, is not specific to HIV but rooted in patriarchal violence. The proliferation of this myth has allowed public outrage to be directed at people living with HIV and contributed to the ignorance surrounding the disease without challenging the patriarchy and unrestrained male sexuality of the problem.

Another related issue is the myth of "curative" rape for gay and lesbian populations, resulting in high rates of domestic violence rates and a perceived lack of safety in public spaces. There is much silence and stigma about alternative sexualities, which only leads to further silence. Research is needed on GBV and HIV issues within gay and lesbian relationships. The situation in South Africa has had interesting social implications, as some women are deliberately engaging in celibacy to avoid either or both GBV and HIV/AIDS.

In drawing lessons from her experience, she stressed the need for a holistic approach. In South Africa, it is increasingly clear that neither issue can be successfully addressed without attention to the other, as well as economic divisions, geographic differences, social norms, etc., and this is most likely the case in any country. In program design, all services must hold to and support the following tenets: do no harm, ensure gender sensitivity, gender transcendence, and empowerment.

#### **UNIFEM: Gender and HIV/AIDS**

*Presenter: Motoko Seko*

Motoko Seko gave a presentation on UNIFEM’s role in addressing gender and HIV/AIDS. UNIFEM has been working in HIV/AIDS for the last seven to eight years, but to date has not solidly addressed the intersection between the HIV/AIDS and GBV epidemics.

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Gender and HIV work is not yet well integrated in the Southeast Asian region. UNIFEM wants to focus on women's rights through legal reforms, women's economic rights, feminized poverty, health rights, eliminating violence against women and the implementation of CEDAW, the Beijing PfA, and the Millennium Development Goals. Programs to date have focused on domestic violence, but not on violence against women per se. One of the main program goals is to halt and reverse the spread of HIV/AIDS amongst women and girls. In Cambodia, UNIFEM is establishing a women's sector within the national network of people living with HIV/AIDS (PLWHA).

Motoko stressed that there is a lot of work to do on HIV and GBV in East and Southeast Asia. Women account for 40% of PLWHA worldwide, but only about 10% in most East Asian countries, so most responses are still male oriented. There is a need to strengthen women's issues and their place on the national agendas. The Regional Coalition on Women and AIDS was launched in March 2004 and many women's organizations are beginning to serve poor HIV-positive women but are not seeing rapid results. UNIFEM and related organizations have had a difficult time finding experts in this region and organizations capable of addressing both HIV/AIDS and GBV. A situation analysis is underway on the intersection of HIV/AIDS vulnerabilities and GBV in Southeast Asia, including which organizations are working on the intersections. When this report is completed, it will provide a checklist of issues of concern and will be available on UNIFEM's website.

### **Integrating GBV and HIV/AIDS Programs: A Review of Current Best Practices**

*Presenter: Mindy Jane Roseman*

Mindy Roseman gave a presentation on globally how the key elements of existing programs have integrated GBV and HIV/AIDS and how this integration may or may not be effective. These findings were based on the five UNAIDS criteria for best practices: effectiveness, ethical soundness, relevance, efficiency, and sustainability. Many of the better programs focus on HIV prevention, as well as incorporating GBV screening, and have included men in their projects, either through sensitization or through effecting behavior changes. All of the better programs included the common elements of participatory research and programming, which often led to effective local responses precisely because they involved local participants. Many programs have training and curricula focusing on connections between the two epidemics, but little else dealing with the intersections.

Some of the general limitations included limited awareness of women's groups about the relevance of HIV, and HIV groups about GBV. HIV was not always the first priority for women's groups in their design, often they identified economic or social empowerment as their priority.. Another major limitation is the lack of available staff for training and new programming.

She noted that important elements for successful programming include training of GBV organizations on HIV/AIDS, and vice versa, to help destigmatize both issues for both service providers and clients. Additionally, targeting specific populations, increasing participation, ensuring sufficient support and situational appropriateness, having the knowledge to make necessary referrals, and the provision of emotional, financial and legal support whenever possible are important in the design of effective programs linking GBV and HIV/AIDS.

