Pan American Health Organization (PAHO/WHO)

HIV and Violence against Women in Belize (Final report)

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Acknowledgments

This study was possible because of the collective efforts and participation of many organizations and individuals. First, we must express our gratitude to the women who accepted the interviewers and took time to respond to the questions posed. Thanks to all the interviewers from the Ministry of Health, Women's Department and Claret Care Center who fully dedicated to the completion of the data collection process as part of their daily work. Sandra Jones, Focal Point of the Units of HIV and Gender, Ethnicity and Health in Belize took the lead in carrying out the study as principal researcher, coordinated the initiative with local and national partners and gathered all the information needed to prepare the final report. At the regional level (PAHO Headquarters), during the period 2005-2006 Amalia del Riego and Elsa Gómez were in charge of the inter- programmatic coordination, Dinys Luciano coordinated the research, and María Dolores Pérez Rosales led the initiative at the subregional level (Central America). Farah Nageer and Anda Samson worked as research assistants at PAHO Headquarters. Paulo Lyra (HIV Unit) and Lilia Jara (Gender, Ethnicity and Health Office) have coordinated the initiative at the regional level since 2007. The final report was written by Dinys Luciano (Development Connections).

Introduction

This study was part of the PAHO/WHO regional initiative "Sexual and domestic violence intersectoral networks as entry point for HIV care and treatment" launched in 2005 by the Units of HIV and Gender, Ethnicity and Health in Belize, Honduras and Nicaragua and later in El Salvador. In Belize it was coordinated by the Belize PAHO Country Office in collaboration with the Ministry of Health, Women's Department, and NGOs working on HIV and violence against women.

The overall objective of this study was to explore the potential intersections between two forms of violence against women (VAW) -partner violence and non-partner violence- among users of VAW and HIV services and to document their experiences, knowledge and perceptions on HIV and violence. The information was collected using a standardized questionnaire in each participant country in order to collect and compare data in a multi-country analysis. In Belize seventy-four (74) women were interviewed, 32 users of HIV services and 42 users of VAW services countrywide during 2007. All the women interviewed were 18 years of age or older.

In Belize there are some ongoing initiatives addressing the linkages between VAW and HIV led by the Women's Department, of the Ministry of Human Services and Social Transformation, NGOs and international agencies. However, the strategies to increase VAW survivors' access to prevention and treatment of HIV/STIs has been very limited, and similarly, HIV care and prevention programs have not incorporated strategies for women who suffer violence. It is anticipated that the results from this study will be utilized for designing strategies for the integration of interventions on both epidemics.

This study made it possible to compile and analyze information about the HIV and VAW epidemics in Belize that will be used to adapt existing instruments and to review policies and strategies at the national and local levels.

1. Background

1.1. General overview

Belize is 22,966 km² in size and its population is 314,300 inhabitants.[1] Its economy depends mainly on agriculture (sugar, bananas and citrus for export), marine products, services[2], and to some extent, the tourism sector. The demographic profile is of a young population. In 2005, 50% of the population was under 15 years of age, 48% was 20 years and older and the elderly (60 years and older) accounted for 4.2% of the total population.[3] In 2002, 33.5% of the population was living in poverty - 23.7% of urban areas and 44.2% of rural. In terms of gender equality, in Gender Gap Index 2008, Belize scored 0.6610, ranking 86th out of 130 countries.[4]

Table 1: Basic indicators of Belize

Urban Population (%) 2009	Annual population growth rate (%) 2009	Life expectancy at birth (years) 2009		Gross National Income (US$ per capita), ppp value 2007	Health Expenditure		Political Participation	
		Female	Male		National Health Expenditure (% of GDP)		Women (%) in	
					Public 2004-08, lay	Private 2007	Parliament 2006-2009, lay	Ministerial
52.2	2.0	78.6	74.7	6,080	1.9	1.4*	11	18

- **Medical care expenses**

Source: PAHO et al. Gender, Health and Development in the Americas. Basic Indicators 2009. Washington D.C.

The patterns of HIV and VAW epidemics in Belize are associated with an ample range of social determinants and intermediary factors that generate specific results at individual, household, community and sectoral levels. The size of the country, its economic reality, population mobility (migration), its status as tourist destination - as well as cultural norms such as transactional sex,

[1] Statistical Institute of Belize, Labor Force Survey 2006.

[2] National AIDS Commission and UNAIDS. 2008. UNGASS Country Progress Report 2008-Belize.

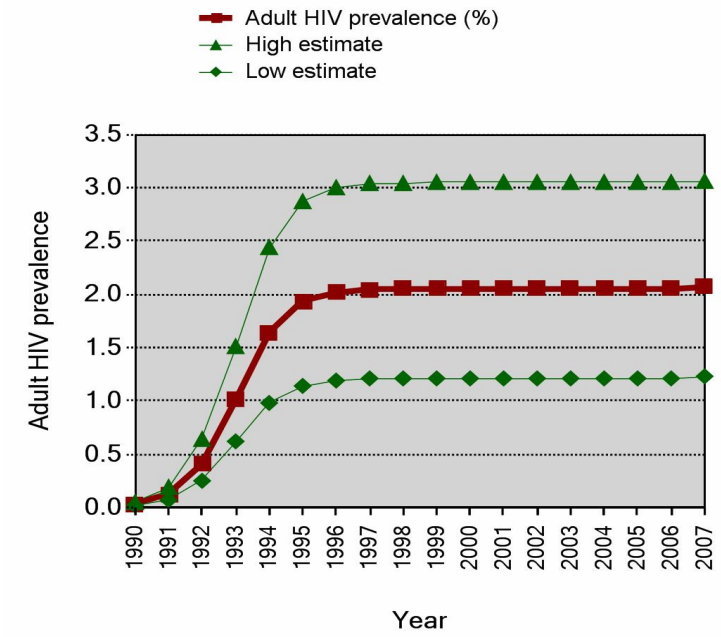
[3] Pan American Health Organization. Health in the Americas, Belize's Chapter. Washington D.C. 2007. Available at: http://new.paho.org/blz/index.php?option=com_content&task=view&id=25&Itemid=135

[4] Gender Gap Index. Prepared by the World Economic Forum. Harvard University and University of California, Berkeley. Available at: http://www.allcountries.org/ranks/gender_gap_gender_equality_country_rankings_2008.html

sugar daddies syndrome, and women's status in the country - interact with each other, creating specific risks and vulnerabilities that can fuel both epidemics.

The first case of HIV was reported in 1986. The Ministry of Health (MoH) reported 3,805 HIV infections as of the end of 2006, and 4,131 as of October 2007. At the end of 2007, Belize had an estimated rate of HIV infection of 2.1%, making it the country with the highest rate of infection per capita in Central America and the fourth highest in the Caribbean.[5] The adult prevalence remained virtually unchanged during the period 2003-2007.[6]

Estimated adult HIV (15-49) prevalence %, 1990-2007



Source: UNAIDS, WHO, and UNICEF. Epidemiological Fact Sheet on HIV and AIDS - Core data on epidemiology and response. Belize. 2008

In 2008, the HIV prevalence among persons tested at the Central Medical Laboratory (CML) was 6.6 in Stann Creek, 5.6 in Belize City, 3.3 in Cayo, 1.6 in Orange Walk, and 0.7 in Corozal.[7] AIDS was ranked the leading cause of death for the age group 30-49 years and the 7th leading cause of mortality of all ages (2008).[8] The age group 15-49 years continues to be heavily affected by the HIV epidemic. The male to female ratio is estimated to be 1:1. Young women are

[5] National AIDS Commission and UNAIDS. 2008

[6] Ministry of Health and PAHO. 2008. National HIV/AIDS Epidemiological Profile 2003 to 2007. Page 4

[7] Ministry of Health, Belize and Pan American Health Organization. Health Situation in Belize -Belize Basic Indicators 2008. Volume No. 6, 2009.

