



➤ Integrating strategies to address **gender-based violence** and **engage men and boys as partners** to advance gender equality through National Strategic Plans on HIV and AIDS

West and Central Africa  
Regional Consultation  
Dakar, Sénégal, September 2013

➤ MEETING SUMMARY



“The AIDS response can be a positive force in challenging rights violations of, and stigma and discrimination against, women and girls, including in laws criminalising HIV transmission, laws infringing upon the rights to privacy and confidentiality and the right to be free from violence, sexual assault and rape inside and outside of marriage as well as within and outside of situations of conflict and emergency, laws involving inheritance, ownership and access to and control over land ownership and family laws and other policies and practices that violate the human rights of women...

... The Operational Plan acknowledges that traditional and stereotypical views of women and men and girls and boys, and the relations between them, that cast females as subordinate and males as superordinate, hinder an effective HIV response. The engagement of men and boys in the implementation of this Operational Plan is therefore critical. Men must work with women for gender equality, question harmful definitions of masculinity and end all forms of violence against women and girls.”

UNAIDS AGENDA FOR ACCELERATED COUNTRY ACTION FOR WOMEN, GIRLS, GENDER EQUALITY AND HIV

#### **Acknowledgements**

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## Abbreviations and acronyms

<b>AIDS</b>	acquired immune deficiency syndrome
<b>AoR</b>	Area of Responsibility
<b>ARV</b>	antiretroviral drugs
<b>COWLHA</b>	Coalition of Women Living with HIV (Malawi)
<b>COMEN</b>	Congo Men's Network (Democratic Republic of the Congo)
<b>DRC</b>	Democratic Republic of the Congo
<b>GBV</b>	gender-based violence
<b>HEARD</b>	Health Economics HIV/AIDS Research Division
<b>HIV</b>	human immunodeficiency virus
<b>HQ</b>	headquarters
<b>MDG</b>	Millennium Development Goal
<b>PEP</b>	post-exposure prophylaxis
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>NSP</b>	national strategic plan
<b>LGBTI</b>	lesbian, gay, bisexual transgender and intersex
<b>MSM</b>	men who have sex with men
<b>RRT</b>	Rapid Response Team
<b>RST</b>	Regional Support Team
<b>UNAIDS</b>	United Nations Joint Programme on AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>UNTF</b>	United Nations Trust Fund to End Violence Against Women and Girls
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	voluntary counselling and testing
<b>WHO</b>	World Health Organization

# Introduction



The last two decades have seen a growing recognition of and attention to gender inequality – including gender-based violence (GBV) and harmful gender norms – as a cause and consequence of HIV. An expanding evidence-base confirms the linkages between HIV, gender inequality, and violence against women and girls. There is also an increasing acknowledgement that HIV needs to be integrated into emergency and recovery contexts. The 2011 Political Declaration on HIV recognised the need “to ensure that financial resources for prevention are targeted to evidence-based prevention measures that reflect the specific nature of each country’s epidemic ... [and] that particular attention is paid to women and girls, young people, orphans and vulnerable children, migrants and people affected by humanitarian emergencies, prisoners, indigenous people and people with disabilities, depending on local circumstances.”<sup>1</sup> Despite this, programming and policies to address the intersection have not had the reach required to reverse the overlapping epidemics of GBV and HIV in the context of conflict and post-conflict situations and emergencies.

Evidence suggests that both women and men often justify violence as acceptable. For example, a study in Ghana found that 56% of boys and 60% of girls argued that it was acceptable for a boy to beat his girlfriend in some circumstances.<sup>2</sup> Studies in Nigeria and Uganda showed that rape was accepted as inevitable among victims because males were seen as uncontrollable and rape was accepted as a “way to teach a haughty girl a lesson.”<sup>3</sup>

West and Central Africa encapsulates a unique intersection of political, geographic and cultural factors that drive HIV in the region, and which make responding to HIV a challenge. Women and girls shoulder the epidemic in the region with women making up more than half of people living with HIV in the region, and girls making up nearly three-quarters of the adolescents living with HIV. Politically, many West and Central African countries are currently in conflict or post-conflict states, including: Sierra Leone, Mali, Chad, the Central African Republic, Guinea Bissau, the Democratic Republic of the Congo (DRC), Cameroun, Guinea, Niger, Nigeria, Equatorial Guinea and Mauritania. Geographically, the Sahel zone, cutting across the region between the Sahara and the Savannah, undermines nutrition, spurs migration and facilitates the need to exchange sex for money or goods. Culturally, gender norms are such that child marriage, sex between girls and older men (often substantially older) to pay for school fees, female genital cutting (FGC) and teenage pregnancy are commonplace. Further, because most of the countries in the region are French-speaking, access to internationally accepted HIV norms and recommendations are not always sufficiently translated and communicated to the region in the same way that they would be to English-speaking countries.

While HIV prevalence may differ prior to, during, and following conflict, there is significant evidence that women and girls in complex emergencies often experience rape and other sexual violence.<sup>4</sup> For example, a survey of internally-displaced families living in three camps in Sierra Leone found that 9% of female respondents reported having been victims and survivors of sexual violence related to the war and 13% of all households reported some member (male and/or female) having experienced sexual violence.<sup>5</sup> A recent film made by the Congo Men’s Network (COMEN) suggests that 20% of women and girls in DRC have experienced rape and other forms of sexual and physical violence.<sup>6</sup> The 2013 UNAIDS Global Report states that of almost 50 countries, 9–60% of women aged 15 to 49 years reported having experienced violence at the hands of an intimate partner in the last 12 months.

In this context, a focus on GBV at policy and legal levels, including and beyond national HIV strategic plans (NSPs), is an opportunity to build on national and regional efforts to strengthen the policy framework for women, girls, gender equality and HIV, including in conflict/post-conflict situations and emergencies.

1. 65.277. Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS.

2. Glover et al in Jejeebhoy, S. and S. Bott. 2003. “Non-Consensual Sexual Experience of Young People: A Review of the Evidence from Developing Countries”. South and East Asia Regional Working Paper No. 16. New Delhi, India: Population Council.

3. Available at: [www.whatworksforwomen.org/chapters/21-Strengthening-the-Enabling-Environment/sections/59-Addressing-Violence-Against-Women](http://www.whatworksforwomen.org/chapters/21-Strengthening-the-Enabling-Environment/sections/59-Addressing-Violence-Against-Women)

4. Shannon, K., A. Kaida, B. Rachlis, E. Lloyd-Smith, G. Gray and S. Strathdee. 2008. “Reconsidering the Impact of Conflict on HIV Infection among Women in the Era of Antiretroviral Treatment Scale-up in Sub-Saharan Africa: A Gender Lens”. *AIDS* 22 (14): 1705–1707. Cited in: [www.whatworksforwomen.org](http://www.whatworksforwomen.org)

5. Physicians for Human Rights (PHR) and UNAMSIL. 2002. “War-Related Sexual Violence in Sierra Leone. A population-based Assessment”. Boston, MA. PHR. Cited in: [www.whatworksforwomen.org](http://www.whatworksforwomen.org)

6. “The Value of Women In The Congo” can be accessed at: <http://vimeo.com/67693454>



## BACKGROUND

The UN Interagency Working Group on Women, Girls, Gender Equality and HIV<sup>7</sup> continues to work in partnership with the ATHENA Network, MenEngage Alliance and Sonke Gender Justice to organise multi-stakeholder consultations to address GBV and engage men and boys for gender equality.

The Dakar regional consultation built on the ongoing collaboration between ATHENA, Sonke Gender Justice, UNAIDS, UNDP, UNFPA and UN Women, among other partners – in particular two global and one regional consultations addressing GBV and engaging men and boys as partners for gender equality in HIV (Nairobi 2010,<sup>8</sup> Istanbul 2011<sup>9</sup> and Johannesburg 2012<sup>10</sup>). The meeting also aligned with and built on related streams of work, including: the UNAIDS, UNDP, International HIV/AIDS Alliance, HEARD and ATHENA September 2011 meeting; the UNFPA, Sonke Gender Justice, MenEngage, ATHENA and HEARD regional workshop on gender transformative norms in October 2012; and the report of the Global Commission on HIV and the Law.

The participating country delegations from Burundi, Cameroun, Côte d'Ivoire, DRC, Ghana and Sénégal were comprised of representatives from the government entity charged with the HIV response and the women's/gender ministry; representatives from civil society organisations addressing GBV and/or women's rights, engaging men and boys for gender equality; networks of women living with HIV; and representatives of the UN family. In addition, a smaller delegation from Nigeria shared good practice, experiences and the challenges of robust GBV work conducted at programme level. Nigeria participated in the 2011 Istanbul meeting and is currently in the process of country follow-up.

## DEFINITIONS

### Violence against women

"Any act of GBV that results in, or is likely to result in physical, sexual or mental harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life"

### UN GENERAL ASSEMBLY DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN 48/104

*Includes: sexual abuse of children, rape, intimate partner violence, sexual assault and harassment, date rape, trafficking and harmful traditional practices*

### Intimate partner violence

"Actual or threatened physical or sexual violence or psychological and emotional abuse directed towards a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner."

