GBV + HIV

Strengthening Gender Based Violence and HIV Response in Sub-Saharan Africa

Report of Workshop Organised by
Liverpool VCT, Care and Treatment (LVCT)
World Health Organization (WHO)
and the Sexual Violence Research Initiative (SVRI)

30th - 31st July, 2012
Kenya School of Monetary Studies
Nairobi - Kenya

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Abbreviations and Acronyms

ANC	Antenatal Care
ART	Anti Retroviral Therapy
CBO	Community-Based Organization
CCC	Comprehensive Care Clinic/ Centre
CITC	Client Initiated Testing and Counselling
COVAW	Coalition on Violence against Women
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
EC	Emergency Contraception
ESAR	Eastern and Southern Africa Region
GBV	Gender Based Violence
GBVRC	Gender Based Violence Recovery Centre
GoK	Government of Kenya
HBTC	Home Based Testing and Counselling
HTC	HIV Testing and Counselling
IDU	Injecting Drug User
IMAGE	Intervention with Microfinance for AIDS & Gender Equity
IPV	Intimate Partner Violence
KHSSP	Kenya Health Sector Strategic Plan KNASP Kenya National Aids Strategic Plan
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MARPs	Most at Risk Populations
MSMs	Men Who Have Sex with Men
NACs	National AIDS Councils
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RCTs	Randomized Controlled Trials
RHRC	Reproductive Health Response in Crises
SAHAPS	South Africa HIV Antenatal Care Post-Test Support Study
SASA!	Start Awareness Support Action
SHARE	Safe Homes and Respect for Everyone
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SVRI	Sexual Violence Research Initiative
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Emergency Fund
VAC	Violence Against Children


women
education
empower
human rights
love
violence
oppression
OPPORTUN
future
family
IMPACT
justice
FEMINISM
MORAL
girl
principle
CHANGE
HIV/AIDS
respect
PARTNER
peace
beauty
discrimination
progress
humanity
war
girls
fairness
love
equality
SUFFRAGE
DIGNITY
INTEGRITY
rights
FREEDOM
fairness
gender =
progress
family planning
health
status
hapiness

Executive Summary

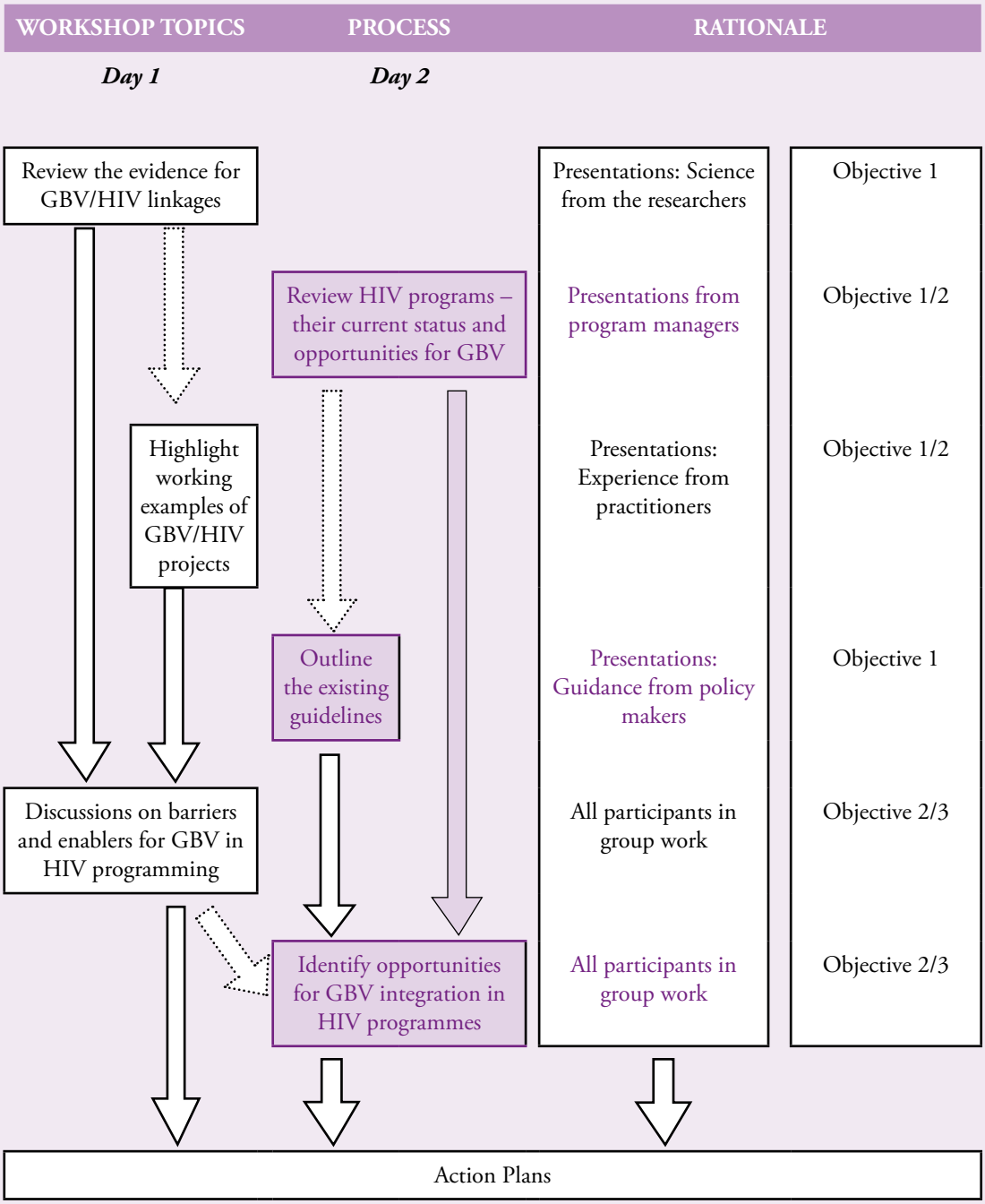
Data reveals high levels of physical and/or sexual violence among women including their intimate partner at some point in their lifetime. The impact of gender based violence on health, productivity, economy, and social life and therefore a country's ability to achieve its goals is documented. Data has shown the inter-connection between different forms of gender based violence and HIV through direct or indirect pathways. Both Gender Based Violence (GBV) and HIV exacerbate psychological, reproductive health and physiological consequences on survivors. Children are more vulnerable to both GBV and HIV. However, there exists limited data, few models and few prevention interventions and services for survivors of GBV. HIV programmes (testing and counselling, prevention interventions, PMTCT and care and treatment among general and key populations), systems and infrastructure (human resources, reporting, commodities), and resources (financing, human, technical capacities) have developed over the last decade. They provide an opportunity for integrating GBV prevention and response services.

The Regional Workshop on Strengthening Gender Based Violence and HIV Response in Sub-Saharan Africa was organized *to explore the evidence, gaps in the evidence, challenges and opportunities to implementing GBV programmes within the HIV response.* It was a collaborative workshop organized by LVCT, the World Health Organization (WHO) and the Sexual Violence Research Initiative (SVRI). It took place from 30th to 31st July, 2012 at the Kenya School of Monetary Studies, Nairobi with 90 participants from 12 countries representing HIV related organizations and programmes that can be utilized as a platform to integrate GBV. It was supported by Comic Relief through Trocaire, the United Nations Trust Fund to End Violence against Women (UNTF), the Elton John AIDS Foundation (EJAF) and the Population Council. The workshop was opened by the Head of Disease Prevention and Control, Ministry of Public Health and Sanitation, Kenya.

Structure of the workshop

A logical flow model was used to organize the workshop to encourage a logical progression of ideas on linkages between HIV/GBV from theory, research to practice, along with the opportunities and challenges (Figure 1). During the first day of the workshop, the evidence for GBV/HIV linkages, existing working programmes and the barriers and enhancers for programming were reviewed. The focus of day 2 was on the review of HIV programmes, existing guidance for integration and identifying practical opportunities for integration. Resource persons (including implementers, donors and researchers) made presentations, and guided discussions in interactive sessions with participants. Country specific work plans were developed based on practical in-country opportunities identified by each team.

Figure 1: Workshop structure



Proceedings of the Workshop

Why must HIV programs invest in GBV?

The HIV prevalence in sub-Saharan Africa is high and peaks in women at a young age below 30 years and in men at approximately 40 years. HIV prevalence and incidence amongst young persons (15-24 years) in East and Southern African Region (ESAR) are high. UNAIDS data and UNAIDS Estimates 2011 indicates new HIV infections among young people as highest in South Africa (160,000) followed by Mozambique (49,000), Uganda (46,000) and Kenya (42,000).

There is a high prevalence of gender based and sexual violence in the region. A WHO multi-country found that between 15 and 71% (ages 15-49 years) women from 10 countries reported experiencing physical and/or sexual violence by an intimate partner in their lifetime. Intimate partner violence is often connected to other forms of violence including sexual violence. Emerging population based data on violence against children aged 13-18 years led by in-country governments and undertaken by UNICEF, Together for Girls and the Centre for Disease Control in 3 countries (Tanzania, Swaziland and Mozambique), showed high levels of sexual violence ranging to 14% in males and 33% in females.

Evidence from demographic health surveys suggests associations between sexual and intimate partner violence (IPV) and increased HIV risk among adult women. The violence against children (VACs) data show association between childhood sexual violence and up-to 3 to 4 times increased likelihood of HIV risky behaviour and presence of sexually transmitted infections among both male and female adolescents. Data from South Africa and Tanzania show higher risk of incidences of HIV infection among women who experienced intimate partner violence or who are in relationships with low gender equality. Perpetration of physical IPV has been associated with elevated HIV prevalence in young men associated with concurrent sexual partners, risky sexual behavior and problematic use of alcohol.

Using HIV programming to address GBV

Despite the evidence linking HIV and GBV, these epidemics are generally not jointly addressed in programming. Examples of how GBV was being addressed by HIV programmes were provided and discussed. The presentations highlighted that GBV was addressed, although very unsystematically. The models presented on how HIV programming integrated GBV highlighted a number of gaps, particularly in terms of the availability of information and data to effectively inform programming, including:

- Lack of commonly agreed on indicators for GBV that can be integrated into programmes
- Lack of surveillance systems for GBV data collection from different service sectors
- Lack of evaluation of existing interventions
- Limited evidence on the cost (impact) of GBV which would help to provide better justification for planning and resource allocation

Research priorities identified included:

- Development of indicators for GBV prevention and response
- Investment in capacity for GBV data generation and use among HIV service providers in-county
- Adapting and testing effective violence and HIV prevention interventions in local settings for different populations including young women, children and people engaged in sex work
- Evaluating the costs of not responding to sexual and gender based violence for the HIV epidemic
- Strengthening collaborative research on GBV across the region through multi-country studies, and broader sharing of tools of measurement with investment in capacity for translation of research into programming

Programming, responses, what works and existing gaps

GBV prevention work in the region was reported as limited with few evidence based interventions available. Responses focused on sexual violence services with few services for other forms of gender based violence such as IPV/domestic violence, workplace violence, traditional harmful practices, child abuse and neglect. Specific areas identified for potential GBV integration into HIV programming include testing and counselling, care and ART, vulnerable groups programming and elimination of vertical transmission programmes. The need for specific interventions that address the needs of children were noted as priority. Multiple approaches and strategies for different contexts were emphasized as critical rather than adopting one model that must fit all contexts.