[8] Ministry of Health, Belize and Pan American Health Organization. 2009…ibid.

disproportionately affected since the HIV prevalence among males aged 15-24 was estimated at 0.5 while the prevalence among their female counterparts was 1.5 (low estimate for males 0.2 and for females 0.8; high estimate 0.9 and 2.4 respectively)[9]. In 2006, 15% of women and men aged 15-49 had received an HIV test in the last twelve months and knew their results and only 26% of women and men 15-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.[10]

According with the gender analysis of HIV/AIDS in Belize (PAHO, Belizean Ministry of Health, and Prairie Women's Health Centre of Excellence, 2009), "*from 2003 to 2007, males were more likely than females to receive positive HIV test results. However, in 2008, new cases in females outnumbered those in males for the first time. Among 425 newly reported HIV infections that year, 224 cases were found in females and 201 were in males*."

To date, no research has been done in the country to estimate the prevalence among different types of VAW. According to information from the National Health Information Surveillance Unit, VAW has increased and since 2001 a total of 3,500 cases of domestic violence including sexual assaults have been registered. In addition to the increasing number of reported cases the severity of the injuries has also increased. According to Police reports, between 1999 and 2003, a total of nine (9) women were killed by their intimate partners as a result of injuries sustained.

Table 2: New Cases of HIV by Sex, and Sex Ratios, Belize 2003-2008

Year	New HIV			Sex Ratio
	Males	Females	Total	M:F
2003	241	206	447	1.2
2004	242	215	457	1.1
2005	224	210	434	1.1
2006	253	190	443	1.3
2007	254	196	450	1.3
2008	201	224	425	0.9

Source: Ministry of Health, Belize
In: Gender Analysis of HIV/AIDS in Belize. PAHO, Ministry of Health/Belize, and Prairie Women's Health Centre of Excellence, 2009

In terms of sectoral responses to sexual violence, limited counseling and prophylaxis are often provided to young girls and women who are raped.[11]

[9] UNAIDS, WHO, and UNICEF. Epidemiological Fact Sheet on HIV and AIDS - Core data on epidemiology and response. Belize. 2008
[10] National AIDS Commission and UNAIDS. 2008

[11] PAHO. 2007. Protocol of the study on HIV and VAW in Belize.

National responses to the intersections of HIV and VAW

Increasingly, government agencies and civil society organizations countrywide are recognizing the need to address the linkages between HIV and VAW in programmes and policies as an important component to achieve specific sectoral goals, improve their performance and general health and development outcomes. Currently, the sectors working on VAW are focusing their efforts to increase access to HIV/STIs services for survivors of sexual violence and to advocate for inclusion of women experiencing violence as an at-risk population within the national HIV/AIDS response. The National Plan of Action on Gender-Based Violence 2010-2012, presently being finalized, includes a goal related to the provision of adequate services and support, in both urban and rural areas, to survivors of VAW. The objective is for all survivors of gender-based violence to have access to adequate health services delivered in a supportive, respectful and confidential manner, and also for the indicators to measure the proportion of survivors of rape, sexual assault and sexual abuse who receive appropriate care, including emergency contraception and prophylactic intervention for HIV.[12]

The activities to reach these goals and objectives are:

a) Implement a system in all hospitals and clinics for providing emergency contraception and prophylactic treatment for HIV for all victims of sexual abuse/sexual assault, and

b) Approach the National AIDS Program to include women who are victims of violence as a highly at-risk population and to develop appropriate strategies to address the link between violence against women and HIV/AIDS.

Also, sectors working on HIV/AIDS have devised policy measures to integrate VAW in their programmatic priorities. The National Plan for HIV/STI/TB (2008) established two activities related to VAW (implementation is pending):

a) All survivors of gender-based violence, including sexual violence (and child abuse) are provided with HIV testing and PEP, if required, as part of ongoing prevention, care and treatment programs, and

b) Collaborate with key stakeholders to ensure that strategies are developed and implemented to address the link between gender-based violence and HIV.[13]

[12] Women's Department, Ministry of Human Development and Social Transformation. The National Plan of Action on Gender-based Violence. October 2009.

[13] Ministry of Health. National AIDS Program. Plan for HIV/STI/TB. Belize, 2008.

Likewise, the protocol "The Management of Child Abuse and Sexual Assault Cases" establishes that serological testing for HIV should be performed at baseline and 6, 12, and 24 weeks after the incident and also the child's mother must be apprised of the possibility of vertical transmission prior to the test.[14]

To better support the efforts of the HIV/AIDS sectors, an initiative was carried out to revise the gender approach of the HIV policy "The Gender Mainstreaming Belize's HIV&AIDS National Strategic Plan 2006 – 2011 of the National AIDS Commission". It was found that little attention has been given within HIV policies and programs to VAW despite the high levels of different types of violence at the national level such as domestic violence, child abuse, coercion and rape of young girls and rape of women generally. Also it was found that although gender equality and equity are identified as important in the NSP as well as the National HIV/AIDS policy, the Plan does not indicate actions to address these.

The Women's Department prepared a "National Assessment of Actions on Ending Violence Against Women" (June 2009), and regarding the National HIV/AIDS Strategic Plan, it stated that "*Unfortunately, neither the Policy nor the Strategic Plan specifically addresses the need to link action on violence against women to an overall strategy on HIV/AIDS, nor are victims of violence acknowledged to face particular barriers to accessing treatment and support. The strategic plan does recognize that young women are particularly at risk due to poverty, child abuse and early sexual initiation, often by older men. It*

The **CARICOM Regional Plan of Action** states in its work on HIV that:
"One approach which crosscuts all policy and programme options is addressing the inequalities of power in sexual relationships. Campaigns to address the abuse of power in sexual relations should begin from the need to challenge the very construction of masculinity and femininity at all levels. In the short term, this means that all campaigns should be guided by an analysis of gender relations so that they oppose, rather than reflect and buttress, stereotypical notions of sexual behaviours."

Source: Framework for Mainstreaming Gender into Key CARICOM Programmes, p 19.

[14] Francis G. Longsworth. The Management of Child Abuse And Sexual Assault Cases. A Policy and Procedural Guide For Medical Professionals. The National Committee for Families and Children. ND

also notes that migrant women are often vulnerable to "survival sex" and sexual assault. But it stops short of a more general recognition that women who are victims of violence are a particularly vulnerable group. As a result, the Plan does not contain specific strategies to break the link between violence against women and HIV/AIDS."[15]

Despite the advances toward addressing the linkages between HIV and VAW in policies and programmes, significant gaps still remain. The lack of information remains a major barrier to ensure the strategies are based on the needs and specific characteristics of the linkages in the country and the social determinants associated. Due the generalized epidemiological HIV scenario in Belize and high levels of VAW, implementing integrated policies on both epidemics can be hindered by the lack of programme budgeting and the dearth of good quality information about their intersections. This descriptive study is the first step toward developing a body of evidence upon which to base those policies, providing information on gender norms, experience of violence as well as knowledge, behaviors and attitudes on HIV among users of HIV and VAW services nationwide.

Objectives

General objective: Explore the relationships between HIV and VAW for women users of HIV and VAW services countrywide, aged 18-49 years, and identify factors that can potentially improve the institutional response to the linkages of both epidemics.