SALTZMAN ET AL, 1999

*Includes: slapping, kicking, burning, strangulation; coerced sex through force, threats, intimidation; isolation, verbal aggression, humiliation, stalking, economic violence, controlling victim's access to healthcare or employment.*

### Violence against women living with HIV

"Any act, structure or process on which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV."

FIONA HALE AND MARIJO VAZQUEZ, 2011

7. Includes UNAIDS Secretariat, Cosponsors (UNDP, UNFPA, UNHCR, ILO, WFP, UNESCO, UNICEF, UNODC, WHO, World Bank) and UN Women (now a Cosponsor).

8. Countries represented: Cambodia, Côte d'Ivoire, Kenya, India, Jamaica, Haiti, Liberia, Pakistan, Papua New Guinea, Rwanda, Serbia, South Africa, Sudan and Ukraine.

9. Countries represented: Belize, Brazil, China, Ecuador, Egypt, Indonesia, Iran, Kazakhstan, Malawi, Moldova, Myanmar, Nigeria, Russia, Swaziland, Tajikistan, Thailand and Uganda.

10. Countries represented: Angola, Malawi, Mozambique, South Africa, Tanzania and Zimbabwe.

## OVERALL GOALS OF THE CONSULTATION

The **2013 West and Central Africa Regional Consultation** aimed to support six country delegations to review and develop action plans for implementing policy and legislative environments for addressing GBV. The review sought to identify the critical policy gaps for their NSPs on HIV and GBV and to address and share experiences across the region. The meeting also aimed to support country teams to develop national roadmaps to strengthen cross-cutting attention to gender equality, GBV, and engaging men and boys. This strengthening was directed at emphasising gender equality in their national planning processes and forthcoming NSPs (or reviews), proposals or implementation of Global Fund to Fight AIDS, Tuberculosis and Malaria proposals under the new funding model. It also potentially pertained to other relevant national plans and processes such as responses to emergencies and recovery (e.g. disaster risk reduction programming).

## MEETING OBJECTIVES

In response to the above commitments and goals, the consultation aimed to:

- Accelerate the inclusion and implementation of policies and programmes around GBV and HIV in West and Central Africa, with a focus on development contexts and fragile settings, by sharing regional experiences and lessons learned.
- Advance the strategy of engaging men and boys as partners, as a means of advancing gender equality and as a key intervention to interrupt and halt the GBV-leads-to-HIV-leads-to-GBV cycle.
- Identify opportunities within NSPs, and their related operational or implementation plans, to address humanitarian responses and post-crisis recovery in HIV planning, implementation, and monitoring and evaluation
- Identify other national policies and operational plans (including legislative reform) to address GBV and opportunities to influence these.
- Consolidate and build on current in-country work supporting governments, including National AIDS Commissions (NACs), around GBV and HIV.
- Strengthen partnerships and synergies across key government officials, women's rights advocates, networks of women living with HIV, entities engaging men and boys for gender equality, and the UN family.

## ANTICIPATED OUTPUTS

- Consensus and understanding regarding the mutually reinforcing cycle of GBV and HIV, and the potential role of engaging men and boys as partners in advancing gender equality in emergency settings to interrupt and halt this cycle.
- Analysis of existing country plans, drawing on lessons learned within the country and across the region.
- Country level action plans to support the integration and attention to GBV, the engagement of men and boys as partners in advancing gender equality, and disaster risk reduction in NSPs.

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

UNAIDS AGENDA P.10

All the presentations and resulting country action plans, are available at:  
[http://salamandertrust.net/index.php/Projects/Dakar\\_Workshop\\_Sep\\_2013/](http://salamandertrust.net/index.php/Projects/Dakar_Workshop_Sep_2013/)

Resources in French are available at:  
[http://salamandertrust.net/index.php/Projects/Dakar\\_Atelier\\_sep\\_2013/](http://salamandertrust.net/index.php/Projects/Dakar_Atelier_sep_2013/)

Additional resources available at: [www.whatworksforwomen.org](http://www.whatworksforwomen.org)



# Meeting proceedings

## Day 1



Criminalisation of all forms of HIV transmission or exposure and of all parts of the population inhibits adequate access

to comprehensive HIV prevention and treatment services and care. In West and Central Africa, whether implicitly or explicitly, every country in the region forbids becoming pregnant or breastfeeding if HIV positive based on the fear women living with HIV will transmit the virus to the child despite scientific evidence to the contrary and established approaches that successfully prevent vertical transmission.<sup>11</sup>

Sierra Leone is one case where criminalisation is explicit, criminalising mother-to-child transmission of HIV in its 2007 law, The Prevention and Control of HIV and AIDS Act.<sup>12</sup> In effect, this prevents women living with HIV from enjoying the right to safe healthy motherhood, and there is a growing body of evidence from across the continent documenting how women living with HIV have been forcibly and/or coercively sterilised as well as pressured to terminate pregnancies due solely to their HIV status.

“Where cultural and traditional legal systems embrace values of dignity and empower women to be equal members of society, women’s vulnerability to HIV is reduced.”

GLOBAL COMMISSION ON HIV AND THE LAW

### KEY CONCEPTS: FRAMING DIALOGUE

#### 1. Introduction: a gender-responsive UNAIDS Susana Fried, UNDP

Addressing gender inequality in the context of, and through, the HIV response, is a key priority of the UN Joint Programme on AIDS (UNAIDS).

The **UNAIDS 2011–2015 Strategy: Getting to Zero, Strategic Direction 3** pledges the UNAIDS family to “*ending the HIV-related stigma, discrimination, gender inequality and violence against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services.*” To this end, UNAIDS and UN partners have committed to achieving the following goals by the end of 2015:

1. HIV-specific needs of women and girls are addressed in at least half of all national HIV responses; and
2. Zero tolerance for gender-based violence.

The **UNAIDS Agenda for Accelerated Action for Women, Girls, Gender Equality and HIV** commits to “*address HIV needs of women and girls and stop violence against women*” and to strengthen and broaden partnerships, build synergies between the women’s rights movement and the HIV response, and actively engage men and boys for gender equality. The overall goal of the Dakar meeting aligns with the three key recommendations of the Agenda:

1. Generate better evidence and increased understanding of the specific needs of women and girls in the context of HIV and ensure tailored national AIDS responses.
2. Translate political commitments into scaled-up action and resources that address the rights and needs of women and girls in the context of HIV.
3. Champion leadership for an enabling environment that promotes and protects women and girls’ human rights and their empowerment, in the context of HIV.

In addition, the **Strategic Investment Framework** recognises gender equality and ending GBV as critical enablers for the successful implementation of basic programme areas, and as development synergies for an effective HIV response.

Further, the UN Secretary-General’s UNiTE to End Violence against Women campaign, the Millennium Declaration and the 2015 deadline of the Millennium Development Goals (MDGs) all make clear the UN’s commitment to ending GBV and advancing women’s rights.

Findings from the Global Commission on HIV and the Law reveal that violence against women and violence against women living with HIV continues with impunity and inadequate laws and law enforcement undermine HIV response. The Commission recommends two key areas moving forward:

- Show zero tolerance for GBV with laws prohibiting violence, full enforcement of laws, and comprehensive and fully resourced national strategies.
- Stop the practice of forced abortion and coerced sterilisation of women living with HIV as well as all other forms of GBV in healthcare settings.

11. Global Commission on HIV and the Law, 2012, “Risks, Rights, and Health”, p. 23.

12. The Prevention and Control of HIV and AIDS Act (2007). Available at: [http://www.ilo.org/wcmsp5/groups/public/---ed\\_protect/---protrav/---ilo\\_aids/documents/legaldocument/wcms\\_127617.pdf](http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_127617.pdf)





## 2. HIV/GBV linkages: structural drivers, addressing gender norms and the need to focus on rights and empowerment Upala Devi, UNFPA; Anthonia Aina, Centers for Disease Control

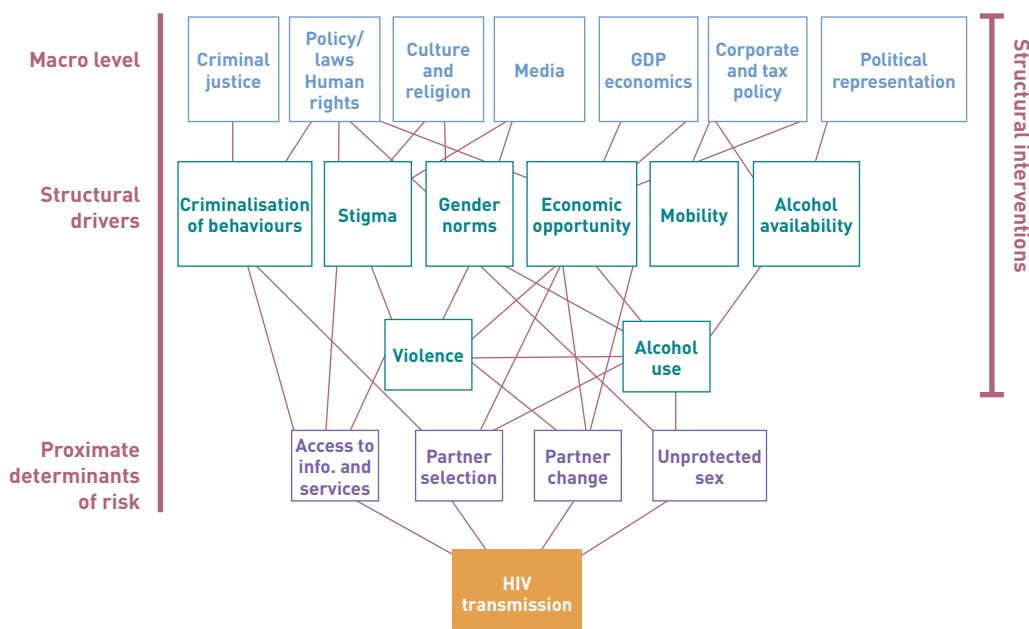
There is ample evidence to demonstrate that women who have experienced violence are more likely to have HIV, and that women living with HIV are more likely to have experienced violence.<sup>13</sup> Violence (or the threat of) can increase women and girls' vulnerability to HIV acquisition, and can also be a barrier in accessing HIV prevention, care and treatment services. This cycle is exacerbated by economic disempowerment and the experience of humanitarian crises such as conflict or post-conflict situations.