## Conceptual Frameworks

### **Integration of Human Rights Framework in HIV/AIDS and GBV Programming**

*Presenter: Sofia Gruskin*

Sofia Gruskin presented an overview of human rights and how this framework relates to the project. Human rights can be used to support advocacy and civil society mobilization. For example, in pushing for wider access to HIV treatment, even if a legal right does not yet exist, the language of a right to treatment can be very powerful. In addressing the power of human rights, Sofia noted that a human rights framework is also useful to a certain degree for accountability. She stressed the ways in which the norms and standards of human rights are useful to design, implement, monitor, and evaluate programs to: explicitly consider a human rights framework in setting up a project; build capacity by using rights to prevent violations from occurring in the first place and using them to think about programs structurally; and ensure attention to the legal and policy context by being aware of the contexts in which the program is being done and the ways that these can constrain or support the goals of the effort.

In trying to bring together GBV and HIV programs, the differences in terminology between risk and vulnerability and how these ideas are conceived of by people with different backgrounds was also discussed. Awareness of the differences in how people understand language is a key factor in working together effectively. She noted the relevance this has to decisions about what types of programs should be implemented, as it connects vulnerability to discrimination to human rights and leads to an appropriate situation analysis and intervention design. The vulnerability and human rights approach provides a useful backdrop for bringing together HIV and GBV efforts.

Applying human rights to programming requires an analysis of the situation of the population or specific problem to be addressed, the process of shaping an intervention, the implementation of the intervention and its monitoring, and a framework within which the success or failure of the intervention can be monitored and evaluated. The next steps in this process are to build up the body of evidence for a rights-based approach, respond to challenges, and further the links of combining HIV/AIDS, GBV, and within a human rights and sexuality framework.

### **Sexuality, Gender-Based Violence, and HIV/AIDS**

*Presenter: Susana T. Fried*

Susana Fried built on Sofia's presentation, adding the dimension of sexuality to it. Social norms of gender and sexuality are equated with and are determinants of risk for GBV and HIV. However defining these terms and determining their intersections is difficult, as sexuality is often mediated through gender and gender includes ideas about sexuality and reproduction.

Femininity and masculinity are also sexualized constructions. What it is to be a woman and feminine contains ideas about a woman's sexuality and other assumptions and expectations of women in society, and can create or increase the risk and vulnerability to HIV and GBV. Defining the components of sexuality is difficult because of their inherently dynamic nature. Gender too is not static, but it is also fluid.

Susana defined heteronormativity and how this consequence had harmful effects for the lives of women and men in the context of HIV/AIDS and GBV. Sexual hierarchies generally presume that the "normal" way to be is heterosexual and then below that fall homosexuality and bi-sexuality, depending on the culture. Those sexual hierarchies are regulated by the state through laws and

policies, as well as by social norms and customs. A sexual rights framework, Susana stressed, has no single, agreed-upon definition, but there are shared principles that recognize the right of each person to experience his or her sexuality freely, fully and consensually, and with an understanding of sexuality as a realm of experience encompassing sexual orientation, gender identity, sexual and gender expression, desire, pleasure and sexual practices. There is no government recognized set of sexual rights, but it is a growing advocacy area within the rights perspective.

When considering programming the following four questions should be considered to incorporate sexual rights principles: Do interventions challenge or support existing norms of gender and sexuality? Are these interventions designed to promote equality and advance freedom? Do they respect and protect diverse sexualities? Do they foster greater access to services for marginalized groups? Answering these questions will help ensure that programs effectively consider sexuality.

### **Presentations on Pilot Projects**

Following are brief outlines of the pilot project that each country team proposed, and a brief summary is done of the participant feedback to the presentations. See Appendix 2 for elaborated descriptions.

#### **CHINA - Wang Lixuan, Hou Zhiming, and Bri Stuart**

China's pilot program will focus on two objectives. The first is the creation of a model training course that will be used to train people working in pre-existing programs with migrant workers. There are four to six organizations already working with migrant workers and the goal is to incorporate training on GBV and HIV issues into these organizations. Training will include information on sexuality and issues related to sexuality. To create this training they will consult experts, NGOs, the migrant worker community, and after this consultation, the plan is to draft an initial training course. Success will be measured through follow-up meetings with the organizations that they train and administration of preliminary and post-training surveys. They will solicit feedback from the migrant workers as well to evaluate the components of the training courses.