Gaps identified in current GBV programming and interventions include:

- Limiting legal frameworks especially to protect vulnerable groups such as sex workers and men who have sex with men
- Different ministries being responsible for different aspects of GBV with no single authority or point of accountability within government
- GBV responses are often mediated through traditional and social structures, bypassing established mechanisms
- Resource limitations for GBV programmes and services
- Lack of political leadership and champions for a GBV response
- GBV and HIV programmes operate in parallel and sometimes in competition with each other
- Programming for GBV should be anchored on gender inequalities as a key structural driver of the HIV epidemic

Opportunities for strengthening the GBV/HIV response

Participants identified a number of opportunities for strengthening the GBV/HIV response in the region, including:

- Investment in leadership and community champions for GBV within HIV programmes and in communities
- Involvement of champions in a range of programme areas requiring further research such as male involvement in GBV responses
- Identify innovative financing options for integrated responses, which include different sectors responsible for GBV (law, order, justice, education and social services)
- Utilization of emerging technology such as mobile and social media in designing interventions and communication approaches
- Sectors such as education offer opportunities for implementing structural interventions that will improve both GBV and HIV outcomes
- Existing curriculum for HIV capacity building and provider training, messaging for HIV, service delivery sites such as VCT should be reviewed and where necessary include GBV information, training and services without development of parallel systems
- HIV data collection systems provide opportunities to collect GBV monitoring and evaluation data

Next steps

During the workshop participants developed action plans by identifying in-country opportunities and potential areas of funding for GBV within HIV programmes. The following were identified as the action areas:

- Finalize and disseminate the country action plans
- Country teams will disseminate the report and action plans and use these to mobilize investment by HIV programmes in GBV services
- Country teams will utilize the country action plans to provide partners, donors with opportunities and areas of prioritization for GBV/HIV integration
- Summarize the country plans outlining implementation research questions and priorities for GBV/HIV that can be disseminated to funding partners

Conclusion

The deliberations, recommendations and action plans provide a platform for participants to engage with funders, government and other implementing partners to pro-actively integrate, measure and report GBV prevention and response in HIV interventions. The need for documentation and data collection remains paramount in developing the case for, and identifying effective GBV responses that take advantage of the existing HIV infrastructure, resources and programmes.


Community can Prevent
Sexual Violence,
Men make a Difference

1.0 Introduction

The Regional Workshop on Strengthening Gender Based Violence and HIV Response and Services in Sub-Saharan Africa was organized jointly by Liverpool VCT, Care and Treatment (LVCT), the World Health Organization (WHO) and the Sexual Violence Research Initiative (SVRI). It was supported by Comic Relief through Trocaire, the United Nations Trust Fund to End Violence against Women, the Elton John AIDS Foundation, and Population Council. The workshop brought together key thinkers and practitioners from the Eastern and Southern Africa Region (ESAR) to discuss existing models in GBV and HIV integration and reflect on the extent to which these models have been applied in the actual delivery of services. The participants also discussed the challenges and opportunities for integration of GBV into HIV responses, and debated on possibilities for translating theory into practice.

The main goal of the workshop was to explore existing evidence and gaps in the evidence in GBV, and HIV, as well as the challenges, and identify opportunities in the implementation of GBV programmes in HIV responses.

The specific workshop objectives were:

- To establish the evidence for GBV/HIV programming and outlining the challenges and opportunities to development of sustained evidence
- To identify barriers and enablers to GBV/HIV programming and evaluation of programmes and outlining opportunities for GBV/HIV programming in existing HIV response interventions (HTC, PMTCT, Care and Treatment, Prevention) for general and key affected populations
- To develop action plans for integrating and evaluating interventions within HIV programming by determining GBV/HIV programming priorities

1.1 Background to the workshop

Evidence shows that women all over the world experience high levels of physical and/or sexual violence at some point in their lifetime [1]. Available data indicates that 1 in 5 women and 1 in 10 men report experiencing sexual abuse as children. The impact of gender based violence on health, productivity, economy, social life and, therefore, a country's ability to achieve its goals is well documented[2]. However, few prevention interventions exist and services for survivors of GBV are limited. In addition, even though available evidence indicates that those persons who are most vulnerable to sexual violence are also more likely to be infected with HIV, there have been very few interventions that integrate GBV in HIV work. The few integrated interventions and services available are of limited scope, coverage and quality[3, 4]. *Also see:* http://bit.ly/XdEjrJ

GBV is often not prioritized and the few services are not institutionalized within national and sector-specific policies, plans, budgets and management information systems. There exists limited data, few models and operational research that provide evidence for the 'how-to' deliver and expand both sector specific and cross-sectorial interventions[5].
HIV programmes are increasingly looking at ways to include interventions to address sexual violence. In sub-Saharan Africa, the dominant method for responding to sexual violence through HIV programmes has been via the delivery of HIV post exposure prophylaxis institutionalised through guidelines, service delivery protocols and provider training. Normative and international guidance such as the WHO guidelines on medical management of sexual violence, PEPFAR GBV/HIV integration, country's national standards for GBV care provides a basis for integrating HIV in GBV services through delivery of prophylaxis, information and linkages. There is also increase in models of sexual violence services being tested and expanded[6-8].

A range of sectors are required to deliver protection, support and rehabilitation services to survivors of gender-based violence including health, law, order, justice and social services[9, 10]. Although services for survivors are limited, even where services do exist, it is widely believed that only a small proportion of those who experience GBV and sexual violence seek any type of institutional care. Qualitative research reveals several barriers in seeking institutional care, for example, police services or health care. Barriers to accessing HIV/AIDS services have also been reported by women and include fear of being physically assaulted or threatened by their husbands or partners, stigma and blame. Additionally, institutional barriers exist (Table 1)[11]. In sub-Saharan Africa, nearly 60 per cent of adolescent girls surveyed were afraid to discuss the use of condoms with their parents for fear of violence[12].

Evidence is emerging on promising and effective interventions on GBV and HIV integration. Evaluated models on structural interventions include a project that includes a micro-finance model with HIV and gender training that demonstrated positive changes beyond HIV prevention to include reduction in household poverty and increased women empowerment[13, 14].

Table 1: Barriers to accessing services

Barriers	Rwanda	Uganda
Preference for community level settlement	X	X
Fear of stigma	X	X
Lack of awareness of services		X
Poverty and distances		X
Overcrowded facilities		X
Threats by perpetrator		X
Bureaucracy and corruption	X	X

(Source: Population Council 2010)

1.2 Rationale of the workshop

Although these data exist, few programmes and services utilize HIV platforms for a comprehensive GBV response. There is also insufficient understanding and capacity among policy and programme personnel regarding 'how-to' integrate GBV in HIV programming holistically.

A number of unanswered questions still remain:

- How do we identify what can be integrated?
- What is the most appropriate entry point or points for optimal GBV services delivery?
- What are the barriers and enhancers to implementing GBV programmes?
- What will it cost?
- How can these programmes be funded and who should finance them?

An agenda to identify country priorities accompanied by action plans is required. GBV prevention programmes that are evaluated and are or can be brought to scale, are fewer. It is these considerations that led to the GBV/HIV integration workshop, to explore the evidence, gaps in the evidence, challenges and opportunities to implementing GBV programmes within the HIV response. The workshop brought together key thinkers and practitioners from the region to discuss the models, the extent to which these models have been applied in actual services, the challenges and more importantly, to identify opportunities for integration of GBV into country and regional HIV responses, and to debate what should be done to ensure theory becomes practice.

1.3 Structure of the workshop and of the report

The workshop took place on 30th and 31st July, 2012, at the Kenya School of Monetary Studies, Nairobi. Participants were drawn from sub-Saharan Africa, especially the Eastern and Southern Africa Region (ESAR). They also included organizations already undertaking HIV related programmes into which they could integrate GBV. The organizations were represented by programme managers, researchers and policy makers.

During the two-day workshop, resource persons made presentations in plenaries on the GBV and HIV integration and response, including case studies. Group sessions were also held, especially in identifying opportunities and aspects of GBV programming, and identifying barriers and enablers in research, policy development, implementation and services.

The report is organized into the main thematic discussions of the workshop and is structured into five sections.

Section 1 - Introduction: outlines the background, rationale and objectives of the workshop, and the opening session.

Section 2 - Evidence on linkages between GBV and HIV makes the argument for why HIV programmes must invest in GBV for the desired outcomes of HIV prevention and treatment.

Section 3 - Responses in programming to link GBV and HIV outlines the current status of HIV programming outlining potential opportunities for research, policy reforms, service delivery, creating an enabling environment and responding to vulnerable populations.

Section 4 - Integration of GBV and HIV services highlights policy and practice gaps and considerations for integration of services drawing from existing programming responses.

Section 5 - Way forward draws on the proceedings of this workshop and existing information to outline *what we know* and *what we need to do*. The country action plans developed during this meeting are attached.

1.4 Opening session

Ms Clare Gardner *– Kenya Country Manager, Trocaire*

Dr. Claudia Garcia Moreno *- Lead Specialist, Sexual Health, Gender, Reproductive Rights and Adolescence, Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland*

Dr. Willis Akhwale *- Head, Department of Disease Prevention and Control at Ministry of Public Health and Sanitation, Kenya*

Dr. Willis Akhwale, the Head of Disease Prevention and Control, Ministry of Public Health and Sanitation officially opened the workshop. Representatives from the organizing partners—LVCT, SVRI, WHO, and Trocaire—made opening remarks.

A new impetus for GBV within the HIV response is a window of opportunity: Although the relationship between GBV and HIV has been widely acknowledged for the last decade of the HIV response, questions regarding the evidence of linkages and the contribution of GBV to the HIV epidemic have constrained an optimal response. Increasing availability of evidence from analysis of cross-sectional data such as demographic health surveys (DHS), longitudinal studies, evaluation of programmes have developed a case for responding to GBV in HIV programmes.

Although national and international commitment is increasingly being seen there is a risk of failing to capture the opportunity to respond to GBV appropriately in the eastern and southern African region. This is seen in the lack of capacities among implementers, lack of knowledge among programmers and lack of budgets by government. However, the emerging investment by researchers, donors, implementing organizations towards integrating GBV in HIV programmes show a new impetus, whose momentum needs to be sustained.

There is an urgent need to address violence against children: Emerging service delivery and research data in the regions shows the urgent need to recognize and respond to sexual violence against children. The impact of violence against children is far reaching on their future lives through perpetration or victimization which all continue the vicious cycle of violence.

Investment in prevention of gender-based violence is a priority: GBV has not been prioritized by national governments as demonstrated by poor policy implementation and lack of or inadequate dedicated resources to the relevant sectors such as police, health, social services, justice for an effective response. The few services available are not institutionalized within national and sector-specific policies, plans, budgets and management information systems and are often run by NGOs.

Models for GBV/HIV integration need to be tested and scaled up: A few models such as Stepping Stones, IMAGE and SASA! have integrated GBV into HIV prevention with positive results. Service delivery models have been tested in Zambia, South Africa, Kenya and Uganda. However, these are not widely implemented, and the capacity and understanding among policy and programme personnel is insufficient. While HIV programmes exist, the opportunities and the 'how-to' of integrating GBV programming have not been optimized.

Much has been achieved, there is a long way to go: The key note speaker Dr. Akwhale, welcomed the participants to Kenya. He noted that many countries including Kenya have developed a response through strengthened legislative frameworks, health sector policy guidance and service delivery protocols and provider training.

However, there remain implementation challenges, gaps in availability of commodities and logistics, and poor coordination among programmers and service providers. He called for a more coordinated and multi-sectorial approach to ensure that every survivor who accessed services can be routed to access health care, police, social services, justice and children's department services without a break in the system. Advocacy for government responsibility for a comprehensive GBV and HIV response must remain consistent and be sustained.

The lessons from a more developed HIV response with programmes, services delivered at scale, capable providers within the public health care system and civil society technical support for service delivery can be drawn to inform GBV services development, and provide a platform for integration.