These factors culminate in a self-perpetuating cycle, whereby the limited opportunities for women and girls, due to lack of access to information and education, lead to a dependence on male partners, including on survival sex. This embeds women's lower social status, resulting in poor negotiating ability in sexual practices, which can lead to HIV acquisition, increasing women's vulnerability to violence and marginalisation. This in turn may lead to a lack of access to quality care, information and services and so the cycle begins again.

Globally, it is estimated that one in three women will experience physical or sexual violence by a partner or sexual violence by a non-partner in their lifetime. In addition to increasing women's vulnerability to HIV, women who experience intimate partner violence are more likely to have mental health issues, drug or alcohol dependency disorders and low birth weight babies.

The intersection of several norms and practices at individual, community and societal levels provide a fertile ground for violence against women.<sup>14</sup> Similarly, structural forces – legal, economic, and social – also shape the HIV risk of individuals and populations. These factors interact in many different ways to affect behaviours, such as choice of sexual partner and use of condoms. These structural factors also undermine treatment and prevention efforts (see Figure 1). Interventions to address violence and efforts to mitigate the impact of HIV need to work at the societal and structural as well as addressing practices at the community and individual behavioural levels.

FIGURE 1



In West and Central Africa, gender norms perpetuate disempowerment, particularly evidenced by child marriage rates exceeding half of all girls under the age of 18 in a number of countries in the region. Strikingly, in Niger, 75% of girls are married before the age of 18.<sup>15</sup> In the Central African Republic, Guinea and Mali, the figures are 68%, 63% and 55% respectively.<sup>16</sup> In Chad, the figure is also 68% and correlates with a high prevalence of HIV, at 2.7% of the adult population.

13. The evidence that women living with HIV are more likely to experience intimate partner violence remains largely unpublished in peer review journals; however, testimonies from women living with HIV around the world support this. See Sophia Forum's list of related materials, available at: <https://www.dropbox.com/sh/25kk5zz8du7rgjm/aZTxELjp32>

14. Individual factors include growing up in a violent household, lack of educational attainment, drug and alcohol consumption. Community factors include viewing violence against women as normal, lack of social sanction for violence, and norms of family privacy. Society factors include lack of economic opportunities for women, discriminatory family laws, and emphasis on family "honour".

15. International Center for Research on Women, "Child Marriage Hot Spots," (2013). Available at [www.icrw.org/child-marriage-facts-and-figures](http://www.icrw.org/child-marriage-facts-and-figures)

16. UNICEF, Chad, Statistics, HIV/AIDS (2012).



Côte d'Ivoire proved a model post-conflict example in programming by Sonke Gender Justice and the

International Rescue Committee's joint programme to engage men and boys in the conversation about GBV. The programming centres around forging an alliance between men and women to equally participate in and benefit from reconstructing Côte d'Ivoire in a post-conflict era.<sup>17</sup>

### 3. Addressing gender norms and the role of men and boys and the use of the gender-transformative approach to address violence against women and HIV Bafana Khumalo, Sonke Gender Justice

Gender inequality has serious negative consequences for women and girls, including lower levels of educational enrolment and attainment (although globally, this gap is closing); easily preventable incidences of maternal mortality; unequal pay and unrecognised/unpaid labour; disproportionately high rates of HIV prevalence among young women aged 15–24; and, exposure to GBV, including sexual violence and harassment. However, gender norms and practices can also have harmful outcomes for men and boys, including suicide, poor mental health and health-seeking behaviour; alcohol, tobacco, and drug consumption; risk-taking; and involvement in situations of violence – including political conflict. Working with men and boys as partners for transforming gender norms and addressing gender inequality is a proven approach for addressing harmful attitudes and practices that can have a negative impact in both men's and women's lives.

Gender transformative approaches actively strive to examine, question and change rigid gender norms and imbalances of power. Often transformative approaches involve working with either women and girls or men and boys to tackle specific issues. A synchronised approach involves working with both men/boys and women/girls – either separately first, then together, or together from the outset. This approach recognises that whole communities are agents in either upholding or challenging gender norms.

#### Key questions for developing a gender transformative programme

- How will the different roles and statuses of women and men within the community, political sphere, workplace, and household affect the work to be undertaken?
- Does the proposed programme respect and support individual rights?
- Does the intervention try to overcome some of the gender inequalities that limit men's and women's lives?
- How do you plan to address these different roles and statuses of women and men with this intervention?
- How will the anticipated results of the work affect women and men differently?

➤ **Key discussion point.** Statistics can be disheartening and induce a sense of defeat. How can we change our outlook and language to approach the HIV response in a more positive, dynamic and creative way? There are many key interventions and approaches that focus on positive living and the involvement of people living with HIV. One example of this is the Positive, Health, Dignity and Prevention Framework.<sup>18</sup> Another is to engage men as partners rather than as perpetrators, and women as agents rather than victims. We need to look at good practice models, approaches and interventions that have worked. Let's use the Three Es: **Empower** women and girls, **Engage** men and boys as partners for gender equality, **Ensure** there is an enabling legal and policy environment for gender equality.

17. See generally, "Sonke works with IRC against GBV in Côte d'Ivoire," available at <http://www.genderjustice.org.za/resources/newsletters/sonke-enewsletter/issue-7/2000651-sonke-works-with-irc-against-gbv-in-cote-divoire.html>

18. Available at: <http://www.gnpplus.net/resources/positive-health-dignity-and-prevention-operational-guidelines/>



#### 4. Young people and adolescents as actors and as a vulnerable group

Abdelkader Bacha, UNICEF

HIV prevalence in West and Central Africa is much lower than in Southern and East Africa but within these figures are concentrated epidemics – prevalence reaches 20–30% within certain populations. The overall prevalence rate also hides the feminisation of the epidemic. The numbers of women with HIV is 50% higher than prevalence among the general adult population. Gender-based violence is a key driver of the epidemic creating a cycle of isolation and exclusion.

Adolescent marriage and pregnancy are also high, with figures exceeding 10% in many countries. Further, there is a very high rate of acceptability of intimate partner violence against women, among both men and women.

In conflict-affected countries, GBV and sexual violence are often exacerbated. Rape is used as a weapon of war. Young women are exposed to different types of violence. Natural disasters also place young women in situations of vulnerability where families and communities may be thrust into poverty.

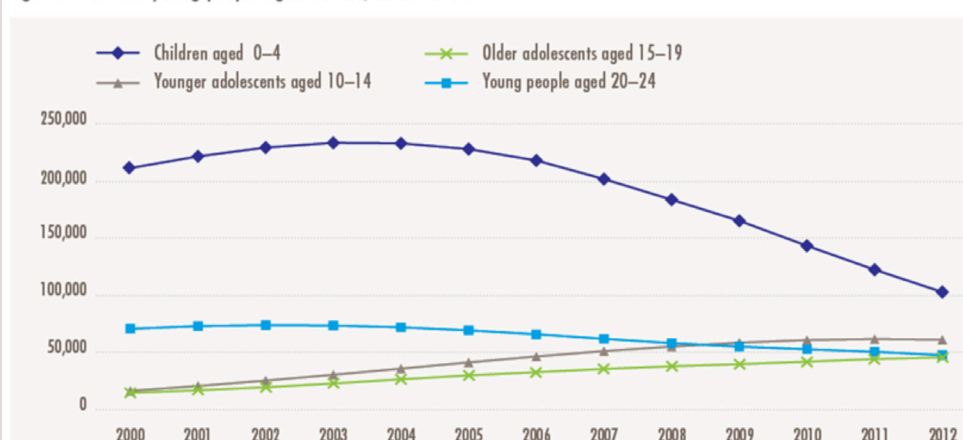
Services tailored to the needs, rights, and priorities of adolescents living with HIV and from key populations are also scarce.