The second objective is to encourage cooperation and information sharing between NGOs and groups working on women's issues and HIV issues. The two organizations--the Beijing AIZHIXING Institute of Health Education and the Red Maple Counseling Center-- have recently held a forum in Beijing that was attended by women's organizations and HIV organizations and journalists from China Women's Daily. They hope to hold more of these forums during Phase 2 of the project. The objective is to involve experts to address the intersections of GBV, HIV, human rights and sexuality issues. They will then distribute information to organizations working in the HIV and GBV fields. Part of this phase will be to figure out how to facilitate cooperation between these two types of organizations. As an entry point, they have started to compile a directory of local and international organizations working on gender issues and HIV/AIDS issues in China.

#### *Selected Presentation Feedback:*

- Participants suggested that they should think more about the ways in which gender can make an impact on the different kinds of services and needs of migrant workers, whether they are men or women, in terms of GBV and HIV/AIDS.
- Many Chinese language materials on HIV, human rights, human rights law, and gender already exist, and were offered as good starting points; Lixuan responded that they have this material, but will consult it as part of their program design.
- Concerns were also raised about the aggressive timeline that China had proposed. The team acknowledged this concern and said they would provide a more detailed timeline and would revise as needed.

## INDIA – Gauri Chaudhury and Geeta Sodhi

India's program will integrate GBV and HIV/AIDS training into pre-existing community based reproductive health and sexuality programs. The goal is to reduce the vulnerability of women and girls to HIV and GBV by using the human rights and sexuality frameworks. They will use integrated responses across different levels, through the partnership between Action India and Swaasthya.

Their program activities will include an orientation for staff on the new projects as well as sharing of information from this meeting in Bangkok. They will also increase the dialogue in communities on the linkages between the two areas. From a clinical approach, they will use training to sensitize health care providers on linkages. Community based workers will also be informed and trained on linkages to educate the people that they work with. The pilot program will happen in phases. Phase 1 includes the program design through consultation with community-based workers and other groups. Phase 2 includes the implementation, documentation, analysis, and information sharing of the pilot program.

India's program will focus on domestic violence and HIV prevention, because the communities where they work are still considered low-prevalence areas for HIV. The target groups will be unmarried adults, girls, and married women. To incorporate human rights, they will review the relevant instruments and create a checklist as to what is appropriate to their program. They will use this process to identify gaps and determine how to fill them. They will follow a similar process for the sexuality framework. These checklists will be available at their consultations and will provide on-going guides for project design.

### *Selected Presentation Feedback:*

- Participants emphasized that the orientation for staff will be very important to gain their buy-in and address any resistance to incorporating human and sexual rights.
- Concerns were raised as to the criteria that would be used for determining the successful completion of the first phase of the project, as this is the phase of the project being funded.
- Comments were also offered that the team's concerns around HIV prevention and the current limitations in finances for prevention efforts.

## THAILAND – Sunee Talawat

The objective of Thailand's program is to improve the capacity of NGOs to address GBV and HIV/AIDS by improving training and education on these issues for NGO workers. The goal is to empower target populations/groups – individuals, families, and communities - by partnering groups working in the eastern part of Thailand (generally strong on GBV but not HIV) where Friends of Women is strong, with groups working in the northern parts of the country (generally strong on HIV but not GBV) where Raks Thai Foundation is strong, to share expertise. Women are the primary target group, and communities and healthcare providers are the secondary targets. The GBV focus will be on domestic violence, sexual violence, incest, trafficking of women, and coercive sex, while HIV/AIDS efforts will focus on prevention, care, and support. The program will also examine the relationship of alcohol to GBV and HIV/AIDS and will include the development of a counseling program for women on violence, human rights, and HIV. The pilot will be designed with a human rights and sexuality framework.

### *Selected Presentation Feedback:*

- Participants commented on use of alcohol as a common vulnerability as an interesting link.
- Questions were then raised on the differences in capacity of Eastern Thailand and Western Thailand, as currently capacity in neither region seems strong on both HIV/AIDS or GBV.