Specific objectives

- To document experiences of violence among women users of HIV and VAW services.
- To describe the experiences, knowledge and attitudes on HIV among women users of HIV and VAW services.[16]

The study also sought to provide appropriate recommendations about priorities for addressing the linkages between HIV and VAW and sensitizing these intersections for policy makers, service providers, program managers, researchers, community groups and intersectoral networks.

[15] Lewis, Debra. 2009. Walking in the darkness, walking in the light. A national assessment of actions on ending violence against women. Belize.

[16] The regional protocol of the study included the provision of a consented HIV test to VAW survivors interviewed but due to the high level of refusals, this component of the study was dropped.

Organization of the study

The research was coordinated by the HIV Unit and the Gender, Ethnicity and Health Office at PAHO Headquarters and the PAHO Country Representative's Office in Belize. In 2005 this initiative was approved in the PAHO Annual Managers Meeting of Central America and the Dominican Republic. In the same year, a meeting was carried out in Honduras with representatives of the organizations involved in the study in Belize, Honduras and Nicaragua to discuss the theoretical framework, definitions, objectives, criteria for selecting the geographical settings, variables and indicators, ethical and safety considerations, and strategies for disseminating the results. Afterwards, a standardized protocol was designed, tested and adapted in each participating country. In Belize the protocol was revised by all the organizations participating in the study and approved by an ad hoc Ethics Committee which included the Ministry of Health and the University of Belize.

Methodology

Population of the study and sample

A sample of 74 women between the ages of 18-59 years: 42 users of VAW services (hereafter **VAW group**) and 32 users of HIV/STI services (hereafter **HIV group**) participated in the study. The study was carried out in the five districts of the country: Belize City, Cayo, Corozal, Orange Walk, Stann Creek and Toledo. The interviewees were selected from the voluntary counseling and testing (VCT) services of the MoH, the Women's Department offices countrywide which provide services for VAW, and Claret Care, a Community-based Organization. Due to the volume of women users of the selected services, the number of centers involved and the quantity of women who fit the criteria for participating in the study, the data collection lasted almost a year. The interviewees were randomly selected among those that fit the eligibility criteria and the questionnaire was administered by the human resources working in the selected services.

The women who met the following criteria were included in the study:

- Age: Eighteen years old or older at the time of the first consultation and/or that received services either on HIV or VAW.

- Use of services: At least one visit to one or more of the selected services from the first of January 2000 until the last day of the month previous to the beginning of the study.

- For women users of HIV services**:** Diagnosis of HIV infection documented and confirmed through a test by analysis of enzyme-immune absorbent (ELISA), Western Blot at a laboratory and should be on care and treatment within medical institutions. Women should be diagnosed within the last 12 months prior the study.

- For women users of VAW services: Documented cases of partner violence and/or non-partner violence.

Definitions of VAW

The operational definitions of violence used in this study were those of the WHO Multi-country Study on Women's Health and Domestic Violence against Women (2005) which includes a range of behavior-specific questions related to each type of violence while asking a limited number of questions about specific acts that commonly occur in violent partnerships.[17]

The behaviors were:

Physical violence by an intimate partner
• Was slapped or had something thrown at her that could hurt her
• Was pushed or shoved
• Was hit with fist or something else that could hurt
• Was kicked, dragged or beaten up
• Was choked or burnt on purpose
• Perpetrator threatened to use or actually used a gun, knife or other weapon against her

Sexual violence by an intimate partner
• Was physically forced to have sexual intercourse when she did not want to
• Had sexual intercourse when she did not want to because she was afraid of what partner might do
• Was forced to do something sexual that she found degrading or humiliating

Emotional abuse by an intimate partner
• Was insulted or made to feel bad about herself
• Was belittled or humiliated in front of other people
• Perpetrator had done things to scare or intimidate her on purpose, e.g. by the way he looked at her, by yelling or smashing things
• Perpetrator had threatened to hurt someone she cared about

Controlling behaviors by an intimate partner
• He tried to keep her from seeing friends
• He tried to restrict contact with her family of birth
• He insisted on knowing where she was at all times

[17] WHO. 2005. WHO Multi-Country Study on Women's Health and Domestic Violence against Women. Available at: http://www.who.int/gender/violence/who_multicountry_study/en/

• He ignored her and treated her indifferently
• He got angry if she spoke with another man
• He was often suspicious that she was unfaithful
• He expected her to ask permission before seeking health care for herself.

Physical violence in pregnancy
• Was slapped, hit or beaten while pregnant
• Was punched or kicked in the abdomen while pregnant

Physical violence since age 15 years by others (non-partners)
• Since age 15 years someone other than partner beat or physically mistreated her

Sexual violence since age 15 years by others (non-partners)
• Since age 15 years someone other than partner forced her to have sex or to perform a sexual act when she did not want to

Childhood sexual abuse (before age 15 years)
• Before age 15 years someone had touched her sexually or made her do something sexual that she did not want to.

The questions on knowledge, behaviors and attitudes on HIV were adapted from standardized surveys used in the Demographic and Health Surveys (DHS) and sexual behaviors in the region.

Research methods

The regional protocol included two methods of data collection: a) a questionnaire to be administered to both subgroups and, b) HIV voluntary test to women users of the selected VAW services. Due to the high level of refusal to have an HIV test during the pretest, this option was excluded from the protocol in Belize but a question for self-reporting HIV status remained in the questionnaire in order to obtain self-reported HIV status from the VAW group.

The standardized questionnaire was translated, reviewed and amended to ensure that it reflected the local and cultural contexts, although minor changes were made. It included the following sections:

- Identification number and location codes
- Introductory statement, confidentiality and consent statements
- Demographic information
- Gender roles and violence
- Experience of emotional, sexual physical violence and controlling behaviors by partner/husband
- Violence by other than intimate partners
- Violence and health outcomes

- Women's coping strategies
- Knowledge, behaviors and attitudes on HIV
- Experience of women living with HIV – users of HIV services.

The draft questionnaire was sent to participating organizations to get their feedback and it was tested on a small sample of respondents in each service to determine the likelihood of respondent fatigue, the feasibility of administrating it within the service settings, as well as instrument nuance and ambiguity. Any necessary changes to the protocol and questionnaire were made before the commencement of the study. The questionnaire was administrated during face-to-face interviews assuring privacy. Interviewers were service providers from the selected organizations who were trained in the application of the questionnaire, as well as the conceptual issues on VAW and HIV to ensure they would be able to contextualize the information received and the quality (completeness and accuracy) of the information obtained.

For women living with HIV, the counselors, social workers and/or case workers administered the questionnaire to the clients. In this manner, the confidentiality of those living with HIV and their preference to remain unknown was respected. All interviewees were given a package of information regarding appropriate services, including prevention, care and treatment on HIV and VAW.

Data were coded and entered into a computerized database using SPSS software.

Ethical considerations

The ethical review of the study was done by an ad hoc Ethics Committee organized by the MOH and the following ethical and safety measures were approved:

Risks and benefits

The risks of women users of selected services to participate in this study may include stigma and discrimination as well as psychological burden due to the recounting of traumatic experiences related to violence and HIV. To prevent those risks the ethical guidelines of the study were consistent with those recommended by the World Health Organization (WHO, 2005):

- Safety of the interviewees and of the research team.
- Confidentiality.
- Prevent and identify potential difficulties of the interviewees.
- Offer information on HIV and VAW (brochures and list of services) to the interviewees.