DOMESTIC
VIOLENCE
ABUSE
PSYCHOLOGIC
PHYSICA
VICTIM
VICTIM'S
SEXUA
PASSIVE
UNWANTED
FREQUENCY
PERPETRATED
OBJECTS
ONAL
NEED
ALSO
SUBTLE
OTHERS
INTIM
HREATS
CRIMINAL
SPOUSAL
SOCIAL
INCLUDE
DEPRIVATION
FORMS
HARM
NONVERBAL
SPIRITUAL
SEVERITY
IMPORTANT
THROWING
RELATIONSHIPS
NON-MARRIE
DESTRUCTI
LEGAL
INTELLECTUAL
VERBA
PARTN

2.0 Evidence on Linkages Between GBV and HIV

Dr. Naeemah Abraham *(South African Medical Research Council) – Review of evidence on the linkages between GBV and HIV*

Dr. Catherine Maternowska *(UNICEF) – Emerging evidence on linkages between VAC and HIV*

Dr. Ian Askew *(Population Council) – State of the evidence: what are the research gaps and priorities for driving forward the GBV/HIV in sub-Saharan Africa*

These presentations aimed to review the evidence of GBV and HIV linkages. Evidence from a systematic review undertaken by the Global Burden of Disease Study, interpersonal violence by the London School of Hygiene and Tropical Medicine and the World Health Organization were presented. Findings from population based data on violence against children and HIV from Botswana, Tanzania and Swaziland undertaken through collaboration between the Governments, Together for Girls, UNICEF, CDC and stakeholders in each country were presented[15-17]. Research gaps and priorities were shared from the experience of a multi-sectorial collaboration of studies by Population Council in five countries (Kenya, Zambia, Malawi, South Africa and Swazi).

Plenary discussions interrogated the data, raised questions on methodology and implications for programming and highlighted key gaps in the research and identified the opportunities for developing an evidence base. The following emerged:

2.1 Evidence shows associations between intimate partner violence/sexual violence and HIV

Data has documented the inter-connectedness between different forms of gender based violence and HIV. Research from low and middle income countries where the burden of HIV is the greatest, show that gender inequality, with and without violence as one of its manifestations, place women and girls at increased risk of HIV[18]. GBV is associated with the increased risk of STI and HIV through a number of indirect pathways. This risk occurs both through direct infection as a result of rape and coerced sex and indirectly as a result of women's inability to protect themselves, seek health care and increased risky behaviour and substance abuse[18-20]. Where partner violence and sexual coercion exists, negotiation for condom use or partner's sexual behaviour is difficult, thus increasing risk of HIV infection.

Population-based demographic health surveys provide the available estimates of the prevalence of intimate partner violence and sexual violence in non-conflict settings. The WHO multi-country study on women's health and domestic violence against women complements these data[1].It showed high levels of physical and/or sexual violence by an intimate partner and high levels of first forced sex ranging 24-40%. Prospective studies show an association between physical and/or sexual IPV and incident Intimate partner violence (IPV) presents a number of pathways for increased risk of HIV.

These risks include:

- Forced sexual intercourse
- Inability of women in abusive relationships to refuse and negotiate for safer sex (including condom use)
- Abusive men being more likely to be involved in risky behaviours such as, being more likely to have multiple partners; abuse alcohol and other substances; visit sex workers; have sexually transmitted infections (STIs)
- Child sexual abuse more likely to happen where there is IPV

In addition, data on reverse causality in which cases women are abused or abandoned because of their HIV status is also present. DHS data have shown that women who have suffered violence are twice as likely to have an STI as women who have not[21].

Sexual violence is associated with an increased risk of a range of sexual and reproductive health problems including, unwanted pregnancies, pelvic inflammatory infections, infertility, gynaecological disorders and the transmission of HIV and other STIs. Although sexual violence is mostly perpetrated by men against girls and women, sexual violence against boys is also common. Studies reveal that approximately 20 per cent of women and 5-10 per cent of men report being victims of sexual violence as children[22].

In high HIV prevalence settings, married girls aged 15-19 years are much more likely than unmarried girls to have HIV infection[23].Young women in rural South Africa who experienced sexual abuse in childhood had a 66% greater risk of HIV infection compared to young women who had not been abused. Similar findings are reported in Rwanda and Tanzania, with the risk for HIV among women who have experienced GBV being up to three times higher compared to women who did not report sexual violence. An analysis of data on women from Rwanda found that women who had experienced sexual and/or emotional abuse from an intimate partner were approximately 3-5 times more likely to test positive for HIV than those who have not experienced abuse[15, 17].

2.2 Violence against children is associated with HIV risk and STIs

Physical and sexual violence against children is prevalent. The short and long-term consequences are severe, not only for those who experience it, but also for families, communities and entire nations. Data is emerging through the population based violence against children studies[22]. Among adolescents, data suggests that sexual activity is not always consensual, putting young women at increased risk of HIV[24, 25]. In South Africa, close to one-third of all girls surveyed said that their first sexual experience was forced, and nearly three-quarters had sex against their will at least once[24, 26, 27]. Other data indicate that coerced sexual initiation is common against girls in the region, and is often viewed as a routine part of relationships[28]. Sexual violence, and in particular against children, increases their susceptibility to risk behaviours including unprotected sex, having multiple partners, participating in sex work, substance abuse and replication of violent behaviour in adulthood. Violence may inhibit children's ability to negotiate safe sex behaviours throughout their lives, reduced self-esteem, increased risk-taking and abusive or victimization behaviors. For orphans and children, poverty puts them at risk of being exploited sexually. Alcohol use has been associated with increased risk of violence and HIV in relationships[16, 29].

In 2002, almost 53,000 children up to the age of 17 years died as a result of homicide worldwide. A study by UNICEF on child disciplinary practices at home, with data from 35 low- and middle income countries, indicates that, on average, three in four children between the ages of 2 and 14 years were subjected to some kind of violent discipline, more often psychological than physical. In 3 ESAR countries where population based data on violence against children has been conducted, females and males aged between 13 and 24 years reported up to 34% and 13% sexual violence. In Kenya, the VAC study conducted in 2010 indicated 1 in 10 girls (10.7%) and 1 in 20 boys (4.2%) had experienced at least one episode of sexual violence in the previous 12 months [22, 30, 31].

Data increasingly associates sexual violence among children with HIV risk. Dependent variables include a child's age when abused, the duration and severity of the abuse or neglect, the child's resilience, and co-occurrence with other maltreatment or adverse exposures such as the mental health of the parents, substance abuse by the parents, and/or violence between parents[22].

A survey conducted in 2003 in South Africa found that youth from communities with greater risk of exposure to sexual violence were significantly less likely to use condoms at their last sexual encounter and were more likely to be HIV positive or to have experienced an adolescent pregnancy than were youths from communities with lower violence. Data from 19-24 year olds from Tanzania show that children who experience sexual violence are twice more likely to have had more than 2 sexual partners, 3 times more likely to have been diagnosed with an STI and twice more likely to not have used a condom within the previous year.

Among adolescents and women, the frequency of pregnancy as a result of rape varies from 5 to 18 per cent and younger women who experience rape often have an increased rate of unintended pregnancies. The VAC studies identified unwanted pregnancy as one of the consequences of sexual abuse—1 in 12 girls who had been raped in the previous 12 months became pregnant. A presentation made during the workshop indicated low health seeking behaviour among survivors as only half of the respondents who indicated they knew where to be tested for HIV actually went and had the test[15].

2.3 Research that links GBV and HIV or provides programming solutions is limited

A systematic review and meta-analysis of studies on violence with HIV and STI end points shows limited research and publications with 35 papers describing 41 datasets (5 prospective, 3 case controlled and 35 cross-sectional)[17]. Data showed that while the body of evidence on direct biologic linkages between GBV and HIV is limited, the evidence available demonstrates a strong correlation in the currently available good quality longitudinal studies. However, relationship between HIV risk and different types, manifestations and severity of violence is unclear. The complexity of pathways between risk factors of perpetration of violence and risk of HIV presents challenges to establishing causality. Although there is emerging data on violence against children in the ESA region, it is grossly insufficient with no accurate prevalence data or longitudinal studies with HIV endpoints[17, 29]. A range of HIV studies exist as population based surveys, cross-sectional studies and longitudinal studies with biological outcomes. However, very few HIV studies incorporate GBV questions [17]. Available evidence shows that addressing gender equality and gender-based violence can improve HIV and other health related outcomes, health seeking behaviour and partner communication[29].

Identified as important in strengthening the evidence is the need to understand the epidemiology of both HIV and GBV links, invest in rigorous monitoring and evaluation and build competences in understanding, documenting, evaluating and responding to GBV among HIV researchers, programmers and evaluators.

Research needed to address key gaps in the GBV/HIV field include:

- Exploration of the behavioural and physiological pathways linking sexual violence and HIV using longitudinal and prospective methods
- Adapting and testing of locally appropriate interventions
- Exploring the impact of and testing interventions to respond to the short and long-term HIV outcomes of sexual violence
- Adapting and testing effective violence and HIV prevention interventions in local settings for different populations including young women, children, men and boys and people engaged in sex work
- Evaluating interventions for violence prevention and response in HIV interventions including couples VCT, care and ART, partner notification and disclosure services and prevention of vertical transmission programmes

- Increased implementation research* on prevention of sexual and intimate partner violence and should include school settings

- Evaluating costs of interventions, the costs accrued by the HIV epidemic not responding to sexual and gender based violence for the HIV epidemic, costs the impact of policy and legal frameworks (or lack of)

2.4 Measuring and estimating violence and its impact is problematic

Prevalence estimates for GBV vary widely as a result of differing definitions of violence, data collection methods, and time periods used in different studies[32]. For instance, evidence from a survey undertaken among adult men in Eastern Cape and Kwa Zulu Natal in South Africa shows that perpetration of physical violence by intimate partners was associated with elevated HIV prevalence in young men aged below 25 years. Similar findings from India also showed that men who have perpetrated IPV have elevated HIV prevalence[17]. However, a systematic analysis of data, as part of a systematic review on the global burden of disease study leads to mixed results that show different levels of effect, whether protective or risk factors of GBV, IPV on HIV risk. A WHO multi-country study found that between 15% and 71% of women reported experiencing physical and/or sexual violence by an intimate partner at some point in their lives. This variation in estimated prevalence may also be a consequence of significant under-reporting due to stigma, shame or other social and cultural factors that deter women from disclosing episodes of GBV, especially from intimate partners[1, 29].

Additional methodological challenges include the reliance of most studies on self-reports rather than biological outcomes. The misclassification of exposure to violence, whether physical or sexual, analysis against partners–current or past and the inability of cross-sectional studies to control for confounding variables such as the concurrent partnerships and partner behaviour.

2.5 Evidence is limited and there is need to harness different opportunities for data collection

The number of studies showing association between violence and HIV are few with differing quality. Although there are a growing number of studies, they are of mixed quality and cross-sectional data presents less consistent findings. The extent to which we can generalize findings across different epidemic settings is unclear. To inform programming there is a need for more evidence. In particular, longitudinal studies will be useful to answer questions of causality, measurement of exposure to violence, and control of confounding variables (male partner variables). Ongoing studies with HIV outcomes provide opportunities for collecting longitudinal data. Population based surveys such as demographic health surveys could be improved to collect additional data on violence exposure to reduce confounding. Integrating violence questions in HIV intervention research will provide a deeper understanding of GBV and HIV linkages.