- Would the program have the capacity to create different training for these two regions? Sunee said the pilot program would create training to address both issues in both regions.
- Others noted that HIV programs are not oriented to GBV and the capacity to sensitize health care workers and train them adequately may not currently exist. Therefore the program might need to set up a referral system. Sunee responded that because no program presently addresses both HIV and GBV, there are already existing mechanisms to refer women who have experienced violence to both government and private sector facilities. It was suggested that it would be worthwhile to include these agencies in the orientation sessions.

### **VIETNAM – Nguyen Thi Van Anh and Nguyen Van Anh**

Vietnam’s program will focus on sexual violence and the risk of HIV infection, and bring together the Institute for Social Development Studies with CSAGA. Their main objective is to raise public concern and awareness through six main activities. The first will be a needs assessment using information from an existing violence telephone hotline. The second will be to adapt a handbook on GBV and sexuality to Vietnamese and use it to train NGOs and other interested organizations. The third is to create a small booklet to provide evidence of sexual violence in Vietnam and provide a resource for women who are looking for information on GBV. This will be distributed through the Women’s Union because of their widespread presence around the country. The fourth is to introduce a training of trainers (TOT) to raise awareness for NGOs and expand the skills and knowledge for people that work at the community level. The fifth will be advocacy and public awareness raising activities. These will be through TV, radio, and newspaper outlets to educate people about GBV and HIV/AIDS and the related issues. The sixth activity will be sensitization workshops for government workers and other organizations working on similar issues. The expected outcomes of the program are to increase public concern and raise the awareness of policy makers.

#### *Selected Presentation Feedback:*

- After this presentation, questions were raised about how the Vietnamese team would engage and finance the media efforts. Van Anh responded that the government of Vietnam has control over the media. Their strategy is to engage them and raise the media’s interest in these issues. They also mentioned their history of working with the media on a project to raise awareness of HIV and decrease stigma.
- A South African soap opera “Soul City” was identified as a potential resource for the Vietnamese team. These producers create education on HIV/AIDS and GBV in ways that are accessible to people with limited resources and literacy. They touch on sensitive issues and even use soap operas to forward social messages.
- Participants questioned why the booklet would be distributed through women’s organizations only, and not also through organizations working on HIV/AIDS. Van Anh responded that the women’s union is throughout the country and has the greatest reach, whereas the NGOs working on HIV/AIDS operate in limited parts of the country.

### **Individual Country Pilot Programs**

Sofia, Susana and Mindy then addressed aspects of the pilot program component of the overall project in general terms. The idea for these pilots came about because of the interest in working across the GBV and HIV sectors. Thus far, the sharing of work and experience in this area has been constrained and as was demonstrated by the presentations, it is hoped that by working with people and groups firmly rooted in these issues that effective programs combining human rights and sexuality could be developed. The work being done in Asia on the two separate issues was very

impressive and so it seemed like a logical place to start. As the presentations made clear, working across countries will ideally enhance the utility of partnership and shared experiences, especially given the diversity of the epidemics in the four countries. The AIDS conference in 2006 in Montreal would be an ideal forum to bring everyone together to consult amongst ourselves to determine common themes and approaches as well as to be able to present at the conference the results of this work.

The diversity in the epidemics and the approaches to addressing them was also discussed. Sofia explained that in some cases within each country the lead partner is a GBV organization, in others it is a HIV program. Some of the involved groups are more community based and some are more academically based, and each exists in different political and legal situations, and the epidemics are in a different place in each of the involved countries. Additionally, the levels of engagement in both areas of governments and civil societies vary from country to country. Therefore, the groups can examine their common challenges and draw on the experiences of each other to enhance their own programming, but common lessons will also be useful to others.

## **PART II**

### **Issues and discussions**

Throughout the two days, several issues continuously appeared as topics for discussion that should be considered in program design and may be appropriate for further research. These are briefly summarized below.