For the research team, universal precautions were adhered to in order to prevent the risk of psychological burden due to the experiences of the interviewees. The benefits for the participants included the opportunity to talk about their HIV and violence experiences, as well

as the possibility to receive information, care, treatment, and counseling, information on prevention measures and available health care, and access to support services. For the research team, the study offered them the opportunity to be pioneering in an initiative of this nature in the country and Central America, and to produce scientific evidence for the development of policies, strategies and programs which will improve the lives of survivors of violence and persons living with HIV.

Confidentiality, privacy, and anonymity

The confidentiality, privacy, and anonymity of the participants were three cross-cutting components in all the phases of the study. Privacy refers to the control of the individual over its personal borders in order to share information. Confidentiality alludes to what PAHO/WHO may or may not do with this data, and anonymity is the commitment that the research team makes that no information will be given that makes it possible to identify the interviewees.

Informed consent was discussed with the potential interviewees before the administration of the questionnaire. The consent forms included: a) purpose of the study; b) what it will mean for them to participate in the study; c) how confidentiality will be kept; d) the right to refuse participation without damaging their relation with the institution or individual member of the research; e) the right to refuse to answer specific questions during the interview; and f) the right to interrupt their participation at any time.

Also, the myths and misconceptions on HIV and VAW were confirmed and corrected, once the survey was concluded. The consent form utilized was that of the MOH. In order to ensure confidentiality and anonymity, the following standard procedures were followed: a) use of a numeric code; b) storage of all the forms and data, particularly the information with individual's information, in locked files.

Rights of the participants of the study

- Participants were well informed on the scope of the study before signing the consent.
- Women who requested assistance were referred to local services including support groups for HIV and VAW.
- Participants were given sufficient time to make the decision to participate in the study.

Challenges and limitations

The implementation of this study faced challenges and limitations that need to be taken into account when interpreting study findings:

a**. Biases inherent in the sampling method:** All interviewees were randomly selected. The following situations affected the level of representation of the sample:

i) Small number of women interviewed – 32 users of HIV services and 42 users of VAW services (total 74).

ii) The number and type of participant settings (HIV and VAW services). The VCT centers are part of the public system so information from the population served by the private sector was not collected. Moreover, "*persons accessing VCT services are usually persons that have engaged in risky behavior and have significant risk factors*"[18], for which reason women considering themselves at low risk to HIV may be less likely to use those services and therefore it is highly probable that data from women from different groups affected by HIV such as pregnant women (PMTCT users), youth and adolescents, etc, was not collected. On the other hand, worldwide evidence on patterns of utilization of services by women victims of violence shows that only a small proportion seek support from agencies or authorities such as police, health services, legal advice, shelter, women's nongovernmental organizations, local leaders and religious leaders, and usually only severe situations push them to seek help. The WHO Multi-Country Study on Women's Health and Domestic Violence against Women (2005) found that in all sites studied, the majority (between 55% and 95%) of physically abused women reported that they had never gone to any of these types of agencies or authorities.[19] In this regard, this might have affected the likelihood that women suffering moderate violence would be included in the study.

iii) Due to the sampling criteria, the proportion of women reporting all types of violence is higher among those interviewed at the VAW services, and on the other hand, due to the access to information, the level of knowledge on HIV is higher in the HIV group than in the group of VAW service users.

Therefore, although the questionnaire was administered countrywide, the data cannot be extrapolated to women users of HIV and VAW services as a whole. Further studies using quantitative and qualitative methods are needed in order to identify needs of women in the general population and "particulars-ability" of different women subgroups, including the users of VAW and HIV/STIs services, to tailor integrated interventions to their needs and contexts.

b. Refusal of the HIV test: The voluntary HIV test on the VAW group could not be performed due to the high level of refusal. Because of the high level of stigma and discrimination regarding HIV and misconceptions, as well as the fear to get a positive result of an HIV test, the rejection to be tested is, in part, explicable. Also, the country is facing a tendency of decrease in testing, therefore the refusal of the VAW service users has to be examined in a context of testing rate decrease in the general population. The rate of testing per 100,000 people decreased by 44.3%

[18] Ministry of Health and PAHO. 2008. National HIV/AIDS Epidemiological Profile 2003 to 2007. Page 3.

[19] WHO. 2005. WHO Multi-Country Study on Women's Health and Domestic Violence against Women. Page74. Available at: http://www.who.int/gender/violence/who_multicountry_study/en/

from 2003 to 2007 with an average decrease of 611 fewer persons tested per 100,000 per year.[20],[21]This decrease is only seen at CML but not at the VCT sites.

c. Barriers posed by service providers: Some HIV service providers were not cooperative in conducting the study and this may have resulted in women not getting testing for HIV as no effort was made to explain to them the benefits of the test as well as the services available. The situation was similar with the NGO working with HIV positive women, since they thought it was too cumbersome to do the questionnaire with women who are HIV positive.

d. Data collection: While quality control measures were put in place during the data collection process, actual enforcement during almost a year was not optimal. Direct supervision in each participant service was not possible because of the length of the data collection period combined with the distance to cover each district countrywide on a regular basis.

e. Information available and sampling: The difficulties for knowing the patterns of utilization of services of women living with HIV and survivors of violence and therefore using a more rigorous method to select the samples and establish a realistic timeframe for collecting data.

f. Limitations of self-reporting: Several highly stigmatized practices and situations in the country - such as multiple partnerships, transactional sex, HIV status among VAW survivors, etc. - are likely to have been underreported.

2. Results

2.1. Demographic characteristics

- **Age**: 12% (9) was aged 19 or less, 23% (17) 20-29 years old, 33.8% (25) 30-39, 23% (17) 40 years old or older, and 8% (6) did not report their age.

- **Ethnicity:** 29.7% identified themselves as being mestizo, 31.1% garífuna, 23% creole, and 16.2% as indigenous or other.

- **Marital status**: 63.5% reported being married or living with a man at the time of the survey.

[20] Ministry of Health and PAHO. 2008. National HIV/AIDS Epidemiological Profile 2003 to 2007. Page 3.

[21] It has been noted that this is a result of the fact that data for the epidemiological report was taken from Central Medical Laboratories and not the VCT Centers.

- **Fertility:** 49 women reported having living children, a third part (32.6%) reported having 2 children, and 38.8% between 3-5 children. 11% of the total indicated they were pregnant at the moment of the interview.

- **Education:** More than half of respondents (52.6%) reported that primary was the highest educational level they had completed. A quarter (25.7%) completed high school, 10.8% finished university studies, 6.8% reported no grade completed, and 4.1% (3) did not respond to the question.

- **Employment:** Almost 7 in every 10 interviewees (67.6%) reported they were not working at the moment of the interview while 50% had worked in the last 12 months prior to the study.

2.2. Gender roles and attitudes toward partner violence against women

Several studies worldwide have shown the role that gender norms play in the patterns of transmission of HIV and also in the magnitude and characteristics of VAW in different countries and settings. Social expectations of men's and women's roles regarding partner/couple relations can affect the access of women to VAW and HIV information and services, the ability of women to negotiate safe sex, as well as their decisions and sexual behaviors.[22] Also, rates of partner violence may be higher in contexts where this behavior is condoned and sexual access to wives is unconditional.[23]

In this study, attitudes on cultural norms about partner relations were examined. 28.4% of the total believed that a good wife obeys her husband even if she does not agree with him. 14.3% (6/24) in the VAW group agreed with this affirmation while 46.8% in the HIV group did so. 12.5% (4/32) of the HIV group and 4.8% (2/42) in the VAW group - considered that it is the obligation of the wife to have sexual relations with her husband even when she does not want. 66.2% believed that if a man abuses his wife, other people who are not of the family should intervene; similar proportions were found in both groups.