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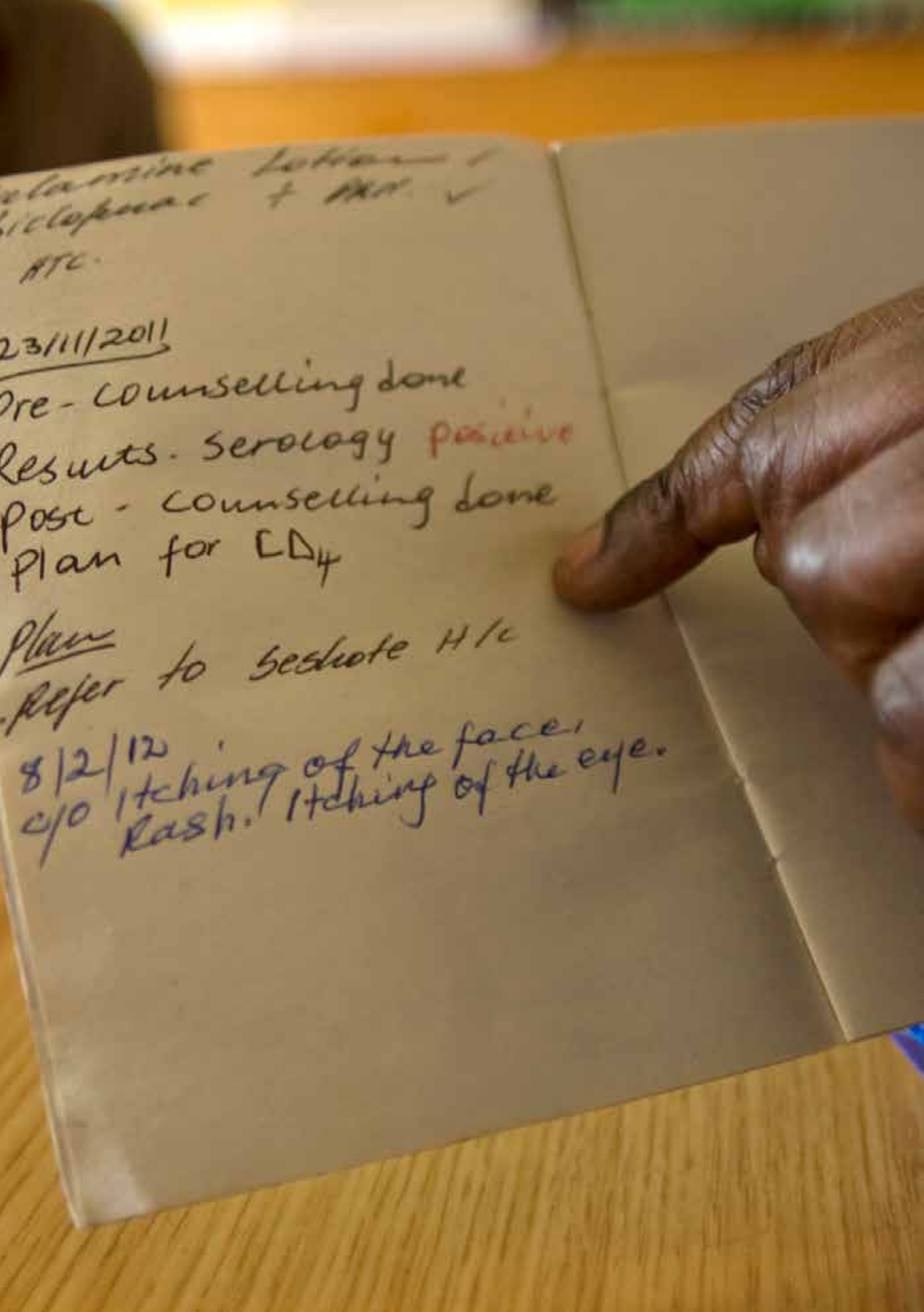
* This is research into the delivery of efficient, sustainable and effective services, appropriate structure of health systems, the policy process and into other components which are necessary to bring new and old control interventions into the routine practice of national health systems. It aims to improve access to efficacious interventions by developing practical solutions to common, critical problems in the implementation of these interventions.

Potential priority research areas include:

- Operational research to test locally appropriate interventions and models for comprehensive, scalable responses to sexual and intimate partner violence
- Studies on multi-sectorial responses and requirements of other sectors beyond health
- Costing data with a focus on evaluating the costs of interventions, the economic contribution of GBV to HIV goals such as elimination of mother to child transmission or maternal and child health indicators, and the cost not responding to sexual and gender based violence for the HIV epidemic is urgently required
- Testing interventions to respond to the short and long-term HIV outcomes of sexual violence in the context of the broader health sector and making links to national goals and priorities such as eMTCT programmes, maternal and child health are primary investments
- Culturally appropriate interventions for effective HIV prevention within communities in local settings should be tested
- Developing and/or adapting effective violence and HIV prevention interventions in local settings for different populations including young women, children and people engaged in sex work
- Evaluating interventions for violence prevention and response in HIV interventions including couples VCT, care and ART, partner notification and disclosure services and prevention of vertical transmission programmes


STOP
VIOLENCE
AGAINST
WOMEN


ATC.
23/11/2011
Pre-counselling done
Results. Serology positive
Post-counselling done
Plan for CD4
Plan
Refer to Sesheke H/c
8/2/12
c/o Itching of the face.
Rash. Itching of the eye.

3.0 Responses in Programming to Link GBV and HIV

Ms. Ruth Masha *(UNAIDS) – Status of the HIV response: Programming and new directions (Services, structures, systems, data, financing)*

Dr. Claudia Garcia-Moreno *(WHO) – Evidence on effectiveness of GBV screening based on systematic reviews undertaken*

Dr. Chi Chi Undie *(Population Council of Kenya) – Acceptability and feasibility of GBV screening and responses in health care settings*

Ms. Lori Michau *(Raising Voices – Uganda) – The SASA model: Integrating primary GBV prevention in community HIV programming*

Ms. Jennifer Wagman *(John Hopkins) – Integrating GBV in HIV testing and counselling*

A brief overview of the status of the HIV response, focussed on programming and emerging directions as provided by the UNAIDS were highlighted. A WHO review of the practise of screening for intimate partner violence in health care settings provided recommendations and considerations for practice. Practical examples of projects that have integrated GBV and HIV from Uganda, and screening for IPV in a public health facility in Kenya presented their experiences and lessons[33-36]. Plenary discussions included more examples from participants, identification of additional gaps and priorities for responses and interrogation of the evidence provided. The following emerged:

3.1 Evidence for routine screening for GBV in health care settings is inconclusive

Screening is a process of testing by use of questionnaires or instruments that may lead to an earlier diagnosis aimed to benefit persons being screened through timely intervention. A test used in a screening programme must have good sensitivity in addition to acceptable specificity to avoid over-diagnosis, misdiagnosis and creating a false sense of security. Studies on tools and approaches show varying levels of acceptability and feasibility of routine screening for intimate partner violence. In Kenya, a study demonstrated acceptability of screening in a public referral hospital when there was IPV support on site through a gender based violence recovery centre. Additional important considerations include planning sessions with providers, training that includes survivor testimonies and ability to harness hidden resources such as auxiliary staff and peer educators. Further testing and evaluation of IPV screening, its impact and optimal interventions, especially in public health facilities and within HIV services is required before routine screening and scale up[35].

A 2010 WHO systematic review concluded that, there was insufficient evidence that routine screening would lead to a reduction in IPV or an improvement in quality of life and health outcomes. The review focused on screening in addition to an immediate action. Three of the four studies undertaken were in emergency departments, with two in family practice and one in an antenatal clinical setting. None of the studies demonstrated a statistically significant reduction in IPV recurrence[33].

The following were observed:

- There is no evidence of lack of potential harms
- Currently, screening does not fulfil the public health criteria for implementation of a scaled up screening programme
- There are limitations of evidence with only a small number of trials, only two studies have gone beyond intermediate and other health outcomes

There is high proportion of potential participants declining to be screened as well as loss of follow-up. Thus:

- 'Universal screening' or 'routine enquiry' (i.e., asking women in all health care encounters) is not recommended
- Healthcare providers should ask about exposure to IPV when assessing conditions that may be caused or complicated by IPV
- Training should focus on enabling all primary health care providers to be aware of IPV and to know how to provide a first-line/support response to anyone who discloses IPV
- Written information on IPV should be available in health care settings for women in the form of posters and pamphlets (with appropriate warnings about taking them home if an abusive partner is there)
- Considerations for WHO recommendation on screening provided include [33]:
    - The opportunity costs of over stretched healthcare providers: While screening increased detection it also tends to increase resistance from clinicians and rates fall off. It potentially becomes a tick-box exercise carried out without due consideration or done in an ineffectual way.
    - The training of providers on asking a question to women when there are limited options could be utilized on enhancing providers' ability to respond adequately to those who disclose violence, or who are suffering from severe forms of abuse.

3.2 Effective community interventions are necessary to implement GBV and HIV prevention and response

3.2.1 The case of the SASA model

SASA! is not only a Kiswahili word for "now!" but it also serves as an acronym for the major phases of the programming approach to addressing GBV - Start Awareness Support Action (SASA!). The approach involves a set of phases that scale up the stages of change to phases of community mobilization as follows:

Start: Start thinking about violence against women and HIV/AIDS as interconnected issues and foster power within yourself to address these issues.

Awareness: Raise awareness about how our communities accept men's use of power over women, fuelling the dual pandemics of violence against women and HIV/AIDS.

Support: Support the women, men and activists directly affected by or involved in these interconnected issues, by joining your power with others'.

Action: Take action. Use your power to prevent violence against women and HIV/AIDS.

SASA! is an exploration of power – what it is, who has it, how it is used, how it is abused and how power dynamics between women and men can change for the better. It demonstrates how understanding power and its effects can help prevent violence against women and HIV & AIDS. Local activism, media and advocacy, communication materials and training to reach a variety of people in a variety of ways are the four strategies that SASA! applies.

Currently, the SASA! Programme involves on going intensive project monitoring in Kampala and 13 sites around the region. In Kampala, the project includes undertaking randomized controlled trials as well as qualitative and costing studies. This is done in partnership with the London School of Hygiene and Tropical Medicine and Center for Domestic Violence Prevention of Makerere University. The programme approach has largely been implemented by moving beyond ABC, helping staff and communities analyze drivers of VAW/HIV, focusing on social rather than bio-medical aspects, building on community strengths not deficits, and incorporating VAW prevention and response into the health sector[34].

3.2.2 The case of SHARE

An evidence-based violence prevention community-level project was locally named the Safe Homes and Respect for Everyone (SHARE) project in Rakai, Uganda.

SHARE goals are to:

- Raise awareness about IPV in general and its link with HIV
- Change attitudes about acceptability of IPV
- Reduce levels of IPV

SHARE uses the following strategies:

- *Capacity building:* Strengthening skills of professionals to handle/prevent IPV
- *Community activism:* Convening village meetings, volunteer networks

- *Campaigns and events:* Using theatre performances, poster, fairs
- *Learning materials:* Using posters, booklets, story cards, stickers
- *Advocacy:* Collaborating with local organizations

Research conducted in Rakai in the early 2000s had established that IPV was relatively common (30% physical violence and 24% sexual violence) and normative and the population was characterized by a generalized HIV epidemic. Both outcomes disproportionately affected women and links were found between the two[36].

The project undertakes:

- Training ARV counsellors to screen for violence, handle cases disclosed by clients, and offer referral
- Establishing support groups for HIV-positive men, women and adolescents
- Supporting groups established for men's female partners in male circumcision for HIV prevention trials
- Establishing peer groups for male and female adolescents in and out of school, and establishing support groups and referrals for married males and females and pregnant teens and their partners

3.2.3 Challenges of implementing comprehensive responses are also located at the community

Communal acceptance and reluctance to challenge norms of masculinity and femininity promote unequal gender power relations which may be manifested as violence. For example, the South African HIV and sexual violence study observed that, among 15-to-19-year-olds, 28 per cent of males and 27 per cent of females believed that a girl did not have the right to refuse sex with her boyfriend. Half of the males and of females felt that sexual violence does not include forcing sex with someone you know. While the evidence base for both HIV structural prevention and GBV prevention are limited, strategies to empower women and girls, engaging men and boys, and challenge of harmful social norms show promise for addressing the underlying drivers of HIV and GBV, simultaneously reducing the risk of and vulnerabilities to both.