In this context, young people are an entry point for addressing these trends and interrupting cycles of violence and vulnerability. There is a need to increase knowledge of the specific ways in which adolescents and young people are vulnerable to HIV acquisition, provide tailored services, and address roadblocks and barriers, including at the legal and policy level. There also needs to be much stronger accountability for young people and adolescents within HIV programming and greater, more meaningful involvement of them in policy and programme design, delivery, monitoring and evaluation.

Good practice examples include Shuga Radio in DRC and Cameroun, which allows young people to discuss their issues in anonymity, and the cartoon strip Aya de Yopougon from Côte d'Ivoire.

FIGURE 2: ADOLESCENT AIDS -RELATED DEATHS

Estimated number of AIDS-related deaths among children aged 0–4, younger adolescents aged 10–14, older adolescents aged 15–19 and young people aged 20–24, 2000–2012



Source: UNICEF analysis of UNAIDS 2012 HIV and AIDS estimates.



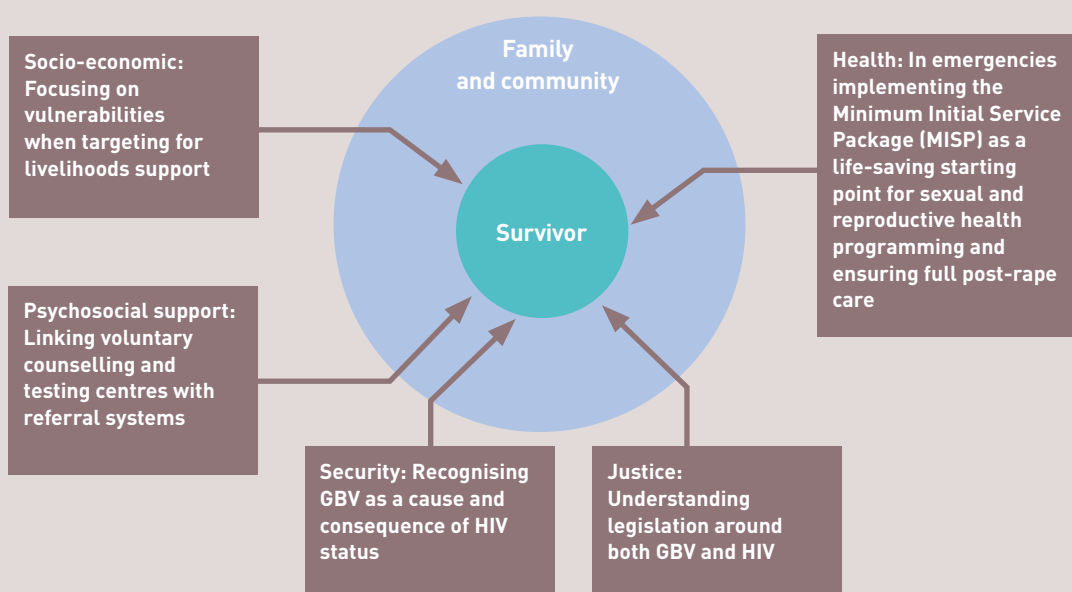
## 5. Violence and vulnerabilities: addressing gender-based violence and HIV in humanitarian settings

Lina Abirafeh, GBV RRT West and Central Africa

Violence, specifically GBV, escalates in emergency settings. Women and girls, and also men and boys, are immediately exposed to a new, different, and/or intensified range of GBV – the most dangerous of which is sexual violence. Existing vulnerabilities are exacerbated, while services and resources to mitigate them become more scarce or unavailable, and laws and policies that might have existed to protect women and girls from violence are disregarded. In emergency contexts, women and girls are also at risk of sexual exploitation and abuse, from people who are supposed to help them. In addition to dealing with their own vulnerabilities, they also carry a disproportionate burden of care for others who might be in need.

GBV prevention and response is not an add-on. It is necessary from the beginning of the emergency. Emergency and non-emergency responses to GBV are not the same. Services need to be flexible, do more with less, and often cover a range of intersecting issues such as GBV and HIV. Co-lead by UNFPA and UNICEF, the GBV Area of Responsibility (AoR) Rapid Response Team (RRT) provides technical support to programmes in emergency situations on an “as needed” basis. GBV response combines three approaches: rights-based, community-based and survivor-centred, and is guided by the principles of safety, confidentiality, respect, and non-discrimination. GBV response puts the survivors at the centre of multi-sectoral support in order to offer survivors the full range of care.

FIGURE 3: ENTRY POINTS FOR HIV PROGRAMMING



## 6. Gender-related vulnerabilities and HIV in conflict and post-conflict settings

Hortense Gbaguidi, UN Women

Conflict and post-conflict settings exacerbate gendered vulnerabilities to HIV and create new risks for exposure. As a part of women's role in society, women tend to be less mobile because they are homebound, making them less able to avert danger. Economic disadvantage perpetuates this vulnerability, as impoverished women are less likely to be educated or aware of the risks of exposure to GBV and HIV.



West and Central Africa has been home to a disproportionate amount of states in emergency, particularly in the conflict and post-conflict setting. As Major General Patrick Cammaert, former UN Peacekeeping Operation commander in the DRC candidly expressed, “It is now more dangerous to be a woman than to be a soldier in modern conflict.”

91% of DRC rape victims and survivors in the South Kivu region reported experiencing rape-related illness (e.g. tissue tears from the use of guns, branches and other objects to violate the survivors<sup>19</sup>). In Liberia, during the conflict period of 1993–2003, the overall proportion of women who experienced non-family member violence was 10 times higher compared to reported violence in post-conflict years.<sup>20</sup>

In the case of an armed conflict, housing loss compels displacement from the home and community. Living in temporary shelters or other people’s homes compromises safety. Women and children are also used as weapons of war, heightening trafficking, domestic and sexual violence, forced prostitution, rape and forced abortion. Female child soldiers are expected to perform sexual services in addition to their other duties. All of these scenarios increase the risk of HIV transmission.

Migration can also be a consequence of armed conflict, increasing the need for transactional sex and diminishing the likelihood of safe sexual practices. Again, each of these increases the chance of HIV exposure.

### How should gender be taken into account in emergency situations?

- **Gender analysis** to inform preparedness before, during and after conflict and/or emergency/humanitarian settings to ensure the right response for all women, girls, boys and men.
- **Vulnerability assessment** to identify who is most vulnerable, and why, which capacities need to be developed/strengthened, as well as what relief and services are specifically needed.
- **Information gathering and management** should be timely and ensure the collection of essential gender and protection information and HIV trends. Attention should be paid to ensuring the appropriate gender mix in assessment team. Ideally, women-to-women and men-to-men discussions should be conducted when identifying the needs, coping abilities and best solutions for all in the affected populations. All follow-up assessments need to capture in more depth the relevant HIV information, and disaggregated data by gender, age, disability and context-relevant vulnerability. Preparedness should always put priority on having agreed GBV/HIV data, assessment tools and approaches in place before conflict or disaster strikes.
- **Planning** to develop country-level contingency plans and cluster work plans. Standards and guidelines need to be agreed upon before either crisis, conflict or disaster strikes. Gender-sensitive planning is also fundamental to effective stockpiling, ensuring that relief (medical and HIV prevention and care supply including post-exposure prophylaxis (PEP) and holistic support) meet assessed needs and do not cause harm.
- **Capacity-building** to build preparedness at community level is key to reducing risk, building on existing knowledge, coping mechanisms and structures, to prevent and respond to GBV and HIV, and actively and equally involving men and women in recovery processes.

19. “Managing Gender-based Violence Programmes in Emergencies,” e-Learning Companion Guide, p.11. Available at [www.unfpa.org/webdav/site/global/shared/documents/publications/2012/GBV%20E-Learning%20Companion%20Guide\\_ENGLISH.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/GBV%20E-Learning%20Companion%20Guide_ENGLISH.pdf)

20. “Managing Gender-based Violence Programmes in Emergencies,” e-Learning Companion Guide, p.11. Available at [www.unfpa.org/webdav/site/global/shared/documents/publications/2012/GBV%20E-Learning%20Companion%20Guide\\_ENGLISH.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/GBV%20E-Learning%20Companion%20Guide_ENGLISH.pdf)



Punitive laws set everyone back, hurting many and protecting no-one. Criminalisation of homosexuality and same-sex relations only ostracises and forces into hiding those who need HIV services the most. Statistics demonstrate the harm of criminalising the marginalised, particularly in Cameroun and Nigeria. In Cameroun, where criminalisation laws are fierce, the generalised epidemic of 4.3% prevalence is dwarfed by the intensity of the epidemic among MSM at 37.2%.<sup>21</sup> In Nigeria, HIV prevalence among MSM has increased from 13.5% (2007) to 17.8% (2012), compared with a decline in the generalised epidemic from 4.6% (2008) to 4.1% (2012).<sup>22</sup>



Nigeria is the most populous country in sub-Saharan Africa and has the second highest HIV prevalence rate across the African continent. With rapid increase in incidence experienced between 1991–2001, the overall percentage of people living with HIV has declined since then. Despite declining to its lowest rate of 4.1% by 2010, this is no safety zone, as the rates continue to rise among MSM. Still, 80% of new HIV cases in Nigeria transmit through “low-risk” heterosexual encounters.<sup>23</sup>