- **Disclosure**

There was much discussion about the relationship between disclosure of HIV status and GBV. The first such issue was disclosure of HIV status and its impact on violence. There was some concern that the findings in the literature review were contradictory. Participants also discussed the close nature of disclosure and stigma. These differences and potential consequences should be noted and addressed in the design and implementation of the pilot programs. It was decided that there is a need to focus on disclosure as a nexus of HIV and GBV intersections.

- **The Role of Men**

Another recurrent issue raised was male involvement - what happens when a man becomes infected? Does it increase violence? Is there a demand for sexual intimacy from his partner? More information is needed on how HIV risk affects violence and why men may or may not disclose their status or obtain test results. There is no significant research on how the HIV status of men impacts women and their families, but this type of relationship should be considered.

- **Globalization and Shifting Socio-Economic Patterns**

The effects of globalization on the two epidemics also came up repeatedly in discussions, as different geographic areas experience shifts in labor patterns. For example, it is felt in many more places that mothers now work out of the home, male unemployment is on the rise, many people migrate to find work, urbanization is common, and the feminization of poverty is increasing. What are the impacts of these changes on HIV/AIDS? In addition, many countries are experiencing changes in the geographic patterns of HIV, as it is spreading from urban areas to small villages. Understanding the shifting patterns and increased population mobility is very important to the design of a successful intervention.

- **Types of Violence Addressed**

The types of violence considered were also discussed. Existing GBV programs focus primarily on intimate partner violence, including the physical and emotional abuse in an ongoing relationship. There are, however, rather fuzzy definitions of physical, sexual, and intimate partner violence. While talking about GBV, it has been defined within individuals and families, but such a definition omits the concept of institutional or structural violence. Economic, social and cultural relations and expectations can be experienced as violence. More clarity on these terms both for general use and in terms of the scope of the pilot projects would be necessary.

- **Impacts of Declining Female to Male Sex Ratio**

Finally, a common point between China and India --the declining female to male sex ratio-- was raised as a structural aspect of GBV. Both countries have been experiencing a declining number of women per the same number of men due to sex-selective abortion in both India and China. This gives rise to new concerns on how this demographic phenomenon will affect HIV and violence in these countries and what can be done to mitigate the potential impacts of these changes.

- **Forced Abortion as GBV**

Another important topic discussed was abortion. Is it the case that women who are HIV-infected are experiencing increased coerced abortion as a form of structural violence? And if so, should this be included in the pilot programs? An example from Thailand has shown that coerced abortion is no longer a major issue because of prevention of mother to child transmission (PMTCT) programs, but ten years ago it was a major concern. In many Southeast Asian countries abortion is illegal, but can be performed for a “reasonable” cause, and this is by law often though to include situations where the mother is HIV-positive. Where PMTCT is available, women are encouraged to keep their babies. However, some countries like Cambodia and the Philippines make it illegal to knowingly pass or transmit HIV to another person. As a punishable crime, it has implications for women's rights and abortion legislation. This law has the potential to protect women, but raises serious concerns if used in countries where the fetus is considered a person. It is crucial to keep the various ways in which laws and policies can play out in mind when thinking of the pilot programs.

- **Effects of War on Patterns of Gender Based Violence**

Participants also discussed the effects of war and historical violence on HIV/AIDS and GBV. Van Ahn offered the example of Vietnam for consideration. Vietnam has experienced 1,000 years of colonization by China, 100 years of French rule, 30 years of war, and then 30 years of peace. History influences culture and norms in terms of sexuality and violence. So far, there is no known research on a history of violence in a society and its affects on GBV and sexuality. There are no available studies, but it seems that the mentality of war increased the likelihood that men who lived through it will be violent towards women. More research is needed in this area to understand the impact on HIV/AIDS and GBV, and the history of a particular setting should be considered for individual pilot programs.

## **PART III**

### ***Administrative and Financial Matters***

#### **Funding**

Motoko Seko from UNIFEM facilitated a discussion on the issue of raising money for work on HIV/AIDS and GBV in the region. She provided suggestions as to additional funding sources which could be approached for program development. Among the agencies and donors she suggested were: UNIFEM trust fund for eliminating violence against women, UNAIDS, WHO/ The Global Coalition on Women and AIDS, UNFPA, The World Bank, DfID (UK), SIDA (Sweden), New Zealand Aid, HIVOS/The Netherlands, GTZ (Germany), AusAID, Asian Development Bank

She also mentioned that private foundations should also be considered for funding, such as the Ford Foundation or Oxfam Hong Kong. Several other organizations were suggested for funding including Mamacash (<http://www.mamacash.nl>) from the Netherlands, and the Global Fund for Women in the US.