3.2.4 There are opportunities for GBV programming within emerging HIV priorities

The HIV response in many countries in sub-Saharan Africa aims to contribute to achievement of the millennium development goals and increasingly recognize the need to address GBV if they are to make significant progress. The UNAIDS has promoted 'know your epidemic' that provides a framework for understanding country epidemics, responding and monitoring the response. The commitment to zero new infections, zero HIV deaths and zero discrimination provides guidance on country prioritization for the HIV response. Zero discrimination goals prioritize zero tolerance to gender based violence, providing an opportunity to utilize HIV resources to respond to gender based violence.

The UNAIDS Investment Framework is expected to be utilized to make investment decisions given the limitation of resources.

The Investment Framework identifies basic programme activities to include:

- Addressing populations at higher risk of HIV
- Behaviour change and communication
- ART (treatment as prevention)
- Condoms and medical male circumcision

Critical social and programme enablers have been identified. Although sub-Saharan African has the highest HIV burden, young women contribute to majority of new infections and women account for nearly 60 per cent of those living with HIV, they are not identified as key populations within the investment framework. Women's and girl's vulnerability to HIV infection stems from a greater biological risk that is compounded by gender inequalities, gender based violence and gender inequalities are considered development synergies in this framework rather than critical enablers. It is essential that UNAIDS include in the investment gender inequality as part of the Investment Frameworks core programmes and young women as a priority population.

HIV prevention has embraced the notion of 'combination prevention' involving biomedical, behavioural and structural interventions recognizing that different approaches at different levels are essential for prevention. HIV programming also includes HIV care and anti-retroviral treatment, and changing social norms to reduce stigma and discrimination. The necessity for different sectors to address vulnerability to HIV has resulted in a multi-sectorial response often led through a national coordinating agency. GBV prevention interventions have demonstrated impact when they involve changing the context – social norms and social, economic and political vulnerability factors as demonstrated by projects such as Stepping Stones, IMAGE and SASA. The lessons from both GBV and HIV, including focusing on social context and a multi-sectorial approach can be useful when integrating GBV in HIV programmes.

HIV service programmes need to evaluate opportunities to address violence including couples VCT, care and ART, partner notification and disclosure services and prevention of vertical transmission programmes. GBV responses have not adopted a multi-sectorial approach, but this is necessary as it harmonizes efforts of different sectors including police, judicial, health and social services sectors. There was recognition from quite early in the AIDS epidemic that gender inequality and violence placed women at risk of HIV. However, high level policy endorsements and commitments at global level such as Ending VAW being a priority area in the UNAIDS Outcome Framework 2009-11, increased GBV funding by PEPFAR and inclusion of GBV into National AIDS Strategic Plans are only emerging. Thus, GBV programmes need to identify indicators that can be collected within HIV programmes, effective interventions at community and facility levels and across different sectors.

3.3 Interrogating key primary GBV/HIV programming areas and exploring solutions

Four priority areas including the need for an enabling environment to integrate GBV and HIV services, evidence development, service delivery, and addressing GBV and HIV among vulnerable groups and in conflict settings were identified as essential when focussing on GBV/HIV integration.

Dr. Catherine Maternowska *(UNICEF) – Opportunities and requirements for research and documentation for GBV responses in sub-Saharan Africa.*

Mr. Alan Maleche *(KELIN) - Issues for consideration in creating/ maintaining an enabling environment for GBV HIV integration*

Dr. Chi Chi Undie *(Population Council) – Scaling up GBV integration in HIV services: models and lessons*

Ms. Florence Gachanja *(UNFPA) – Vulnerable groups and conflict settings: rationale and evidence for GBV/HIV linkages*

The four areas for group discussion were:

1. *Enabling environment*: Considerations in creating/maintaining an enabling environment and the barriers and enablers for policy development, implementation and advocacy for GBV/HIV integration were discussed (moderated by Mr Buluma Bwire of GIZ).

2. *Evidence:* Opportunities and requirements for research and documentation for GBV responses were identified and the barriers and enablers to undertaking GBV HIV research being discussed (moderated by Ms Lizle Loots of SVRI).

3. *Service delivery*: Models and considerations for scaling up GBV and HIV integration and barriers and enablers to GBV services in HIV programmes and establishing the necessary linkages to other programmes were discussed (moderated by Mr Odongo Odiyo of ECSA).

4. *Addressing GBV and HIV&AIDS among vulnerable groups and conflict settings*: the rationale and evidence for GBV/HIV linkages and barriers and enablers to providing services to these populations and in challenging settings were discussed (moderated by Ms Gloria Gakii of ECSA).

Table 2: Summary of key action points from technical discussions

Enabling environment	Research	Scaling up integration of services	Addressing vulnerable group and conflict settings
• Strengthen linkages with traditional structures and practices since these are also the greatest enablers among local communities where interventions happen. • Understanding local communities and building on the positive aspects of their cultures and experiences while simultaneously building capacity in weak areas. • Working at all levels in ways that are self-reinforcing – evidence from the community level is important to shape policy at the national level. • Underfunding is chronic, but innovation lacks in resource mobilization – e.g. the advantage of opportunities presented by multiple funding pots available for financing GBV across justice, social, education, health and other sectors is under explored. • Mobilization of political leadership to make GBV gain the necessary political prominence is important for maximum impact.	• Research organizations and bodies need to tap into existing data that is continuously collected by CBOs and NGOs. • Collaboration among those involved in different forms of research to develop agreed upon methodologies/indicators for quality assurance and for comparisons. • Capacity building on research is needed for all who claim to be doing some kind of research. • Development and dissemination of shared definitions, research tools and methodologies and guidelines for doing research in this field • A need for multi-sectorial collaborations between and within sectors, in-country research institutions; south-south research institutions; north-south institutions, etc. • Translation of research to make it accessible to all stakeholders. • Need for research evidence to show that by reducing GBV we can reduce HIV infections.	• Building on existing structures and opportunities presented by HIV & AIDS programmes. • Optimizing existing human and financial resources, e.g. HIV&AIDS peer educators and counsellors could be used to promote GBV agenda; integrating GBV into HIV programmes using current financial resource envelopes. • Building on established relationships with local communities from HIV programmes can be used as a platform to launch GBV work. • Integrate GBV into HIV messaging. • Capacity building for frontline service providers, e.g. health service providers, teachers, justice and social systems. • Harmonizing HIV with GBV policies, guidelines and training curriculum.	• Consider children and adolescents as a key priority of GBV & HIV to address long term interventions. • Increase awareness on what constitutes abuse at all levels. • Sensitization of frontline public officers such as local leaders, administrators, religious leaders, and police should be undertaken • Capacity building for the legislative and judicial arms of government is key to ensuring access to services. • Addressing gender in school curricula to address concepts of masculinities and femininities. • Advocacy on holistic approaches to GBV.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4.0 Integration of GBV Prevention and Services

Dr. Nduku Kilonzo *(LVCT) – Barriers, entry points and opportunities to integrating GBV prevention and services in HIV services or programmes and services*

Ms. Emma Mwamburi *(USAID) – Existing PEPFAR Guidance on GBV/HIV integration: Entry points and opportunities*

Dr. Claudia Garcia-Moreno *(WHO) – Effective interventions for addressing GBV and HIV: Implications for programming*

Ms. Michelle Moloney-Kitts *(Together for Girls) – Opportunities for developing evidence for GBV programming in HIV service*

The policy framework that responds to GBV/HIV linkages should take cognizance of requirements for appropriate models, indicators and mechanisms for scale up. Discussions emphasized the need for the programmatic infrastructure for rolling out integrated GBV/HIV programmes. Monitoring and evaluation systems are required for reliable data for policy formulation and advocacy. HIV testing and counselling, treatment and prevention programmes focusing on vulnerable groups and women (PMTCT) provide opportunities for GBV/HIV integration that should be prioritized and harnessed. Structural interventions that address the GBV/HIV linkage for prevention should be informed by evidence. [29, 37-39]

4.1 There are policy gaps in GBV and HIV integration

Although the magnitude of the problem is increasingly well-understood, effective solutions are much less understood. Some of the policy gaps that need to be addressed include:

- What interventions would be most effective with which populations given the diversity of target groups for instance:
    - Which service models are most effective for the health, justice, law, order and social sectors in combination and as different sectors?
    - What target populations require what different services – children, sub-groups such as sex workers?
    - What prevention interventions will work in the local settings?
- Lack of commonly agreed on indicators for GBV programmes and within HIV services, lack of national GBV data systems that mean that routine data does not have a national collation and utilization point make data collection inconsistent and unavailable for decision making.
- Opportunities, and cost for scaling up effective responses
- How and what innovations including mobile technologies can be utilized for GBV prevention, GBV/HIV services uptake and effective linkages across different sectors

The HIV response framework is based on the '3 ones' principles with a multi-sectorial coordinating agency, national plan and monitoring and evaluation framework.

Common gaps across the region in the structure of this framework that could impact on successful GBV programming include:

- Weak links between the health sector and National AIDS Councils (NACs) and between NACs and health structures at sub-national levels
- Disconnect between M & E frameworks of the health sector and of HIV responses
- Limited coordination among civil society organizations (CSOs) which are very diverse, operating in parallel and rarely consulting each other

4.2 There are a range of considerations for GBV and HIV integration

At the program level, a number of gaps will still require to be addressed. Implementers may not know how effective their programs really are, including which particular elements may be truly effective and where improvements are needed. Although this can be identified in good M & E frameworks, there may still be questions on what particular aspects of the programme worked well and which ones did not. The draft anticipated WHO tool identifies programming strategies that are broadly categorized into those that address gender inequality as a driver of both VAW and HIV, and integrate VAW into HIV prevention (risk reduction), testing and counselling, treatment and care, including provision of services such as post-rape care. Within each category, there are specific strategies that are reviewed, and rationale for each programming strategy are provided.

With specific regard to the health sector, the lack of integration of services and organization of services as either vertical (single disease issues managed from centre and specific mechanisms but often face sustainability challenges) or horizontal (decentralized management, utilize health care system but suffer limited infrastructure) adds a layer of complexity to integrating GBV in HIV programmes. Considerations required are classified into three categories as shown in Table 3.

Table 3: Considerations for integrating programmes

Services	Personnel	Tools and approaches
• Adherence to common standards of service delivery including WHO and national standards • Service management at facility level • Referrals and effective linkages of survivors, evidence and lessons from testing to treatment • Availability of commodities at desired service points including costs of addition into supply management chain	Standards for building human resource capacities which include: • Targeted provider training based on type/complexity of technical skills e.g. trauma counsellors from HIV counsellors • Targeted police and prosecution officers training • On-the-job vs. classroom based training • Leverage on community providers (ART, HTC), use of systematic community engagement and follow up	M & E – indicators and data (for each sector) including: • Provider workloads in respect to additional data tools • Service level indicators vs. national planning indicators. • Data collection – responsibility, reporting mechanisms • Data collation to national level reporting • Data for medico- legal purposes

4.3 Monitoring and evaluation are essential and currently underdeveloped

The role of monitoring and evaluation in GBV responses is critical to building an effective response and drawing the necessary resources towards a comprehensive response across the different sectors. Lack of routine service data is a missed opportunity for programme strengthening and advocacy.

Programmes need to:

- Identify indicators and outcomes they will track and establish a system to collect them that outlines who will collect what data, where, when and with what tools
- Identify the review process and feedback to a national level
- Gather qualitative data to better understand the problem and to address stigma

Design of data tools, collection, reporting and feedback must go beyond the HIV programmes, health sector, and extend to the justice, law and order sectors, and social services. Data will inform programme interventions to develop efficient multi-sectorial responses and especially for cross referral of survivors. The limited capacity available to design monitoring and evaluation may mean the need for technical assistance for programmes especially for evaluation, which requires a rigorous methodology.