Among the reasons for which it is considered acceptable for a man to hit or physically mistreat his wife, the most common justification was if the woman had been unfaithful, reaching more than one in every ten of the total interviewees (12.2%), and almost 10% said they do not know. This finding is consistent with the results of the study on masculinities and reproductive health in Central America (PAHO 2005) where Belize (Belize City) had the highest rate of men's

[22] Luciano, Dinys. 2009. A manual for integrating the programmes and services of HIV and violence against women. Washington D.C.

[23] WHO. 2005. WHO Multi-Country Study on Women's Health and Domestic Violence against Women. Page39.

justification of physical violence against women (37.5%) if the woman betrays her partner and 16.4% if the woman does not want to have sex when the man does. [24]

The attitudes toward women's sexual autonomy can also constitute a significant barrier to negotiate safe sex, talk about sexuality and HIV/STIs prevention. In the four circumstances examining whether and when a woman may refuse to have sex with her husband, around 2 in every ten interviewees believed wives have no right to refuse sex with their husband reaching proportions of 22% even if he is drunk, 20% if he abuses her, 19% if she does not desire it, and 16% even if she is sick. The beliefs related to sex as a wife's obligation can prevent women to protect themselves from this type of violence but also puts them at greater risk to HIV and other STIs.

2.3. Intimate partner violence

Physical violence

Six of every 10 interviewees (60%) reported having experienced physical violence by a partner, 47% among HIV service users and 71.4% among VAW service users. The percentages of acts of physical violence reported during the 12 months prior the survey are consistently lower than in lifetime in both groups.

Table 3: Percentage of women who have experienced different acts of physical violence by an intimate partner

Acts of physical violence	HIV group (32)		VAW group (42)	
	Ever (%)	Last 12 months (%)	Ever (%)	Last 12 months (%)
Boxed or thrown things that could wound her	25	18.7	47.6	35.7
Pushed, cornered or pulled your hair	37.5	15.6	40.5	30.9
Stricken you with his fist or with some other thing that could hurt you	31	18.7	45.2	30.9
Kicked, dragged or beat you up	18.7	12.5	38.1	21.4
Attempted to strangulate you or burn you on purpose	18.7	9.4	16.7	9.5
Threatened with using or used a handgun, knife or	25	18.7	19	14.3

[24] OPS/OMS. 2005. La salud sexual y reproductiva: También un asunto de hombres. Washington D.C. Page 95.

another weapon against you

Situations defined as severe violence, such as being hit with a fist, kicked, dragged or beaten up, were most commonly reported by the VAW group which is explained by the sampling criteria. Although the proportion that reported severe violence in the HIV group was also high.

Violence during pregnancy: The proportion of ever-pregnant women who reported experiencing physical violence during at least one pregnancy was 37% (10/27) among HIV service users and 46% (17/37) among SV service users.

Emotional violence and controlling behaviors

Emotional abuse by an intimate partner plays an important role in the ways women perceive themselves, their ability to make decisions, talk with others about HIV and/or violence, and the confidence to insist on safe sex and self-protection (self-efficacy). More than four in every ten interviewees reported experiencing emotional abuse by an intimate partner at least once. Insulting or making her feel bad about herself was the most common emotional abuse reported by both groups – 71% by the VAW group and 50% by the HIV group – followed by acts of doing things on purpose in order to frighten her or intimidate her (62% and 37% respectively).

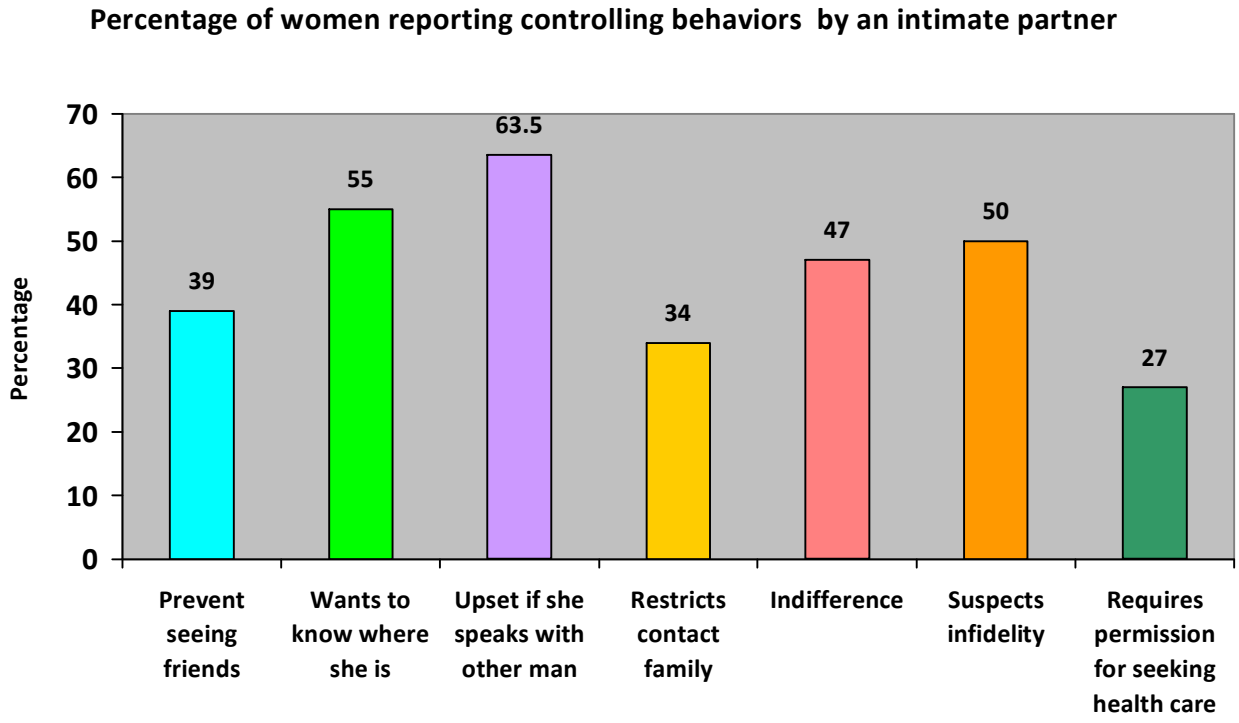
Table 4: Percentage of women who have experienced different acts of emotional violence by an intimate partner

Emotional violence acts	Ever (%)	Last 12 months (%)
Insults you or causes you to feel bad about yourself	61	36.5
Underrates you or humiliates you in the presence of other people	43.2	24.3
Does things on purpose in order to frighten you or intimidate you	50	31.1
Threatens to harm you or someone important to you	43.2	24.3

Controlling behaviors

Controlling behaviors affect the ability of women to seek help or access to services and information required to protect themselves from HIV and violence. The proportion of women that reported controlling behaviors by partners/husbands ranged from 4 in every 10 interviewees in the situation of preventing her from seeing her friends to 6.5 in every 10 in the situation of getting upset if she speaks with another man. Trying to restrict her contact with her family was reported by 34%, insisting on knowing where she is at all times (55.4%), treating her

with indifference (47.3%), often suspecting that she is unfaithful to him (50%). Almost 3 out ten (26.5%) reported that the partner required her to request his permission before seeking health services, this situation was indicated by 31% of the VAW group and 22% of the HIV group.