21. “Cameroun, Country Progress Report”, p.10 (2012). Available at: [www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce\\_CM\\_Narrative\\_Report.pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_CM_Narrative_Report.pdf)

22. “Nigeria, Country Progress Report”, p.11, 22 (2012). Available at: [www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/Nigeria%202012%20GARPR%20Report%20Revised.pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/Nigeria%202012%20GARPR%20Report%20Revised.pdf)

23. “Nigeria, Country Progress Report”, p.10–11 (2012). Available at: [www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/Nigeria%202012%20GARPR%20Report%20Revised.pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/Nigeria%202012%20GARPR%20Report%20Revised.pdf)

## 7. Higher risk of HIV among key populations

**Bechir N'Daw, UNDP**

The Global Commission on HIV and the Law is an independent body established in 2010 to examine high-impact issues of HIV and the law, which have important ramifications for global health and development. The Commission advocates for evidence and human rights-based legal environments for effective and efficient HIV responses. The Commission found that:

- many countries have laws to protect people from HIV-related stigma and discrimination or other forms of discrimination that increase vulnerability of specific populations to HIV, but that these laws are often ineffectively implemented
- laws that criminalise HIV exposure or transmission discourage people from getting tested or treated, in fear of being prosecuted for transmitting HIV
- the law can dehumanise many of those at highest risk for HIV: sex workers, transgender people, men who have sex with men (MSM), injecting drug users, prisoners and migrants, rendering them more vulnerable to HIV
- laws and legally condoned customs – from genital mutilation to denial of property rights – produce profound gender inequality.

A summary of the recommendations of the Commission is available at: [www.hivlawcommission.org/resources/report/Executive-Summary-GCHL-EN.pdf](http://www.hivlawcommission.org/resources/report/Executive-Summary-GCHL-EN.pdf)

## NIGERIA EXPERIENCE

**Ifeoma Madueke, UNDP**

Nigeria is in the process of conducting a readiness assessment as part of developing an integrated response to address GBV and engage men and boys as partners for gender equality, through NSPs on HIV. The process is undertaken with a range of stakeholders from government, donor communities, technical agencies and civil society to gain broad consensus and support. The readiness assessment has comprised a mapping of entry points, barriers and capacity needs of key stakeholders to integrate GBV into the country's HIV response, including through key informant interviews and a desk review of current policies and practices.

### Initial findings

- Nigeria has a number of GBV-related laws at national and state levels
- At state level the laws are more concentrated in the south
- Response to GBV and HIV has not been well integrated
- Poor coordination of the components of a comprehensive response to GBV and HIV
- Poor linkage between actors responding to the problem, e.g. Mirabel Centre and Hello Lagos
- Lack of information at different levels – women, girls, and boys often do not know what to do or where to turn to when they experience abuse
- Gaps in knowledge of GBV/HIV among medical personnel, social workers, legal and law enforcement agents, etc.
- No single authority or point of accountability for addressing GBV/HIV link within government
- Police are ill-equipped to determine appropriate charges, prepare appropriate court papers and prosecute cases to secure convictions

## GREEN-LIGHT THINKING

Alice Welbourn, Salamander Trust

If our aim is “getting to zero” – an end or elimination of violence – what lies beyond that point? Starting at a point of ‘beginning’, rather than moving towards a point of ‘ending’, may help to explore broader horizons and creative possibilities.

Cognitive research in the last decade has increased our understanding of positive thinking. The part of the brain that deals with threats and protection is the oldest and the first to kick in during any situation. The newer part – drive and achievement – enables us to invent, build, plan and succeed, but can also lead us down a destructive path. A third part is the one we are the least likely to engage and is the area that supports kindness, connectedness, empathy and profound creativity. We need to engage all three parts of our brain and in particular practise using this least-used third part.

**What do communities look like when we apply “green light thinking” using all three parts of our brains?**

**Ghana:** a society where we work with all of the partners ...

**Cameroun:** a society without GBV and with opportunities – where tolerance exists and when problems arise they are immediately solved because we have the tools.

**Nigeria:** a society where we socialise our children ... and see faith as a platform to spread the HIV prevention message to promote information about GBV.

**Sénégal:** people will be informed of their rights as human beings.

**Côte d’Ivoire:** sensitise children at school age so that they can understand good and bad gender issues as early as possible.

**DRC:** a pacified and developed country ... with more gender-positive laws so that we can have more peace and greater gender equality.

## REVIEW OF POLICY ENVIRONMENT

Sonke Policy Scan Nkonzo Khanyile, Sonke Gender Justice

In 2012, Sonke and MenEngage carried out an Africa regional policy analysis of 15 countries, looking at whether policies, laws, and plans contained language relating to the proactive and progressive engagement of men and boys, focusing on five key areas:

- HIV and AIDS
- Gender-based violence
- Sexual and reproductive health and rights
- Parenting
- LGBTI (lesbian, gay, bisexual, transgender, intersex)

Preliminary findings show that countries do address some links between GBV and HIV, and that about half adequately recognise the benefits of engaging men in ‘vertical transmission of HIV’ programmes. The scan revealed serious gaps in the areas of engaging men in GBV prevention efforts, in addressing negative attitudes among men towards condoms, and in encouraging men to become involved in care work. Men were also rarely targeted for VCT, HIV treatment or health-seeking behaviour in general, and no country had adequate provisions for addressing the needs of marginalised men, such as men in prisons, men who inject drugs, MSM or male refugees.

Are we ending violence?

Or seeking safeness?



The People Living with HIV Stigma Index reveals through a sampling of participants the experiences of stigma across 50 countries, including those in West and Central Africa. Of particular note, in Cameroun 17% of respondents indicated that they had<sup>24</sup> been abused by a family member. In Nigeria, one in five participants had been denied access to health care on account of HIV status.<sup>25</sup>

24. “Cameroun: Self stigma an all too common barrier to accessing services”. Available at: <http://www.stigmaindex.org/437/press-releases/cameroun-self-stigma-an-all-too-common-barrier-to-accessing-services.html>

25. “Nigeria, People Living with HIV Stigma Index”, p.10 (2011).





## UNAIDS Gender Scorecard Berthilde Gahongayire, UNAIDS

In 2011 UNAIDS conducted a global review progress against the implementation of the UNAIDS Agenda for Accelerated Country Action on Women, Girls, Gender Equality and HIV. Each country was given a questionnaire with 14 markers, following the three recommendations of the Agenda – evidence, translation of policy into action and enabling/empowering environment. Countries were asked how they rated the progress in each country: Red, for no progress; yellow, if some small or localised projects had been implemented; and green, if the intervention had been on a national scale.

From a regional perspective, West and Central Africa have done comparatively well in some areas (e.g. gender-disaggregated data and having conducted situational analyses exploring the vulnerabilities of women and girls). However, in other areas the region is lagging behind (e.g. collecting data on GBV and HIV and programming for the engagement of men and boys as partners for gender equality – there is beginning to be some progress here, but no “greens”).

FIGURE 4: UNAIDS GENDER SCORECARD RESULTS: WEST AND CENTRAL AFRICA

COUNTRY	1. Disaggregated data	2. Qualitative assessments	3. National response gender review	4. GBV/HIV data	5. Data on national responses for women's programmes	6. Funding for men/boys programmes	7. SRH-HIV integration	8. Health sector GBV policy	9. HIV plans/budgets in women ministries	10. Female condoms	11. HIV positive women participation in response review	12. Affected women participation in CEDAW monitoring	13. Social protection for HIV positive women	14. Response budget for women's organisations
Benin														
Burkina Faso														
Burundi														
Central African Republic														
Chad														
DRC														
Ghana														
Guinea														
Liberia														
Mali														
Niger														
Nigeria														
Republic of Congo														
Sénégal														
Sierra Leone														
The Gambia														
Togo														



## Day 2



### FROM CONCEPT TO PRACTICE 1: MEANINGFUL INVOLVEMENT OF WOMEN LIVING WITH HIV

**Calorine Kenkem, Cameroun Network of Women Living with HIV;  
Alice Welbourn, Salamander Trust**

There is a significant feminisation of the HIV epidemic in West and Central Africa, with a higher prevalence of women with HIV among the general population and in particular young women. Women experience specific vulnerabilities in relation to HIV, including increased exposure to GBV among women living with HIV.

Cameroun and Sénégal have recently used the Stigma Index, Human Rights Count and GIPA Scorecard to understand the experiences of stigma by people living with HIV in order to strengthen advocacy efforts.

The research was carried out by and with women and men living with HIV, with a greater number of women involved as researchers and research participants. The testimonies revealed the depth and level of GBV and other human rights violations experienced by women living with HIV in the two countries.

The study also revealed that almost half of people living with HIV felt that they had no influence at local, national or international levels on policies and programmes addressing HIV. In each area, more women felt excluded from influencing forums than did men.

Women's networks often provide care and support in the community but with few resources. In Côte d'Ivoire, the network provides psychosocial support to women who have experienced violence. In eight years, it has supported 850 women and helped over 300 with training and income-generation. In Burundi the network was only established in 2011 and is still finding a foothold in policy forums. Two members of the network are on high-level prevention of mother-to-child transmission (PMTCT) committees, however, funding remains a challenge.