4.4 There are opportunities for integration of GBV programming into HIV responses

Participants deliberated at length on some of the opportunities and aspects of GBV programming that can be integrated into specific areas of HIV programming, priority action points as well as developing action agenda, and implementation plans. The opportunities for integration covered five key areas – HIV Testing and Counselling, Treatment, HIV Prevention (with a focus on vulnerable groups), PMTCT as well as HIV Prevention and structural Interventions and drivers from multi-sectoral view.

Table 4 and 5 contain a summary of the opportunities of GBV programming and how they can be integrated into the key areas of HIV programming, immidiate programming opportunities and required capacities for such work.

Immediate programming priorities that can facilitate harnessing of these opportunities across all programmes include:

- Integrate GBV messages in existing information, education and communication materials
- Develop awareness and sensitization packages for GBV and related information that can be made available to service delivery sites, these facilities can be utilized by counsellors and health care providers and need to be widely disseminated
- Develop formative research on possible criteria for identifying clients who may require screening for GBV
- Develop evidence-based, locally appropriate protocols for supporting disclosure, confidentiality, referral tracking and follow up that can be integrated into provider training and service delivery processes
- Audit current HTC, care and treatment, HIV prevention intervention tools to identify opportunities for including GBV related questions, information and data and update these
- Develop key indicators and integrate relevant data variables in existing programme and service delivery data collection tools
- Develop modules and update existing training curriculum for counsellors to cover GBV in HIV testing and counselling provider training and test the feasibility of these
- Introduce on-the-job training for counsellors to include trauma counselling to begin to develop a base of competent providers for a scaled up IPV response

Table 4: Opportunities for integration of GBV programming into HIV responses

HIV Testing and Counselling	Treatment	HIV Prevention (vulnerable groups)	PMTCT
• HIV testing and counselling providers should be trained in GBV and counselling skills • HIV Testing and Counselling offers an entry point for GBV screening only if there is a clear mechanism for identifying who is most at risk of IPV, a criteria is available and there are linkages to further support • Referral mechanisms similar to those available in between testing and treatment services are necessary to ensure that GBV survivors are linked to post-test counselling support services .	• HIV treatment services provide longitudinal care for clients and should devise criteria to identify who should be screened, screening tools and approaches and options for on-going support • Community health workers can be utilized to identify partner violence in the homes they visit and be trained to provide confidential linkage to those who need it • Community health workers can be equipped to become champions of change • GBV should be integrated in all HIV training materials • Develop supportive disclosure protocols for use in treatment sites that allow survivors of violence to disclose and get help	• Identify specific GBV issues relevant to vulnerable populations and design appropriate messaging, provide information and training required • Integration of GBV messages in existing HIV information, education and communication materials targeting vulnerable populations • Training of sex workers and other key risk groups on where to get services and advocacy on GBV • Modify and test GBV information, training modules and activities within existing evidence based HIV prevention interventions that are targeted to specific populations	• Identify primary GBV indicators and incorporate in eMTCT data collection to build evidence for integration and for appropriate response strategies • Involve men in PMTCT programmes provide opportunities to discuss GBV and its impact on health and the family and should be explored in a structured manner. • Integrating GBV messages within HIV prevention in PMTCT services • PMTCT offers an entry point for GBV screening only if there is an identification mechanism for who is most at risk of IPV, a criteria is available and there are linkages to further support • Build capacity of PMTCT providers with information to appropriately refer and track clients (during follow up visits) who are at risk or experiencing GBV through training.

4.5 GBV and HIV integration needs to include evidence based prevention programming at a structural level

Effective programming requires interventions that target structural drivers of GBV. The key structural issues identified included:

- Gender inequalities based on patriarchal systems understanding of cultural and social norms/ religious norms and accepted masculinities and femininities
- Political will, a legal and policy environment in which laws and policies are implemented and systems address GBV at community level. The lessons of the HIV response in lobby, awareness creation, stigma reduction and advocacy can be used for learning purposes
- Poverty and socio-economic structures and systems impact on GBV and HIV and need to be considerations for any programming
- Education systems, curriculum and the school setting itself are all potential avenues for norms creation and change, and require advocacy and engagement with the Ministries of Education and teacher associations

In recognition of the ecological model of GBV that frames these structural issues as key to programming, the WHO systematic review on GBV and HIV has developed a draft tool that will help HIV programme managers identify and develop evidence-based interventions to jointly address GBV and HIV.

Emerging guidance includes:

- Integrated interventions that promote gender equality and HIV training with women (combined with economic empowerment) and with men show strong promise
- Interventions that include GBV and HIV as joint outcomes, for example, mass media, working with men, inter-personal and group counselling, are promising
- Interventions – such as group therapy and counselling – targeting survivors of GBV with or at risk of HIV may be promising, but feasibility and adaptability are still an area for more reflection
- The likelihood of increased occurrence of GBV as an outcome of HIV testing and counselling, and disclosure is small, but real, and need to be monitored

Structural programming strategies for addressing gender equality have been included:

- Sub-category that focuses on empowerment of women, which includes integrated gender equality, microfinance or livelihood and HIV training, securing property and inheritance rights, conditional cash transfers, and community empowerment of sex workers
- Sub-category that focuses on transforming harmful gender norms and male behaviour
- Sub-category that focuses on promoting gender equality laws and other laws


You hurt a
WOMAN
You hurt a
NATION

5.0 Way Forward

This section of the report highlights the key issues from the discussions and action steps as identified by the participants. It outlines the existing knowledge, what needs to be done, and provides suggestions about how it can be done.

5.1 Existing knowledge – What we know

1. Data reveals a high prevalence of GBV in different regions with documented impact on health, productivity and a country's economy

2. The GBV/HIV response has tended to focus on sexual violence. However, different forms of gender-based violence are interconnected and evidence suggests that survivors of sexual violence are likely to experience other forms of violence, and intimate partner sexual and physical violence is associated with HIV outcomes

3. The impact of childhood sexual violence on HIV, sexual risk behaviour in addition to other health consequences is increasingly documented

4. GBV prevention programmes and services are few and of limited scope, coverage and quality in many countries in sub-Saharan Africa

5. The much more developed HIV response in scientific evidence, programming, service delivery infrastructure and data availability provides opportunities for GBV integration at policy, for prevention and service delivery

6. Although the magnitude of GBV and its intersections with HIV is increasingly understood there are gaps in research for effective local solutions for different populations and in different settings are much less understood

7. Funding for GBV within the HIV response is increasing, but there are resource constraints for GBV responses in general across the justice, law, order, health and social sectors

8. Consistent, sustained advocacy by communities and vulnerable populations has worked for HIV policy actions and reforms and funding for service delivery. The lessons herein can be borrowed to support the development of GBV responses and financing

9. Opportunities and costs for scaling up effective GBV and HIV responses are now well understood or harnessed

10. Monitoring and evaluation systems, indicators, data collection and collation at national levels for GBV as a stand alone issue and within HIV programmes are currently weak and impact negatively on funding advocacy and programme decision

11. There is no single model that works in all settings. Effective local models for GBV and HIV prevention, especially those that address community and structural factors are limited

12. A cross-sectoral response that includes effective linkages for survivors and for evidence, data availability are required to deliver protection, support and rehabilitation services to survivors of gender-based violence including health, law/order/justice and social services[9, 10]. These are currently weak, under-developed with few effective models to learn from and scale up

5.2 New direction – What we need to do

1. Translate the evidence into practice and develop new models:

    a. Programmes should identify opportunities within HIV services, target audiences and services or products that can respond to GBV

    b. Test different approaches, strategies and models for different settings for GBV and HIV and for a cross-sectoral response

    c. Identify evidence based interventions and adapt them to local settings and document

    d. Test innovative approaches and utilize existing technologies

2. Invest in further research, monitoring of existing programmes and evaluation of models:

    a. Develop key indicators for GBV that can be collected through HIV programmes, data collections tools for the health and other sectors, reporting and feedback mechanisms

    b. Review already established mechanisms and tools for health management information systems and optimize opportunities for data collection

    c. Identify opportunities for integrating GBV questions in on-going HIV longitudinal studies, population based surveys and cross-sectional data collection

    d. Countries should identify primary agencies responsible for GBV that can coordinate a multi-sectoral response including data collation for financing, policy reforms and programming

3. Identify and act on policy opportunities:

    a. Review national policy, such as AIDS and Health, strategic plans and ensure GBV integration in policy committments, normative guidance, service and operational procedures and reporting frameworks

    b. Engage with national planning and prioritization processes that determine funding and programme priorities

4. Share information and invest in consistent, sustained advocacy:

    a. Develop information sharing platforms and mechanisms to build synergies in-country and across the region

    b. Mobilize resources to undertake consistent, sustained, synergized advocacy based on common goals and a shared agenda through networks and shared platforms

    c. Identify opportunities within research, M & E data that make the case for why the HIV and other health priorities must address GBV to achieve their stated goals

5. Invest in capacity building:

    a. Collect and utilize routine data from GBV and HIV programmes, especially for civil society organizations

    b. Interpret the existing evidence, develop, test and evaluate models for prevention and service delivery

    c. Prioritize what should be evaluated within existing programmes, how to undertake evaluations or where to source for technical assistance

6. Build Partnerships:

    a. Develop collaborative partnerships to harness diverse capacities and transfer information, undertake research and evaluate new approaches

    b. Develop working arrangements that promote access to regional funding opportunities, aiming to promote use of common tools to promote the evidence base and advocacy products

5.3 Priorities and Action Plans

Country based group discussions to identify no more than 3 actionable priorities for integrating GBV in any of the HIV programmes were undertaken and action plans developed. These plans as presented by the groups are presented in Table 5 below.

Table 5: Consolidated Action Plans (by country groups)

GBV & HIV integration	Next steps for action	Timeline/ By when	Key partners and their role	What support will be needed (technical, political/ advocacy, financial
South Africa and Swaziland				
Priority 1: School-based health interventions	• Training and bringing in PHC School Health Nurses • Target schools for children with special needs • Research to develop a model to do interventions	• TBD	• Department of Education – curriculum development and implementation • Department of Health – training of nurses • Social Development -- women, children and people with disabilities	• Technical assistance to develop curriculum for school health nurses • Funds to train health nurses
Priority 2: PMTCT and antenatal	• Capacity building within PMTCT to assist in management of disclosure • Sensitivity training of health providers to support special populations (e.g. drug users)	• TBD	• Department of Health – training • Community counsellors	• Funds for training health management staff and health providers
Priority 3: Social mobilization	• Sensitivity and awareness for the media and traditional leaders • Advocacy training for CBOs, NGOs • Create a network of stakeholders	• TBD	• Media • Communities • Traditional leaders	• Link to existing programmes
Priority 4: Mental health	• Developing trauma counselling skills of health providers • Provide psycho-social support to address vicarious trauma and burn-out among health providers	• TBD	• Department of health • Social Development -capacity	• Technical assistance from development partners
Priority 5: Engaging men in prevention	• Use male-circumcision sites (evidence based interventions) to integrate gender and GBV awareness, sensitivity and training	• TBD	• Department of Health • Other implementing agencies	• Link to existing programmes (funding)