#### ***Discussion***

For the purposes of the project resulting from these pilots, it was recognized that it will likely be easier to raise funds independently, as almost all bi-lateral aid is administered at the country level and donors prefer to do one-country programs. In applying for funds, teams should stress their participation in this larger project or include the Harvard School of Public Health (HSPH) involvement if they feel that it will be useful. It was also requested that country programs let HSPH know where they are applying for funds, and HSPH will keep a list of where all of the countries are applying as a reference.

#### **Next Steps**

A discussion of the next steps ensued in which the following topics were discussed:

##### **1. Subcontract and Timeline**

- a. In going over the terms of reference outlined in the subcontract, it was noted that each country team was now responsible for moving solidly into the design of the pilot programs. HSPH will take the pilot outlines as an initial proposal, and provide comments on these, as soon as all have been received from each country team. They will then be sent back for revision to be submitted as a formal proposal.
- b. Upon receipt of the formal proposal, they will be submitted and put through Harvard's financial processing apparatus so that the second installment of funds under the subcontract can be transferred over.
- c. The International AIDS conference to be held in Montreal in July 2006 is an important venue, and efforts will be taken to ensure that all teams can get there. As such, all pilots will ideally begin by the start of December 2005 and be completed by June 2006 so that findings can be presented at the conference. The ability for all to meet in Montreal unfortunately relies on the individual fundraising efforts of each team.

##### **2. Human Subjects and the HSPH requirements**

- a. There was considerable attention paid to human subjects. All pilots will have to go through HSPH's Human Subjects Committee.
- b. Given what was discussed at the meeting, according to Sofia's experience, it would appear that none of what has been proposed is "research," and thus would be

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exempted. However, when IHHRP receives the subcontract proposals they will submit them to the Human Subjects office, stating that they believe them to be exempt. If the Human Subjects office believes that there are any human subject issues involved, this will need to be handled appropriately.

### **3. Technical Support/Communications**

- a. Through existing funding, technical support from IHHRP, FXBC is available for one visit/consultation to each of the countries; technical assistance and support is on going via email and phone.
- b. Individual countries should include in their pilot project proposal the level of technical assistance that they think they would need from IHHRP. This should include not only the desired timing of the visit, but also the type of engagement the team would prefer.
- c. At least once a month IHHRP would communicate with each team, updating everyone, and sending out any relevant information.

### **4. Means of Ongoing Communication**

- a. It was agreed that individual questions from the teams on any issues should be directed to all three of the meeting conveners (Susana, Mindy, and Sofia) so that timely answers could be provided in light of their diverging schedules.
- b. If teams want to communicate with the entire group and people would find that helpful, that would be fine as well.

### **5. Follow-up**

- a. The intention to reconvene in Montreal in July 2006 was discussed.
- b. The group believed that the July 2006 AIDS conference would be an ideal time and place to bring everyone back together to review the work collectively, and present our initial results for discussion to the scientific, academic, policy, and activist audience in attendance.
- c. It was decided to propose to the conference organizers an “abstract driven session,” where oral presentations based on the pilot projects would be made.
- d. IHHRP will draft a proposed agenda and solicit feedback from all of the teams for our internal meeting to take place at the time of the conference.
- e. The initial project review, the materials produced in each place, program commonalities and differences will be then combined into a larger “lessons learned” document.

To conclude, while it was stated that one could assume a weakness of this program is that none of the groups have worked together before, it is an important strength, as the individual expertise that each group has to offer is extremely valuable. The willingness and ability to share information and experiences during the pilot project phases will be very important to the success of the next phase. All participants expressed their interest and delight in working together in the future.

The meeting then wrapped-up and an evaluation was distributed to all participants. A summary of the evaluation is attached as Appendix 3.