Consultation with women living with HIV is vital to avoid the introduction of laws and policies, which may inadvertently punish women – such as the criminalisation of HIV exposure and transmission, including vertical transmission. In Sierra Leone swift mobilisation among women living with HIV resulted in legal change. In Namibia, young women living with HIV took the government to court, where it was ruled that a number of women had been sterilised without full and informed consent, although the Ministry of Health is appealing against the decision.

"After my husband died, my brother-in-law revealed my status and they treated me like a witch, like a criminal. They hurled abuse at me and made me leave the house that night. They took everything that their brother had left behind."

"It was my husband who disclosed my status before abandoning me, saying that I was a girl of loose morals, which was why I had become infected."



## TREE OF PARTICIPATION

Using the ICW Tree of Participation, participants of the meeting representing networks of women living with HIV, discussed the extent to which they and their networks are involved in decision-making in their countries. Women living with HIV from each country then described their own experiences in relation to the tree.

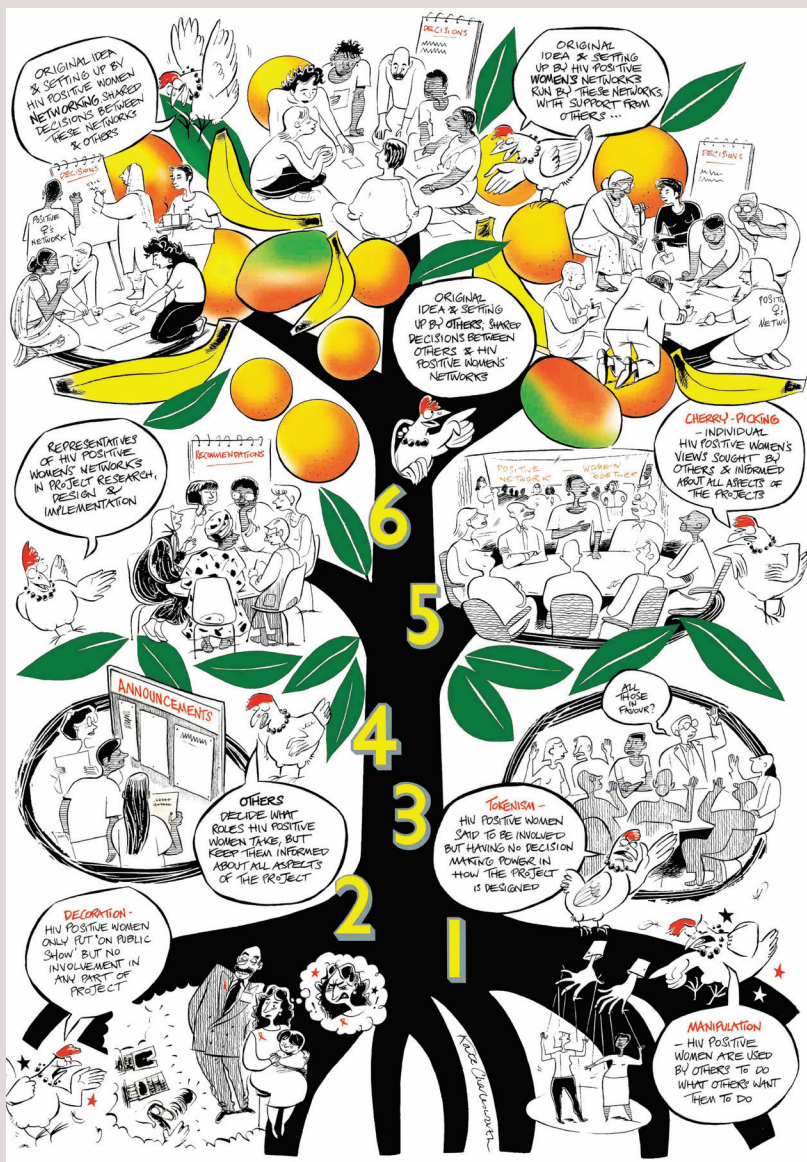
**Burundi:** At the grassroots level we are just decorative, so to speak. We don't have resources but we have reps in all the provinces of the country. We are involved in all marches and protests and many activities but at the decision-making level we are not very present. Since the organisation was born, the authorities made a timid attempt to involve us in decision-making, and we have had to struggle.

**Cameroun:** Regarding financing, Cameroun doesn't have the necessary resources to finance the activities of women living with HIV. We can't do much because of that.

**Côte d'Ivoire:** Sometimes we are consulted. It is not done routinely, and also I don't think it's done sincerely. With the Global Fund when they want a lot of hype and talk, they call us for decorative purposes but we have said that we refuse to be used in this way when it is just for the sake of making politicians look good.

**DRC:** Half of the network are women. Gender equality is a given. So much so that in the board of directors the chair person is a woman and 40% of the provincial leaders are women, but when you go to the secretariat only one out of seven is a woman – so the representation is somewhat symbolic

**Nigeria:** There is a national association of people living with HIV in Nigeria, but the women came out of that and formed their own network because they felt they were not properly represented. I can comfortably say that sometimes they are called as representatives, but other times the ideas originate from them. They speak for themselves and have a voice.



Available at: [http://www.womeneurope.net/resources/Policybriefing\\_ENGJuly2011.pdf](http://www.womeneurope.net/resources/Policybriefing_ENGJuly2011.pdf)



## FROM CONCEPT TO PRACTICE 2: WORKING WITH UNIFORMED PERSONNEL

**Berthilde Gahongayire, UNAIDS; Sibili Yelibi, UNFPA**

UN Security Council resolution 1983 (based on resolution 1308) recognises that situations of conflict can have an exacerbating effect on the HIV epidemic of a country, and that a public health crisis can have a destabilising effect on peace and security. Resolution 1983 calls for peace-keeping forces to address HIV, including the needs of people living with HIV.

It can be applied in situations of conflict and post-conflict; humanitarian crisis; natural disasters; widespread sexual violence, where rape is used as a weapon of war; among vulnerable populations including internally-displaced people, refugees, women and girls in times of war. Three priority areas for implementation are:

- **Empowerment of women and sensitisation of men** in the armed forces on GBV
- **Disarmament, demobilisation, and reintegration**
- **Reform of the security sector** (i.e. police, prison officers, border personnel)

Sexual violence and GBV are often committed by members of the armed forces. Efforts to address this include using peer educators within the armed forces, and training-of-trainers. Best practices are emerging from Côte d'Ivoire, Liberia and DRC where programmes are rolled out by peace-keepers.

- **Côte d'Ivoire:** Uniformed personnel and prison populations are considered key populations. Specific training on GBV is being rolled out among police, gendarmerie, forest guards, etc.
- **Liberia:** Efforts have concentrated on the empowerment of women. Even if training is organised within the peace-keeping mission, they move away from the mission itself to train women.
- **DRC:** Efforts include with survivors of rape. This is important because 20% of women have been raped, often by security forces.

Recommendations to emerge from a regional meeting of the West and Central Africa armed forces network responding to HIV, apply to national military forces whether they have peace-keeping forces or not (see below). New HIV programmes targeting uniformed personnel will establish links between HIV and violence. Previously there have been stand-alone programmes on HIV and on GBV – now we are trying to bring the two together.

Uniformed personnel are both a population at risk of HIV, and frequent perpetrators of GBV, including sexual violence and rape. Women within police and armed forces may be subject to gender discrimination and violence from their colleagues. They are a young and sexually active population, living within the community but often with more purchasing power than the average community member. This gives them disproportionate power to exploit others, and they themselves may become vectors of HIV or STI transmission and unwanted pregnancies. This is at odds with their mission to protect the population regardless of gender or religion (among other factors) – and these core objectives and values should be promoted. The military should be engaged in the prevention of GBV and HIV, and trained in human rights, and should be ready and equipped to respond quickly when cases of rights violations are reported to them.

**Burundi:** A voluntary counselling and testing (VCT) centre has been established for armed forces that has a treatment solidarity fund for uniformed personnel and their families. Through this they can also access third-line treatment. **Recommendations:** Pre- and post-deployment testing and counselling; sensitisation among policewomen around HIV and GBV linkages.



**Ghana:** UNAIDS Ghana AIDS Commission, UNFPA and police held a sensitisation workshop with law enforcement officers, sex workers and other stakeholders. Sex workers were invited to present on their experiences with the police. A crisis line was established for sex workers to call in the case of police abuse. **Recommendations:** Capacity-building for health workers and law enforcement agencies to respond to GBV among all women, including sex workers; stronger multi-agency support and collaboration.

**Sénégal:** In 2008 a number of MSM were arrested; a multi-sectoral committee was created (Ministry of Justice, civil society, the Association of Lawyers, and other stakeholders) who contributed to their release from jail. **Recommendations:** People in Sénégal are still not ready to accept homosexuality. There should be a synergy of stakeholders to address the high prevalence of violence against sexual minorities. Where there is on-going conflict, the prevalence rate of GBV is higher. The synergies and collaborations of the 2008 crisis should be renewed.