GBV & HIV integration	Next steps for action	Timeline/ By when	Key partners and their role	What support will be needed (technical, political/ advocacy, financial
Uganda				
Priority 1: Capacity building in GBV/HIV programming	• Develop training manuals and train health workers in GBV/HIV integration • Deliver 'how-to' guidance for health providers in GBV/HIV integration at service delivery points • Establish a monitoring framework for GBV that is integrated in the National Health Management Information System	• 2013 • 2015 • 2013	• Ministry of Health, Ministry of Gender and Local Development, NGOs, development partners and academic institutions	• Financial, technical, political
Priority 2: Advocacy for GBV/HIV programming	• Establish a forum for key stakeholders for the GBV/ HIV advocacy agenda • Identify existing research to inform advocacy	• 2013 • 2013	• NGOs, CBOs focusing on health and human rights agenda, local leaders, national political leaders	• Financial, technical, political
Priority 3: Research in GBV/HIV	• Review existing research on GBV/HIV in Uganda • Identify gaps in GBV/HIV research • Develop a research strategy on GBV/HIV • Invest in and undertake GBV/HIV research	• 2013 • 2013 • 2014 • 2014 ongoing	• Research bodies and academic institutions	• Financial, technical assistance, political will
Sudan				
Priority 1: Awareness raising on GBV and HIV	• Conduct engagement meeting with community elders and stakeholders • Strengthen CSO advocacy and awareness through training • Disseminate information to Government agencies such as law enforcement, social services	• 2013	• Ministry of the health, Ministry of Gender, Child and Social Welfare, Ministry of Interior , SSAC	• Advocacy and political will
Priority 2: Strength the referral system	• Training of the health service providers • Training of other providers	• 2013	• NGOs, CBOs, MOH, UNFPA, UNWOMEN, UNAIDS, UNICEF	• Technical • Funding • Supply of equipment

GBV & HIV integration	Next steps for action	Timeline/ By when	Key partners and their role	What support will be needed (technical, political/ advocacy, financial
Zambia and Malawi				
Priority 1: Awareness creation	• Community sensitization • Strengthening male involvement	• Immediate and on going	• CHAZ, CHWS, CHAM, PLHIV, traditional/religious leaders, FBOS, CHEP, NAC, MOHA, MOCDMCH	• Financial, political, advocacy
Priority 2: Capacity building	• Training health providers in GBV/HIV integration	• 2013	• NAC, UNAIDS, UNFPA, MOH, MOJ	• Financial, technical, human resource
Priority 3: Systems strengthening	• Infrastructure for improved service delivery and reporting of GBV in health and within HIV programmes	• 2015	• Government/partners and local leaders	• Financial, technical and political
Ethiopia and Somalia				
Priority 1: Integrating GBV in HIV care and treatment programmes	• Training of HIV care and treatment providers in GBV • Integrating GBV in pre-service training of health professionals	• 2015 - to find funding and change the pre- service curriculum	• Ministry of Health • Ministry of Education • HIV Prevention and Control Office • NGOs, CBOs • Professional associations • Ministry of Women, Children and Youth Affairs • Ministry of Justice	• Financial support • Technical support to develop training manuals • Positive implementation policy
Priority 2: Integration of HIV into already existing community based GBV response committee	• Train the community based GBV response committee to become HIV peer educators	• 2015 – to provide the training and to pilot working approach.	• Ministry of Health • Ministry of Education • HIV Prevention and Control Office • NGOs, CBOs • Professional associations • Ministry of Women, Children and Youth Affairs • Ministry of Justice • Local Administrator	• Financial support • Technical support • Access to the local community by the local leaders

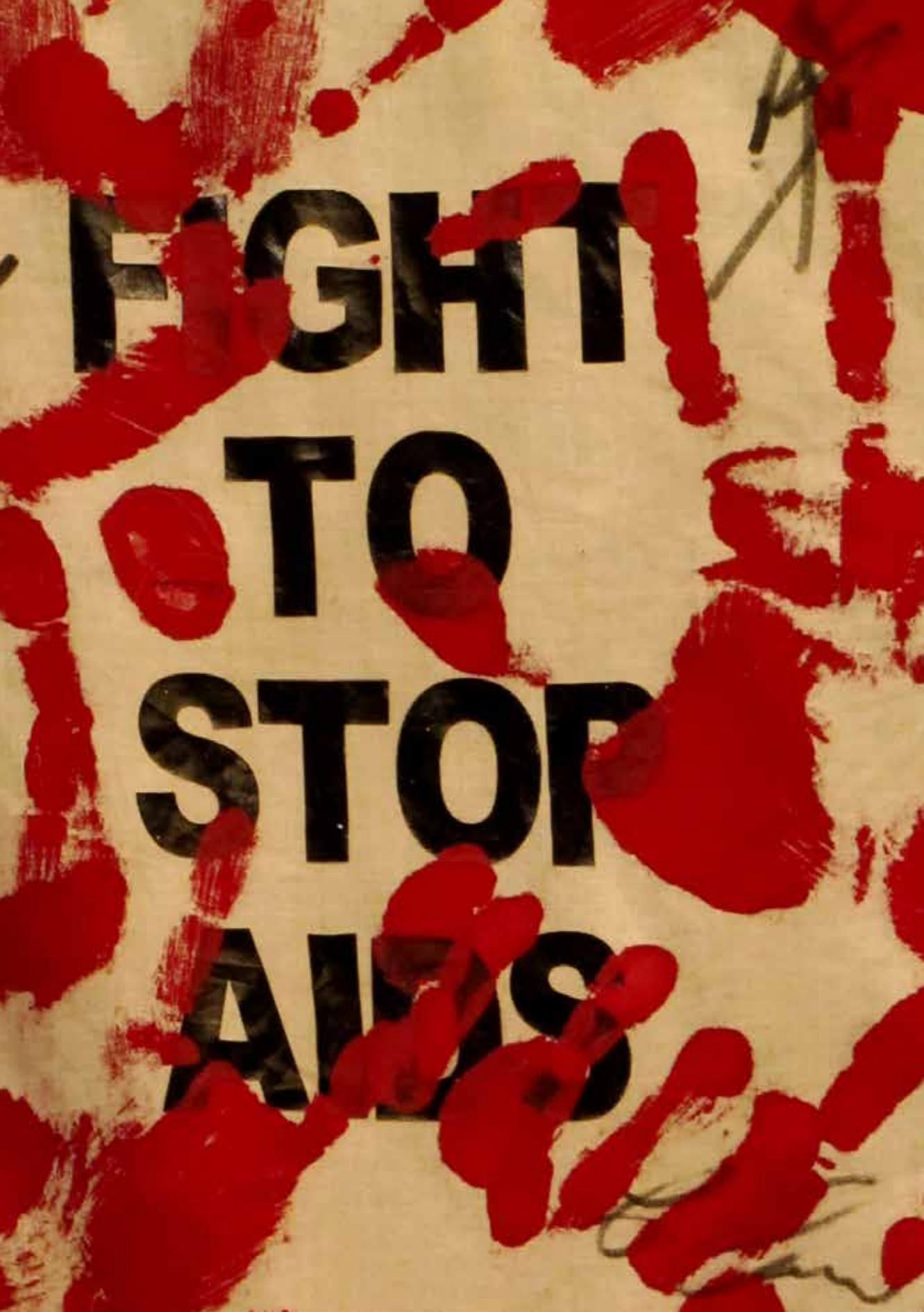
GBV & HIV integration	Next steps for action	Timeline/ By when	Key partners and their role	What support will be needed (technical, political/ advocacy, financial
Priority 3: Integration of GBV in secondary school life skills education	• Integration of GBV in the secondary school curriculum, • Implementation of GBV prevention in schools	• 2016 - to change the curriculum and teach secondary school teachers on the new curriculum	• Ministry of Education. • MOH and professional associations	• Technical and financial support
Botswana				
Priority 1: Train TVCT and CBO partner providers in HIV and GBV programming	• Identify staff to train within the organization • Offer GBV services within HTC settings in TVCT and among CBO partners • Develop a CSO GBV Forum	• 2013	• Ministry of Health • NACA • PEPFAR	• Financial and technical support
Priority 2: Formulate advocacy strategy for GBV /HIV in Botswana	• Identify partners with whom to develop a common agenda and synergized advocacy plan • Develop a strategy and advocate with Ministry of Health, Department of Administration of Justice (Police, Magistrate, Prisons), Department of Social Services, House of Chiefs, Parliamentary Committee on HIV & AIDS	• 2013	• Women's Affairs Department • NAC –Women, Men, and Ethics, Law and Human Sector • Botswana Network of AIDS Service Organizations (BONASO) • NACA	• Technical support • Political support • Financial support
Kenya				
Priority 1: Capacity building for health providers	• Form a Technical Working Group on GBV/HIV to provide guidance on integration • Develop simple 'how-to' integrate GBV and HIV guidance in service delivery for health providers • Integrate GBV into HIV trainings, continuing medical education • Develop additional GBV material required for HIV programmes and ensure provider sensitization	• 2014	• LVCT • Division of Reproductive Health • National AIDS Control Council • National AIDS and STI Control Programme • National Gender and Equality Commission • Ministry of Gender • Ministry of Education	• Financial • Human

GBV & HIV integration	Next steps for action	Timeline/ By when	Key partners and their role	What support will be needed (technical, political/ advocacy, financial
Priority 2: GBV Prevention	• Test GBV screening and service delivery models in HIV programming • Integrate the GBV messaging in evidence based behavioural HIV prevention interventions which are being implemented • Develop materials and sensitize other providers and stakeholder (law, judiciary, teachers, administration) on GBV/HIV linkages and opportunities for GBV prevention through their HIV programmes	• 2016	• Vulnerable groups • Ministry of Gender • Criminal justice – DPP • Education • State Law Office • Media • Religious organizations • Local administrators. • Paralegals • Programme implementers • Court users committees • General population	• Funding • Political good will by government • Identify champions for GBV prevention • COTU General Secretary • Opinion leaders
Priority 3: Treatment	• Incorporate gender issues in the card that is used for screening clients in health facilities (MOH 257) • Train Comprehensive Care Clinic to screen and address GBV among HIV positive clients		• LVCT • DRH • HIV TWG-NACC, NASCOP • NGEC • Ministry of Gender • Ministry of Education • Police service	• Financial • Human
Priority 4: Advocacy	• Create awareness to all stakeholders in GBV on integration with HIV e.g. civil society organizations, law enforcers. • Media • Change seriousness of viewing GBV and HIV issues • Targets set to ensure sustainability and consistency of issues in interviews • Strategically use media journalists who are trained and sensitive in gender and health issues • Work with civil societies that advance gender and health issues		• LVCT • DRH • HIV TWG-NACC, NASCOP • NGEC • Ministry of Gender • Police service	• Financial • Human

GBV & HIV integration	Next steps for action	Timeline/ By when	Key partners and their role	What support will be needed (technical, political/ advocacy, financial
Tanzania				
Priority 1: Capacity building	• Capacity building among implementers of either HIV or GBV or both	• 2013	• Youth2Youth movement (in/out of school youth) • Chem Chemi (PMTCT) • PEPFAR partners	• Technical support would be provided on how to integrate GBV and HIV

Priority 2: Awareness creation	• Scaling up of community sensitization for GBV and HIV integration	• 2013 onwards
		  • Kivulini
		  • Youth 2Youth Movement
		  • Chemi Chemi
		  • PEPFAR
			• Local government leaders
			• Community immobilizers
			• Community health care providers
			• Facility health care providers
			• Women support groups
				• Financial support (for implementers) to reach and deepen understanding of GBV, HIV and health services uptakes by many/ more communities

Priority 3: Monitoring and evaluation	• Sharing/adopting community monitoring and evaluation tools	• 2013 • Kivulini • PEPFAR	• Local government leaders • Community immobilizers • Community health care providers • Facility health care providers • Women support groups	• Technical support/ orientation of the tools to adopt or adjust according to our context


FIGHT
TO
STOP
AIDS

6.0 Conclusion

From this workshop, participants left convinced that:

- Integrating GBV and HIV was an area that required urgent action from all players – researchers, donors and programme implementers

- Engaging governments and highlighting to them the economic sense of GBV and HIV work was identified as a key area of advocacy

- Evidence that links the reduction of both GBV and HIV with economic development is an important area of advocay that needs to be given priority

- Collaborative research between research institutions and implementing agencies at local and national level is an important area to make sure that evidence which comes out is reliable and can be used to convince all into action


THANK YOU FOR MAKING
ENDING GENDER-BASED
VIOLENCE A TOP PRIORITY.
KEEP UP THE GOOD WORK!