Sexual violence

Experiences of sexual violence were very common among the interviewees. 38.2% (19/42 of the VAW group and 10/32 of the HIV group) reported that they have been forced physically to have sexual relations they did not desire and 20.5% (26% of the VAW group and 15% of the HIV group) indicated it happened in the last 12 months. 43.2% had had sexual relations when they did not want it because they feared what the partner could do to them, including 21.3% in the last 12 months, [12.5% (4/32) of the HIV group and 30.9% (13/42) of the VAW group]. 20.3% indicated they had been forced to carry out some sexual act that they found to be humiliating or degrading, including 8.1% in the last 12 months.

Among women ever married/partnered, the proportion who had ever experienced physical and/or sexual violence by an intimate partner was 56.6% (17/30) in the HIV group and 78% (32/41) in the VAW group.

Violence incidents and forced sex: 31.1% - with similar proportions between the two groups - reported that during or after a violent incident they had been forced to have sexual intercourse by an intimate partner at least once.

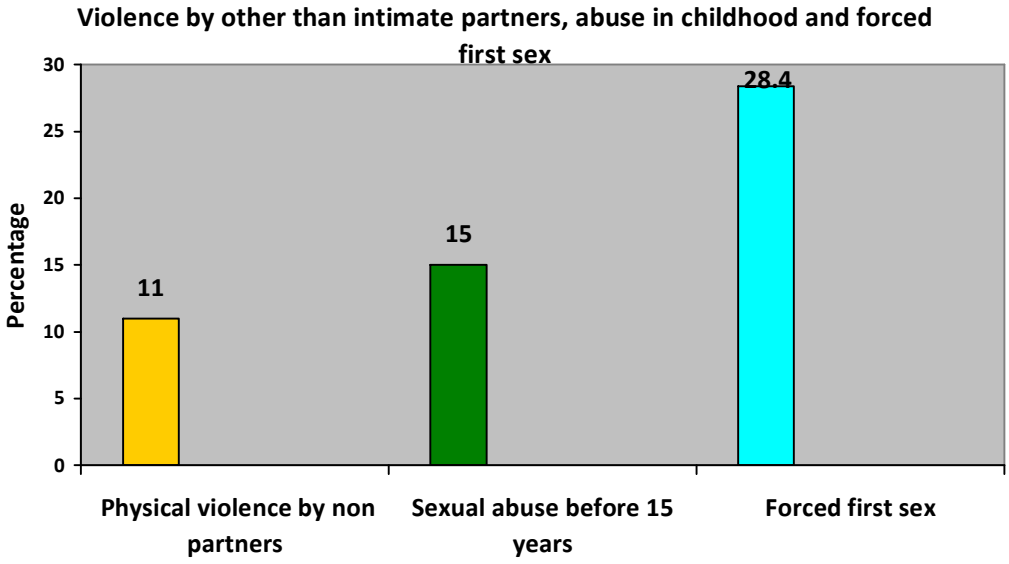
2.4. Violence by perpetrators other than intimate partners since the age of 15 years

Physical violence by non-partners: 11% (8/74) reported that from the age of 15, someone aside from the husband/partner has hit her or abused her physically in any way, mostly by people they know well such as father, boyfriend, a friend or a woman in the family. Future research should explore the factors associated with differences in levels of reported violence by partners and non-partners.

2.5. Sexual abuse in childhood and forced first sexual experience

Sexual abuse before 15 years: 15% reported sexual abuse before the age of 15 years: someone in the family touched her sexually or forced her to do something sexual against her will.

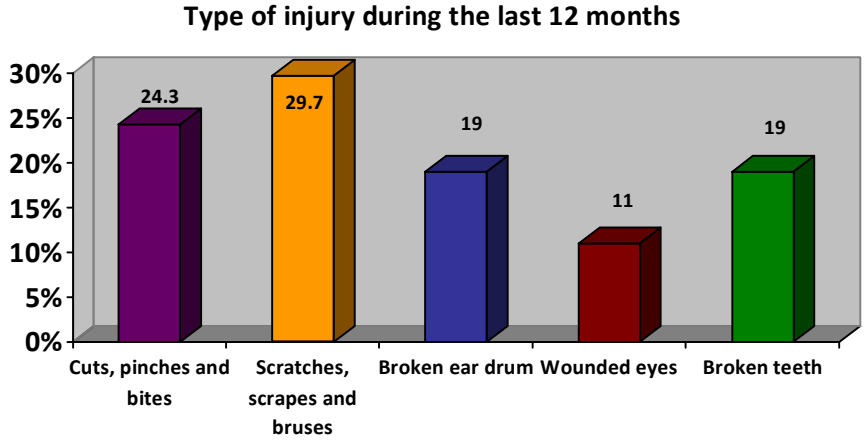
Forced first sex: 28.4% of the interviewees described their first intercourse as something that they did not want to happen or that was forced.



2.6. Violence and health outcomes

Injuries caused by physical violence by an intimate partner

Among those that responded to the question, 28/35 in the VAW group and 11/25 in the HIV group, reported having been injured as a result of violence by current or previous husband/partner. 36.5% of the total indicated that they were injured several times (3-5) or many times (more than 5). In the last 12 months, 24.3% suffered cuts, pinches and bites, 29.7% suffered scratches, scrapes and bruises, 5.4% sprains or dislocations, 4.1% burns, 1.9% broken ear drum, 11% wounded in the eyes, 19% broken teeth, and 2.7% fractures and broken bones.



Utilization of medical services due to injuries

32.4% (24) of the total reported having received medical care for their injuries, and among those that received health assistance, around half (13) told the health worker the real cause of her injuries.

2.7. Women's coping strategies and responses to violence

Who women tell about violence and who helps?

Among those that responded to the question about who they talked to, 11/20 reported that they told no one of the violent situation they were suffering, 19/25 reported they talked to their parents, 22/26 told their friends, 11/19 talked to brothers and/or sisters, 14/20 told the family of the husband/partner, while only 5/14 talked to their neighbors. In order of importance the people who tried to help the interviewees were: parents (15/21), friends (13/20), and brothers/sisters (12/18).

Agencies or authorities to which women turn

24/27 reported they went to the police to request assistance, 12/17 visited a hospital/health services, 7/10 went to a judge/attorney, and 20/22 went to an organization for women. In order of importance the agencies or authorities that tried to help the interviewees were the police (10/17) and NGOs for women (7/12). Surprisingly, only 1/8 mentioned that doctors/health workers tried to help them, and 3/10 indicated a counselor. Friends and family (13/20) were mainly the ones who encouraged the interviewees to seek help.

Why did they seek assistance? Women's help-seeking behavior was strongly related to the severity or impact of the violence: unable to take it anymore (23/26), and she was wounded critically or feared being killed (14/18). The risks and/or effects on children were also a significant reason to seek help: threatened or beat the children (7/13), and she saw the children suffering (12/17). Feared of wanting to kill him was reported by 10/16.

Why they did not seek help? The most common response was that the woman feared threat or consequences (12/14).

2.8. Knowledge, behaviors and attitudes on HIV

The HIV epidemic is related to behaviors and situations that expose individuals to the virus and so increase the risk of infection. Information on knowledge about HIV, sexual behaviors and risk situations of women users of HIV and VAW services is important in identifying and better understanding their risks and context of vulnerability. Violence plays an important role defining the ways in which knowledge, behaviors, attitudes and contexts interact among them, creating significant gaps between what women know about HIV and what they can really do to prevent it. Individual behaviors are intertwined with social structures, interpersonal relationships and the accumulation of different vulnerabilities during women's lifespan. Intermediate factors such as cultural norms, institutional response, biases on research and knowledge also influence

the ability of women to protect themselves from HIV and violence.