**Cameroun:** In the northern province a rapid intervention force has been established to protect internally-displaced people and refugees from armed robbers from neighbouring conflict-affected countries. **Recommendations:** Prevention, awareness-raising and training in human rights for armed forces; counselling centres for people who experience GBV in conflict situation; bolster economic capacity of the organisations who implement these actions.

## PRESENTATION OF GENDER TOOLS

Susana Fried, UNDP; Upala Devi, UNFPA; Luisa Orza, ATHENA Network; Lina Abirafeh, GBV RRT West and Central Africa

The following set of tools, produced by workshop partners, provide a comprehensive toolkit for gender mainstreaming.



FIGURE 5: STAGES IN THE ROADMAP

The stages are sequential but you can jump in at any point. The Roadmap provides, or links to, tools to support the process at each stage.

### 1. Gender Roadmap (UNDP) “On Course”

The Gender Roadmap is a step-by-step guide to mainstreaming gender into national HIV strategies and plans. It is a tool for governments and civil society to address multi-dimensional issues in national HIV efforts and has been designed to align with other tools on gender and HIV. Available at: [www.undp.org/content/undp/en/home/librarypage/hiv-aids/roadmap-on-mainstreaming-gender-into-national-hiv-strategies-and/](http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/roadmap-on-mainstreaming-gender-into-national-hiv-strategies-and/)

### 2. Gender assessment tool (UNAIDS)

The UNAIDS gender assessment tool is being finalised. A pilot assessment has been conducted in five countries, and a second round of pilots is underway.

The tool assists countries to fill gaps in the gender response to HIV, both at the level of data and evidence, to support strategic approaches, and at the level of budgets and financing to meet the needs of women in all their diversity. The tool helps to:

- Improve quality of data to inform the national strategic planning process.
- Position gender equality and violence in the “strategic investment” discussion
- Apply a modular approach, building on available information, to allow flexibility as per local context
- Identify remaining gaps in information.



### 3. Tools for working with men and boys as partners for gender equality (UNFPA)

UNFPA have produced a number of tools looking at:

- Case studies documenting good practice in preventing and responding to GBV. [www.unfpa.org/public/home/publications/pid/4412](http://www.unfpa.org/public/home/publications/pid/4412)
- Conceptual and practical information on engaging with men and boys to address GBV. [www.unfpa.org/public/home/publications/pid/6815](http://www.unfpa.org/public/home/publications/pid/6815)
- Lessons learnt and recommendations for engaging men and boys in advancing gender equality and reproductive health. [www.unfpa.org/public/home/publications/pid/8050](http://www.unfpa.org/public/home/publications/pid/8050)
- How to engage men and boys to respond to GBV in conflict/post-conflict settings. [www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Advocacy%20Brief-%20Sexual%20Violence%20FINAL.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Advocacy%20Brief-%20Sexual%20Violence%20FINAL.pdf)
- A background and rationale for engaging men and boys, and a series of lessons learnt in the areas of evidence and data on engaging men and boys; research, knowledge, and tools for working with men and boys; advocacy, network and partnership-building; support at policy and institutional levels; as well as engaging men and boys at community and individual levels. [www.unfpa.org/public/home/publications/pid/13532](http://www.unfpa.org/public/home/publications/pid/13532)

### 4. Framework for integrating women, girls, and gender equality into NSPs (HEARD/ATHENA)

Since 2010, ATHENA has partnered with researchers at the Health Economics and HIV/AIDS Research Division of the University of KwaZulu-Natal (HEARD) to strengthen language, content, and approach of the next generation of NSPs, to comprehensively address women, girls, and gender equality; expand the knowledge of and engagement by women living with and affected by HIV in national planning processes on HIV; and, continue to foster regional networking, alliance-building, and dialogue across civil society, in particular networks or organisations of women living with HIV. The Framework has been used to establish a baseline review of NSPs in East and southern Africa showing over-arching strengths and weaknesses. Easy-to-use policy analysis tools, derived from each of the nine areas of the Framework, can be used for advocacy and planning.

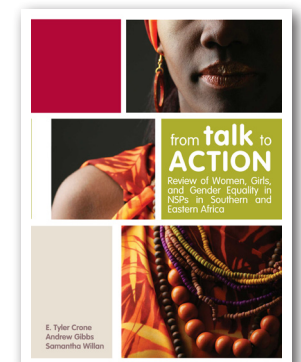
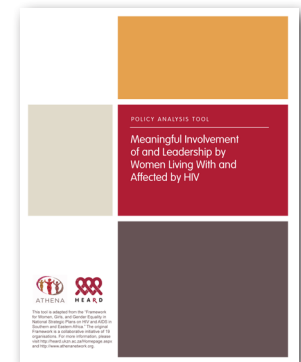
### 5. Linking GBV and HIV: health as a concrete entry point (Lina Abirafeh, GBV RRT West and Central Africa)

If properly prepared and equipped, health services provide an effective entry point to address HIV and GBV together. Health services need to be able to:

- provide appropriate clinical care (i.e. examination, evaluation, documentation, and follow-up)
- collect evidence and instigate further investigation if needed
- make referrals
- ensure proper medical equipment is in place.

Supplies (such as post-rape kits) need to be accurately named, and aligned with national protocols; administered by properly trained staff; and part of a comprehensive system of care including referrals. Communication with communities in relation to care packages is also important to create knowledge and demand for healthcare.

Access to health services is context-specific and includes attention to availability (distance, opening times); affordability (transport and childcare); and acceptability (privacy, confidentiality, sensitivity of health providers, male/female staff). Health services should also be seen as part of a more holistic healthcare culture that includes self-care, social protections, social networks, and support.







## FROM CONCEPT TO PRACTICE 3: WORKING HOLISTICALLY ACROSS COMMUNITIES AND ENGAGING MEN AND BOYS AS PARTNERS FOR GENDER EQUALITY

**Nkonzo Khanyile, Sonke Gender Justice; Alice Welbourn, Salamander Trust**

Engaging men and boys as gender equality activists involves “supply” and “demand” side investment. Service providers should be made more aware of men’s needs as clients and partners, and offer services tailored to their needs; at the same time, men should be encouraged through information, media, and outreach to seek services and be more involved in the health and well-being of their partners and children.

### SONKE GENDER JUSTICE PROGRAMMES

**One Man Can:** Working at community level to bring men and women together to look at the role men can play in ending violence against women, and promoting health and equitable relationships. The programme uses the Stepping Stones model of sex-disaggregated groups for discussion, then coming together to share insights. The action-focused programme interrogates men’s behaviour and encourages them to be more equitable. Men challenge other men to step up.

**Brothers for Life:** National media and community mobilisation targeting men age 30 years+ on a number of risk factors around HIV. “Real men” will use condoms and won’t use violence.

Evaluations of both programmes show self-reported behaviour change in terms of accessing services and increased use of condoms.

### RECOMMENDED LANGUAGE FOR NSPS ON MEN, GENDER INEQUALITIES, GBV AND HIV

<b>Overall</b>	➤ Gender norms to be addressed as a root cause of HIV
<b>Education</b>	➤ Education on gender equality highlight benefits for men ➤ Comprehensive sexuality education for boys and girls
<b>Gender-based violence</b>	➤ Interventions to highlight the role men can play in preventing GBV, supporting GBV victims and survivors, and being advocates for change ➤ Address underlying gender-norms linked to violence
<b>Vertical transmission</b>	➤ Encourage men to support PMTCT as partners and advocates (ensuring the do no harm and safety first principles)
<b>Medical male circumcision</b>	➤ Interventions to be part of a broader package and include gender equality education ➤ Interventions to guard against inhibition
<b>Condoms</b>	➤ Research on men’s attitudes towards condom use ➤ Changing men’s attitudes towards condom use
<b>Testing</b>	➤ Understand why men don’t test ➤ Use innovative methods to increase men’s HIV testing
<b>Vulnerable men</b>	➤ Condoms, lubrication, treatment and testing for prisoners ➤ Interventions tailored to migrants, refugees and MSM
<b>Treatment</b>	➤ Encourage male health-seeking behaviour, as part of strategy to improve their uptake of treatment ➤ Challenge gender norm that sickness = weakness
<b>Care economy</b>	➤ Promote men in care work. Target for trained male care-givers ➤ Address gender-norms that caring is a female domain



For women living with HIV, safety at home and within healthcare settings are vital for treatment adherence. Research in Malawi shows that one of the first things to go when women experience violence in the home is treatment adherence. Governments and healthcare systems need to be accountable to ensure that their programmes are not increasing women's risk of violence and are safe for women to join.

Women must be given the choice of when and whether to start on life-long treatment. If they start treatment before they are ready to, or if adhering to their treatment regimen actually increases their risk or fear of violence in the home, the chances of long-term adherence are slim. This has implications for the treatment programme Option B+, recently trialled in Malawi, which starts women in ante-natal care on treatment for life.

The Coalition of Women Living with HIV (COWLHA) in Malawi have rolled out a Stepping Stones programme in 28 districts. Women living with HIV are at the centre of the programme design, development, implementation and monitoring. It engages men and boys as partners to improve gender relations and transform gender norms, and it involves the community working together to create an enabling environment in which it is safe for women to be tested and treated.