7.0 Appendices

Appendix 1: Workshop programme

STRENGTHENING GBV AND HIV INTEGRATION AND RESPONSES IN SUB-SAHARAN AFRICA Organized by: Liverpool VCT, Care and Treatment (LVCT); World Health Organization (WHO); The Sexual Violence Research Initiative (SVRI) With the support of Comic Relief through Trocaire; United Nations Trust Fund to End Violence Against Women; Elton John AIDS Foundation; Population Council Date: 30th – 31st July, 2012 Venue: Kenya School of Monetary Studies	
	Day Chairs: Ms Millie Odongo --Commissioner – Task Force on Implementation of the Sexual Offences Act, Kenya **Dr Wanjiru Mukoma – Liverpool VCT, Care and Treatment**
0830-0930	**Introductions to the workshop - LVCT (20 minutes) and opening remarks** • Ms Lizle Loots – Sexual Violence Research Initiative • Ms Clare Gardner – Kenya Country Manager, Trocaire • Dr. Claudia Garcia Moreno – World Health Organization • Dr. Willis Akhwale – Ministry of Public Health and Sanitation
0930-1030	**Presentation 1:** Review of evidence on the linkages between GBV and HIV (15 minutes) – **Dr Naeemah Abrahams (Medical Research Council)** **Presentation 2:** Emerging evidence on linkages between VAC and HIV(15 minutes)- **Dr Catherine Maternowska (UNICEF)** **Presentation 3:** State of the evidence: what are the research gaps and priorities for driving forward the GBV/HIV in sub-Saharan Africa (15 mins)- **Dr. Ian Askew (Population Council)** **Question/Answer Session (15 minutes)**
1030-1100	**TEABREAK**

11.00 – 1.00	**Session Moderator: Dr Nduku Kilonzo** **Presentation:** Status of the HIV response: Programming and new directions (Services, structures, systems, data, financing) - (15 minutes)-**Ms Ruth Masha (UNAIDS)** **Question/Answer Session (30 minutes)** **CASE STUDIES** 1. Evidence on effectiveness of GBV screening based on systematic reviews undertaken (15 minutes) – **Dr. Claudia Garcia-Moreno(WHO)** 2. Acceptability and Feasibility of GBV screening and responses in health care settings (15 minutes) – **Dr Chi Chi Undie (Population Council, Kenya)** 3. The SASA model: Integrating primary GBV prevention in community HIV programming (15 minutes) – **Ms Lori Michau (Raising Voices, Uganda)** 4. Integrating GBV in HIV testing and counselling (15 minutes) – **Ms Jennifer Wagman, (John Hopkins)** **Question/Answer Session (20 minutes**)
1300-1400	**LUNCH BREAK**
1400-1500	**Breakout sessions (1 hour)**
	Presentation: Opportunities and requirements for research and documentation for GBV responses in sub-Saharan Africa Discussant: Dr Catherine Maternowska (UNICEF) Group work: Research Barriers/ Enablers to undertaking GBV and HIV related research Moderator: Ms Lizle Loots (SVRI) Presentation: Issues for consideration in creating/ maintaining an enabling environment for GBV HIV integration (15 mins) Discussant: Mr Allan Maleche Group work: Advocacy Barriers/ Enablers to policy development and implementation advocacy for GBV/HIV integration Moderator: Mr. Buluma Bwire (GIZ) Rapporteur: Mr Jason Oyugi Presentation: Scaling up GBV integration in HIV services: models and lessons Discussant: Dr Chi Chi Undie (Population Council Kenya) Group work: Service delivery Implementation Barriers/Enablers to integrating GBV prevention & services in HIV programmes Moderator: Mr. Odongo Odiyo (ECSA) Presentation: vulnerable groups and conflict settings : Rationale and evidence for GBV/HIV linkages (15 mins) Discussant: Ms Florence Gachanja (UNFPA) Group work: Vulnerable Groups and conflict settings: Barriers/ Enablers to integrating GBV prevention & services in HIV ProgrammesModerator: Ms Gloria Gakii (SWOP)
1500-1600	Group presentation (Questions and Answers)
1600	**TEA BREAK AND SHARING OF RESOURCES**
	DAY 2: 31ST JULY 2012

	DAY CHAIRS: Dr. Saiqa Mullick – Country Director, Population Council, South Africa **Mr Paul Gichuki –Gender Programme Officer, Trocaire, Kenya**
0830-0900	**RECAP OF DAY 1**
0900 -1030	**Presentation 1:** Barriers, entry points and opportunities to integrating GBV prevention and services in HIV services or programmes (HIV prevention, care and treatment, testing and counselling, PMTCT) - (15 minutes) – **Dr Nduku Kilonzo, LVCT** **Presentation 2:** Effective interventions for addressing GBV and HIV: Implications for programming (15 minutes) - **Dr. Claudia Garcia-Moreno (WHO)** **Presentation 3:** Existing PEPFAR Guidance on GBV/HIV integration: Entry points and opportunities (15 minutes) – **Ms Emmah Mwamburi (USAID)** **Presentation 4:** Opportunities for developing evidence for GBV programming in HIV services (15 minutes) – **Ms. Michelle Moloney Kitts (Together For Girls)** **Question/Answer Session – 30 minutes**
1030-1100	**TEA BREAK**
1030-1200	**Group Sessions (1 ½ hours)** **Identify Opportunities and which aspects of GBV programming can be integrated into these areas of the HIV response and how in order of priority (immediacy, resources, capacity); and the documentation/research opportunities available**
	HIV Testing and Counselling **Discussant: Dr. Alfred Kangolle** **Moderator: Dr. Ann Gatuguta (LVCT)** Treatment **Discussant: Dr. Lilian Otiso** **Moderator: Mary Zama (Population Council)** HIV prevention – focus on vulnerable groups interventions **Discussant: Gail Andrews-CDC** **Moderator: Ms Jeniffer Wagman – John Hopkins** PMTCT **Discussant: Prof. Ruth Nduati** **Moderator: Dr. Catherine Odenyo Ndekera**
1200-1230	Feedback session
1230-1300	Brief overview of emerging issues – **Dr. Wanjiru Mukoma, LVCT**
1300 – 1400	**LUNCH BREAK**
1400-1600	Development of action agendas and implementation plan (2 hours) – **LVCT, WHO, SVRI**
1600-1630	Consolidation/Way forward **– Dr. Nduku Kilonzo, Executive Director, LVCT**
	Cocktail

Appendix 2: Workshop participants

Strengthening The GBV/HIV Response and Services in Sub-Saharan Africa
Date: 30th – 31st July 2012; Venue: Kenya School of Monetary Studies

Dr. Abdihakin Farah Ali, World Vision, Ethiopia
Dr. Alfred Kangolle, CDC, Tanzania
Mr. Allan Maleche, KELIN, Kenya
Ms. Alice Onsarigo, FHI360, Kenya
Dr. Anne Gatuguta, LVCT, Kenya
Ms. Annie Banda, COWHLA, Malawi
Mr. Brian Oling'a, LVCT, Kenya
Ms. Betty Mugo, USAID, Kenya
Mr. Buluma Bwire, GIZ, Kenya
Ms. Carol Ajema, LVCT, Kenya
Dr. Catherine Maternowska, UNICEF, Kenya
Dr. Catherine Ndekera, PREFA, Uganda
Ms. Cebile Manzini, SWAGAA, Swaziland
Ms. Charity Muturi-Njeru, FHI 360, Kenya
Mr. Charles Wani Elikana, Street Children Aid Sudan
Dr. Chi Chi Undie, Population Council, Kenya
Ms. Christine Butegwa, IPPF, Kenya
Dr. Claudia Garcia-Moreno, WHO, Switzerland
Ms. Catherine Githae, MENKEN, Kenya
Mr. John Chege, GVRC, Kenya
Mr. Douglas Were, LVCT, Kenya
Dr. Judith Kose, EGPAF, Kenya
Dr. Maricianah Onono, KEMRI, Kenya
Dr. Meshack Ndirangu, AMREF, Kenya
Dr. Willis Akhwale, MOPHS, Kenya
Ms. Elizabeth Aroka, ICRH, Kenya
Ms. Emma Mwamburi, USAID, Kenya
Ms. Emmah Nungari, NGEC, Kenya
Mr. Ewenat G, ACIPH, Ethiopia
Ms. Fiona Nicholson, TVEP, South Africa
Ms. Florence Fanny Awuor, IRDO, Kenya
Ms. Florence Gachanja, UNFPA, Kenya
Dr. Gail Andrews, CDC, South Africa
Mr. George Ogutu Nyawalo, Ministry of Health, Kenya
Ms. Gloria Gakii, SWOP, Kenya
Ms. Hellen A. Otieno, WOFAK, Kenya
Mr. Hesborn Mburu, Film Aid, Kenya
Ms. Hilda Maringa, CDC, South Africa
Dr. Ian Askew, PopulationCouncil, Kenya
Ms. Jane Otai, JHPIEGO, Kenya
Ms. Jane Nafula, Straight Talk, Uganda
Dr. Jemma Bisimba, USAID, Tanzania
Ms. Jennifer Wagman, Johns Hopkins Bloomberg, United States of America
Mr. John Wafula, LVCT, Kenya
Dr Kawimbe Alexander Bambala, Ministry of Health, Zambia
Dr. Lilian Otiso, LVCT, Kenya
Ms. Lizle Loots, SVRI, South Africa
Ms. Lori Michau, Raising Voices, Uganda
Ms. Magdalene Mwele, TSC, Kenya
Ms. Maimuna Kanyamala, KWRO, Tanzania
Ms. Margaret Macharia, KANCO, Kenya
Dr. Margaret Mak'anyengo, KNH, Kenya
Ms. Mary Valai, LVCT, Kenya
Dr. Mary Mwangi, CDC, Kenya
Ms. Mary Zama, Population Council, Zambia
Ms. Maureen Obbayi, LVCT, LVCT
Mr. Michael Owigar, PSI, Kenya
Ms. Michelle Moloney, TFPG, USA
Ms. Milly Odongo, SOATF, Kenya
Ms. Miriam Bomet, FIDA, Kenya
Mr. Paul Gichuki, Trocaire, Kenya
Dr. Naeemah Abrahams, MRC, South Africa
Ms. Ndindi Mutisya, LVCT, Kenya
Dr. Nduku Kilonzo, LVCT, Kenya
Ms. Ntlogeleng Modise, TVCT, Botswana
Mr. Odongo Odiyo, ECSA, Tanzania
Mr. Osborne Mawanza, Department of Police, Kenya
Ms. Patricia Oluoch, CDC, Kenya
Mr. Peter Ngura, AMREF, Kenya
Mr. Perez Akello, Ministry of Health, Kenya
Ms. Phylis Awimbo, LVCT, Kenya
Prof. Cate Ndungo, Kenyatta University, Kenya
Ms. Peninah Mwangi, Bar Hostess, Kenya
Ms. Redemptor Atieno, LVCT, Kenya
Ms. Ruth Masha, UNAIDS, Kenya
Ms. Ruth Nekura, COVAW, Kenya
Dr. Saiqa Mullick, Population Council, SA
Mr. Sam Kanga, I-TECH, Kenya
Mr. Samson Mainye, SOATF, Kenya
Ms. Spana Rose Motsisi, TVCT, Botswana
Ms. Suhayla Aboud, MSF- France, Kenya
Ms. Susan Oduor, LVCT, Kenya
Ms. Sylviah Kavengi, GALCK, Kenya
Ms. Theresia Mutuku, JHPIEGO, Kenya
Mr. Tony Mwiti, GCN, Kenya
Ms. Victoria Natoni Zindo, International HIV/AIDS Alliance, Sudan
Ms. Winnie Osulah, Population Council, Kenya
Dr. Wanjiru Mukoma, LVCT, Kenya

Appendix 3: Reference list

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