- **Knowledge of HIV:** Almost every woman interviewed had heard about HIV or the disease called AIDS. Only a small proportion (4.8% = 2/42) in the VAW group indicated they had never heard about HIV infection or a disease called AIDS.

- **Knowledge of HIV prevention strategies**: Out of the total, three in every four interviewees (75.7%) and 66.6% in the VAW group, said that there is something people can do in order to avoid being infected with the virus that causes AIDS.

The most common prevention methods identified by respondents were: condoms (71.6%), abstinence (51.4%), and being faithful (47.3%). In the VAW group, the proportion indicating these options for each alternative explored in this study were lower than in the HIV group, but still significant: condoms (64.3%), abstinence (45%), and sex with a single partner (26.2%).

Other alternatives responded by 15% or more of the total interviewees were:

- Diminishing the number of sexual partners (28.4%)
- Not having sex with a person who has more than one partner (20.3%)
- Not sharing needles (20.3%)
- Not having sex with someone who is injecting drugs (16.2%)

It is important to note that the three strategies most commonly identified by interviewees are not realistic ways to prevent HIV for women experiencing violence. The possibility of negotiating the use of condoms with their partners can be limited by the imbalance in power and also the low level of communication about STIs/HIV that, in general, is present in abusive relationships. Women's abstinence does not ensure safety, because marriage itself provides no protection from infection since they may not know the HIV status of their partners, and cannot be certain that their partner is being faithful. Also gender norms related to women's obedience to their partners/husbands can increase the risk of HIV while reducing their ability to negotiate safer sex, access to information and use of prevention options.

Rejection of myths about HIV

Nine (12.2%) of the total interviewees indicated that kissing or hugging people living with HIV, as well as mosquito bites, might transmit HIV, and that not sharing plates, sheets or food, and having a good diet are ways to prevent the transmission of HIV. 77% (57) said that it is possible that a person who looks healthy can have HIV. In 2006, nationwide only 26% of young women aged 15-24 correctly indentified two ways of preventing the sexual transmission of HIV and correctly rejected two misconceptions about HIV transmission.[25]

[25] UNAIDS, WHO, and UNICEF. Epidemiological Fact Sheet on HIV and AIDS – Core data on epidemiology and response. Belize. 2008

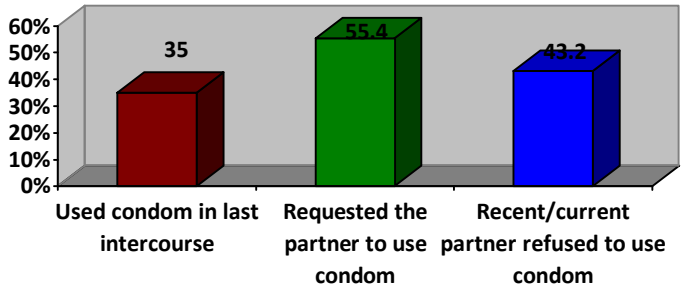
Risk perception

Knowing the HIV risk perception among women experiencing violence is crucial for developing effective prevention strategies. Several theories of health behavior suggest that it is an individual's perception of risk rather than the actual risk involved that determines behavior.[26] Among VAW service users, 66.7% of those that responded to the question (18/27) said they think that their possibility of being infected or having been infected with HIV was small or none, 22.2% (6/27) indicated their likelihood was moderate and almost one in ten who responded to the question (3/27) thought their possibility was great.

- **Communication with partner about HIV prevention**: 54.1% of the total interviewees said they had spoken with husband/partner on ways to avoid being infected with HIV. Among VAW service users, 69% of those that responded to the question (18/26) said they had done it.

- **Condom use:** One in every three (35.5%) of the total said that they used a condom during the last time they had sexual intercourse - 24% in the VAW group and 47% in the HIV group. 55.4% reported they had requested to their current partner or others recently to use a condom, and more than 4 in every 10 (43.2%) reported that their current partner or other recent partners refused to use a condom.

Behaviors related to condom use in total interviewees



Sexual behavior of interviewees and partners

Number of sexual partners in the last 12 months: 35.4% of interviewees said they had had sexual intercourse with 2 or more different men in the last 12 months prior the study, 33.3% of the VAW group and 37.5% of the HIV group. This data widely varies from the results of the

[26] *Andrea M. Fenaughty, Holly A. Massay, and Dennis G. Fisher. H*IV Risk Perception. Available at: http://justice.uaa.alaska.edu/forum/11/4winter1995/d_hiv.html

Labor Force Survey (2006) where 1.78% of women between ages of 15-24 reported they had had sexual intercourse with more than one partner in the last twelve months.[27]

Transactional sex: Regardless of the HIV epidemiological scenario, the exchange of sex for money, gifts, favors and in some cases security/survival, is of central interest. 8.1% (6) reported they had had sex in exchange for money, gifts or favors in the last 12 months.

Multiple sex partners of their husbands: 17/40 of the VAW group and 14/27 of the HIV group reported that their recent/current husband/partner had had relations with another woman while being with her, 11% indicated that it was possible and 27% said they did not know.

Perceptions on sharing HIV status: Six of the interviewees said that if a person knows that he/she has the virus that causes AIDS, that information should be personal and private and should not been know by all the community. If a person lives with HIV the respondents considered he/she should inform: partner (54.1%), parents (47.3%), family members (35.1%), and children (27%).

Knowledge and utilization of HIV services

Where to get a test: Three in every four interviewees reported they know where to get an HIV test, 62% (26/42) of the VAW group. The places named by at least 15% of the respondents were: public hospitals (43.2%), public laboratories (27%), and rural clinics (15%). 65% reported that they know places offering assistance/support to people living with HIV, and the most commonly identified were Belize Family Life Association (BFLA) by 27.0% of the total, and the VCT clinics (25.7%)

Treatment for PLWH: 63.5% of the total said they know about drugs to treat people who live with HIV (including 52.4% of the VAW group). More than half of the total (56.8%) responded that the purpose of these drugs is to avoid AIDS from developing rapidly (including 4 in every 10 of the VAW group).

Use of information on HIV: In the last 2 months only 29.7% of the total has utilized information on HIV, and 24% (10/42) in the VAW group reported they did so.

[27] Statistical Institute Of Belize. 2006. Labor Force Survey. Cited by UNAIDS and National AIDS Commission in: UNGASS Country Report 2008 – Belize, page 11.

HIV testing history

Belize has undergone important efforts to expand voluntary testing at the community level countrywide and according to the Sexual Behaviors Survey (2006), among women and men ages 15-24, 15.05% received an HIV test in the last 12 months and know their status. This information in most-at-risk populations is not available.[28]

In this study, 81.1% of the total (60/74) have had an HIV test and among those, 86.6% (52/60) reported their permission was sought before conducting the HIV test. 66.6% (40/60) indicated they received counseling before they took the HIV test.