"I used to abuse my wife when she went to the hospital to collect her ARV treatment because she came back late and I didn't like it. I stopped the abuse after COWLHA members came to my house to counsel me that what I was doing was violence"

### STEPPING STONES

Stepping Stones is a gender-transformative behaviour change communication package aiming to challenge prevailing gender norms in relation to HIV and GBV. It was conceived and developed by Alice Welbourn after she was diagnosed with HIV in 1992. Originally developed for use in Uganda, the package has been adapted for use in different contexts, including by and for people who use drugs, sex workers and LGBTI communities. Stepping Stones has been evaluated by the South African Medical Research Council and as a result has been recognised by both WHO and USAID as one of the few programmes which reduces GBV in communities.

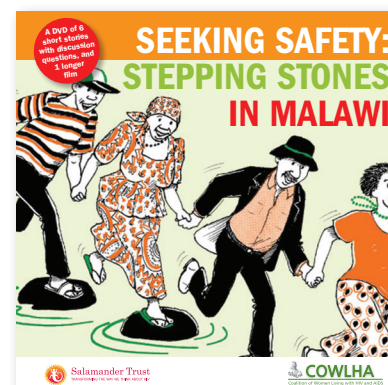
## FROM CONCEPT TO PRACTICE 4: PROGRAMMING WITH AND FOR KEY POPULATIONS

**Steve Letsike, ATHENA Network; Bechir N'Daw, UNDP; Daouda Diouf, Enda Santé**

Key populations in the context of HIV vary, but in general they include MSM, sex workers, transgender people, people who inject drugs, prisoners and migrants. They are often marginalised by society and at risk of stigma and discrimination, which may frequently be sanctioned by punitive laws that criminalise them.

Key populations are affected by disproportionately high incidence and prevalence rates of HIV when compared with the general population. Prevalence tends to be higher where legislation does not protect the rights of key populations, and where healthcare systems fail to ensure their right to health. This means providing tailored HIV prevention, care, treatment and support to address structural, social and individual vulnerabilities.

Key populations – especially sex workers and people from sexual minority groups – are often invisible populations. Their identity is denied, they are forced underground, and they experience higher rates of HIV and GBV. Many have scant access to basic needs, including treatment, and what care they do receive is often second rate. For example, sex workers are asked to come to clinics in the late evening so that other clients don't have to see them. They often experience verbal or physical violence by health workers and cases of violence are not taken seriously. For example, if a sex worker reports to the police she has been raped, nobody believes her. In the same way, if a gay man in Africa goes to the police to



Salamander Trust and COWLHA held a participatory film-making workshop in Malawi. Seeking Safety and the story of the making of the films, can be viewed at: <http://tinyurl.com/pxafv34>



"We are abused by clients, by law enforcement agents, and even at the market the police stop and harass us, asking for money and health cards. Every month we contribute 10,000 CFA so that we can practise our activities at the weekend freely. We are stigmatised by the community and also within our families we have no voice. There is no confidentiality within the police if we take our ARVs in front of them. If they arrest a sex worker who is on ARVs ... we have to intervene very often on behalf of other sex workers who are arrested."

DEBO SOW, PRESIDENT OF KARLENE,  
(ASSOCIATION OF SEX WORKERS  
LIVING WITH HIV)

say he has been raped they will beat him up and put him in jail. Being "invisible" increases risk – interventions don't reach hidden populations. For example, few countries implement a free distribution of lubricants programme. Few organisations are interested in mitigating risk for the most vulnerable groups.

In Gambia the existence and rights of key populations are totally denied. Many people from key populations flee to Sénégal, in fear for their lives, where there are no adequate services and programmes to receive them. There is a need for greater cross-border collaboration to remove the need for border-crossing to access treatment.

A priority action is capacity-building for organisations that work in HIV and AIDS control. The majority of organisations are not prepared to work with key populations and vulnerable groups – especially in care and treatment. We also have to build the capacity of key-affected populations to be advocates for their own access to services.

How ready are we to implement programmes that will include everyone? Sex workers living with HIV have little voice. Working in groups and establishing sex worker associations has increased sex workers' visibility and voice. As a result, more sex workers are receiving VCT and working together to insist on condom use. With financial support from Enda Santé, mediation with the police when sex workers are arrested, and social reintegration are offered. Care and treatment continue to present challenges, because of the need for sex workers to carry health cards. If they are not registered or the health card has expired they are deemed to be operating "underground" and can go to jail for six months.

**➤ Key discussion point.** In Sénégal MSM are criminalised, as in most African countries. We use a rights-based approach to health interventions. We have initiated many interventions for MSM through our Round 8 Global Fund funding, and key populations have been taken on board through our NSP. In addition to laws and guidelines, there is also practice. There is discrimination everywhere, including at service-delivery, which prevents people from accessing services. You can have all the rights in the world, but if you cannot access them it's meaningless. Everyone should be given sensitisation so that they can understand the issues faced by MSM. *"We all talk about equal access but capacity-building is especially important at the health service level so they can properly take care of these populations."*

Key populations are disproportionately affected by HIV with respect to the rest of the population. In Sénégal the general prevalence rate is about 0.7% but among MSM it's 24%. Sex workers are also disproportionately affected. However, other populations are also threatened. In Cameroun, Pygmy communities are extremely threatened and marginalised. The situation for them is dire.

This meeting should challenge us to organise and see where resources can be found to address all these issues.





### STRATEGIES FOR RESOURCE MOBILISATION

**Mariam Kamara, UN Women; Anthonia Aina, Centers for Disease Control; Clement San Sebastian, UNDP**

The implementation of the Global Fund's New Funding Model (NFM) offers more flexibility for countries to access funds when they need them and work more collaboratively with the Global Fund. The NFM also places greater emphasis on country level dialogue involving a range of stakeholders, and while it does not require countries to include gender in their concept notes, it strongly recommends that they do so. Omitting GBV from Global Fund concept notes (which are based on the country's NSP) in some countries in the region would be questioned. However, the experience at country level has been that the Global Fund places too many demands and restrictions on countries vis-à-vis what to include in their proposals.

It is an important time to start diversifying funding and increasingly we are beginning to look to the private sector – especially oil and mining companies, who are being held to account with regards to corporate social responsibility.

PEPFAR has 15 priority countries, but only two, Nigeria and Côte d'Ivoire, are in West and Central Africa. Funds are disbursed to implementing partners, and can be accessed through them. The perception in the region is that PEPFAR is more "NGO-friendly" than the Global Fund, but it only operates in two countries. Nevertheless, US embassies are present in all countries, so there may be some leverage in talking to the USAID Health Advisory regarding issues and problems with Global Fund processes and mechanisms.

There are also smaller funding entities, such as Mama Cash and the African Women's Development Fund. These are more connected to civil society and may be "friendlier" to work with than the Global Fund or PEPFAR.

The UN Trust Fund to End Violence Against Women and Girls (UNTF) is another potential source of significant funds. COWLHA in Malawi is a UNTF grant recipient, and has done great work on addressing GBV in the context of HIV using Stepping Stones. However, the application process is extremely labour-intensive and does not guarantee funding.



The development of country roadmaps (including timeframes and budgets) was woven through the different discussions on Day 2, and these were presented on Day 3.

## KEY STRATEGIES

Key strategies identified by the country teams included, but were not limited to:

- **Building the capacity of women living with HIV, including to enhance their economic empowerment**
- **Involvement of women living with HIV in the development of NSPs to address HIV and GBV**
- **Advocacy and sensitisation around the importance of keeping girls in schools**
- **Resource mobilisation to ensure implementation of NSPs**
- **Context specific identification and involvement of key populations**
- **Advocacy to strengthen the legal framework on GBV**
- **Capacity building on gender, human rights, and rights-based approaches among members of the armed forces**
- **Integration of strategies to engage men and boys in gender equality in NSPs**
- **Introducing mechanisms for detecting and referring incidences of GBV**
- **Media campaigns for sensitising men and boys around GBV and HIV**
- **Elaborating action plans around working with and for key populations**
- **Promoting literacy programmes for women and girls**

# Annex 1

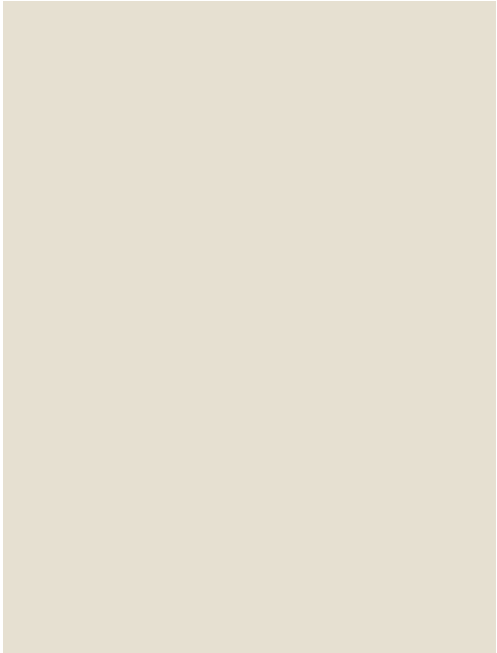
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