Self-reported HIV status among VAW service users

Among the 30 women users of VAW services who responded that they had had an HIV test and that they felt comfortable sharing the results of the HIV test with the interviewers, two (2) reported that they had a positive result of an HIV test. Out of the 42 users of SV services, the rate of self-reported being HIV positive was 4.76%. These two women were among those who reported ever having experienced physical and/or sexual violence by an intimate partner. Despite the small number of VAW users interviewed, the rate of self-reported HIV positive status obtained in this study is significant taking in consideration that at the end of 2007, Belize had an estimated HIV rate of infection of 2.1% and is considered to have a generalized epidemic. The estimated prevalence rate in pregnant women has been approximately 0.9% for the past 5 years which allowed the MoH to theorize that there are concentrated pockets of populations with a higher prevalence rate.[29]

Since the HIV rate cannot be confirmed because the test among VAW service users was not performed, the self-reported rate should be examined with caution and the validity of self-reported HIV status among women should be analyzed in future studies.

- **Partner HIV status**: 37.5% (12) of the HIV service users responded they have a partner/husband who is HIV positive.

[28] Statistical Institute Of Belize. 2006. Labor Force Survey. Cited by UNAIDS and National AIDS Commission in: UNGASS Country Report 2008 – Belize. Page 11.

[29] Ministry of Health and PAHO. 2008. National HIV/AIDS Epidemiological Profile 2003 to 2007. Page 1.

2.9. Experience of women living with HIV - users of HIV services

Adequate social support from partners and family can influence behaviors of women living with HIV, such as safe sex, use of health services and support groups, adherence to treatment, nutrition and self-care.

- **Sharing the results of the HIV test:** 87.5% (28/32) reported that they talked with someone about it when the results were delivered, mostly to their partners (50%; 16/32) and 60% (19/32) did it the same day.

- **Behavior of partner and family after sharing the HIV test results:** 43.7% (14/32) feel the husband/partner treated them the same. Negative reactions from the husband/partner, such as hitting her, being angry, or accusing her of infecting him, were reported by 3 (9.4%). 53.1% reported that their family members treated them the same while 3 (9.4%) said it is worse. One in every four reported that her family was sad when she shared the results of the test and the same proportion said the family provided her with support and/or helped her to obtain treatment.

  Among those that did not speak to her husband, partner or family, 1 in every ten indicated the reason was fear of rejection.

- **Suicide ideation after a positive test**: Among those who responded to the question, 19.2% (5/26) reported they had thought about committing suicide after receiving the results.

3. Conclusions and recommendations

Conclusions

a. The significant level of acceptance of gender norms related to women's obedience to their partners/husbands, the obligation of women to have sex with their partners and the reasons under which it is acceptable that a man can physically abuse a women; showed the need to address cultural values on women's rights as a central component of the strategies to address HIV and VAW.

b. The different types of VAW are widespread with variations between the two population subgroups studied. While variations between both groups were found in levels of physical violence, some acts of emotional violence and controlling behaviors reported, no significant differences were found regarding physical violence during pregnancy and types of emotional violence most commonly reported.

c. The high levels of violence among women living with HIV shows the need for urgent action from HIV programmes to integrate VAW interventions in their strategies:

- Almost half of the women living with HIV reported physical violence by an intimate partner. Almost 4 in every ten reported that they have a partner/husband who is HIV positive.
- Almost four in every ten ever-pregnant women suffered physical violence by a partner.
- Three in every 10 reported sexual violence. 5.7 in every 10 women living with HIV ever married/partnered had experienced physical and/or sexual violence by an intimate partner.

d. Violence by perpetrators other than partners was also common in both groups showing the need to address the problem as a continuum during women's lifespan more than isolated events.

e. Violence can have serious consequences and can constitute a barrier to access to services:

- Almost 3 out 10 reported that they have to request their partner's permission before seeking health services.
- Among those that responded to the question, 8.0 out of 10 from the VAW group and 4.4 out of 10 from the HIV group were injured as a result of the violence by a partner/husband, revealing not only the magnitude but its severity.

f. The patterns of disclosing violence and use of services showed the importance of addressing the stigma and discrimination regarding being a survivor of violence as well as working at the

institutional, community and individual levels to increase the access to available help:

- Women from both groups reported having told people close to them about their situation of violence: partner, family and friends. The institutions women suffering violence used more frequently are, in order of importance: the police, organizations for women and health services.
- Family and friends are the main encouragers to women experiencing violence to seek help.
- Key pushing factors to seek assistance/support are the severity or impact of the violence, the risks and effects on the children and the fear that she wanted to kill the perpetrator.

g. Violence can affect the ability of women to protect themselves from HIV, negotiate safer sex, and increase the range of situations that make them more vulnerable to HIV:

- Knowledge of HIV is high in both groups, including the prevention strategies, although the most recognized (condoms, fidelity and abstinence) are troubling for women facing violence.

- HIV risk perception among users of VAW services is very low which increases their vulnerability to the virus.

- Although communication with partners about HIV prevention was reported by 1 in every 2 interviewees, only one in every three used a condom during the last time they had sexual intercourse.

- The level of refusal to use condoms by partners of both groups, reported by 4.3 of every 10 interviewees, showed the importance of the need for addressing patterns of condom use and the power of women to prevent HIV in a context of an abusive relationship.

- Sexual behaviors such as multiple sex partners of their husbands/companions, transactional sex and number of partners of women users of HIV and VAW services should be a central issue when analyzing their specific vulnerabilities to HIV and VAW.

- Knowledge and use of HIV services in the VAW group was found to be low although a significant proportion of them had had a HIV test.

h. The self-reported HIV positive status reported by women users of VAW is very high (4.76%), taking in consideration the high levels of stigma related to HIV which usually prevent women from disclosing their HIV status. This data was not verified by performing HIV tests on the VAW group of interviewees so it is important to examine it with caution.

i. Disclosing HIV status among users of HIV services was common – 8.7 of every ten

interviewees – and an important proportion reported positive responses from partners and family, although the proportion of those reporting negative responses is significant. Fear of rejection was reported as the main barrier to disclose the HIV status and five women said they had suicide ideation after receiving the positive HIV test result.

Recommendations

1. Devise a policy dialogue process at the national and local levels with the participation of all sectors involved in the VAW and HIV response to revise current policies and programmes and design interventions to address the key challenges found in the results of the study.

2. Prevention strategies of HIV and VAW that traditionally have worked separately should integrate specific components to address the underlying factors pushing both epidemics as well as their specific intersections in intermediate factors and results:

- Gender norms and their role in women's specific risks and vulnerabilities to HIV and violence.
- Stigma and discrimination surrounding both epidemics and its effects in access to prevention, care, treatment and support.
- The importance of using/accessing services/information on both problems.
- Men's involvement in stopping both epidemics.
- Prevention of VAW during the lifespan using a development approach and therefore tailoring the strategies to each developmental stage.
- Effects of HIV and violence on women, families, communities and society as a whole.
- Violence against women living with HIV with a sero–concordant partner.

3. Intersectoral responses are urgently needed to reduce the missed opportunities to prevent both epidemics and address the specific needs of VAW and HIV services users:

- Establish a referral system/intersectoral networks with organizations (public and private, and community groups) working on both issues.
- Update the current HIV and VAW protocols to integrate interventions linking both issues.
- Develop pilot experiences of structural interventions that include individual and collective empowerment of women in the general population and the users of HIV and VAW services.
- Linkages between HIV and VAW should be an integral part of strategies addressing gender equality and development in the country.

4. Develop a capacity building process with policy makers, service providers, program managers, activists and community leaders to strengthen competencies for addressing the strategic and logistical implications of the intersections between HIV and VAW.

5. Meaningful participation of women living with HIV and survivors of violence in the development of policies and programmes at the national and local levels, as well as gender equality and development.

6. Further studies are needed to get a better understanding of the linkages between HIV and VAW in different population groups in order to develop a solid body of evidence to sustain the policies and programmes.