USAID FROM THE AMERICAN PEOPLE | HEALTH POLICY INITIATIVE

MOBILIZING RELIGIOUS COMMUNITIES TO RESPOND TO GENDER-BASED VIOLENCE AND HIV:

A TRAINING MANUAL

OCTOBER 2009
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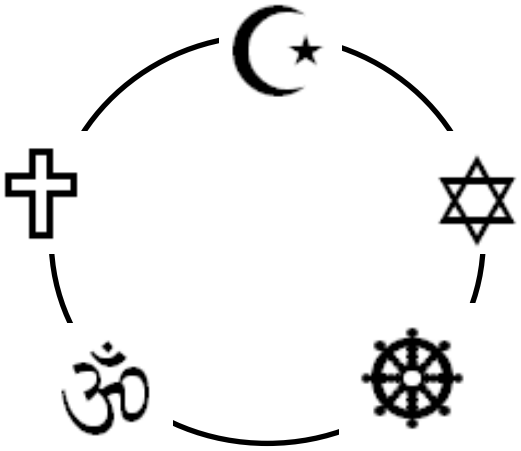

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
FBO	faith-based organization
FGC	female genital cutting
GBV	gender-based violence
GIPA	greater involvement of people living with or affected by HIV or AIDS
HIV	human immunodeficiency virus
IGWG	Interagency Gender Working Group
IRC	Inter-religious Council
PLHIV	people living with HIV
PPT	PowerPoint
RFP	Religions for Peace
STI	sexually transmitted infection
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGMENTS

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In addition, thanks are due to facilitators and organizers involved in the training. They include the following: Dr. Elishiba Kimani, Kenyatta University; Futures Group staff Britt Herstad, Mary Kincaid, Myra Betron, and Ken Morrison; consultants Frances Houck and Anne Eckman; Religions for Peace staff Jacqueline Ogega, Emma Kang'ethe, and Jim Cairns; and the Religions for Peace regional office in Africa.

IMPLEMENTING ORGANIZATIONS

Under the USAID | Health Policy Initiative, Task Order 1, two organizations implemented this activity—Religions for Peace and Futures Group.

Religions for Peace

Religions for Peace (RFP) is an international coalition of representatives from religions around the world dedicated to promoting peace. Religions for Peace creates multi-religious partnerships to confront the issues of stopping war, ending poverty, and protecting the earth. Religions for Peace builds and equips Inter-Religious Councils (IRCs) at the local, national, regional, and international levels to achieve consensus on common problems and engage the power of religious communities at the grassroots level.

Religions for Peace has an established Global Network of Women of Faith as part of its Women's Mobilization Program to build, equip, and network women of faith all over the world to work together on common concerns. The Women's Mobilization Program has convened and launched regional women of faith networks in Africa, Latin America and the Caribbean, South and Southeast Asia, and Southeast Europe. Through their national women's networks or women's committees, IRCs are linked to these regional and global bodies to share experiences, exchange best practices, and participate in their efforts to address issues that cross borders. In Africa, Religions for Peace's African Women of Faith Network works with more than 500 organizations of women of faith, representing all of the diverse religions and nations of Africa.

Futures Group

Specializing in providing assistance in the design and implementation of public health and social programs for developing countries, Futures Group has implemented projects in more than 100 countries. Futures Group works collaboratively with in-country counterparts to improve policies and programs that address population issues, reproductive health, HIV, infectious diseases, and maternal and child health. Futures Group provides services to support policy development, advocacy, monitoring and evaluation, computer modeling, strategic planning, and social marketing.

Futures Group is the Task Order 1 holder of the USAID | Health Policy Initiative. With a focus on policy dialogue, the Health Policy Initiative empowers new partners to participate in the policymaking process. With an additional focus on policy implementation, the project helps countries and organizations translate policies, strategic plans, and operational guidelines into effective programs and services, especially for the poor and other under-served groups.

The project is committed to working to eliminate gender-based violence (GBV) and its root cause of gender inequity. The project carries out GBV-focused interventions related to HIV and reproductive health that range from the formulation and implementation of global, regional, and national policies and strategies, to advocacy and community mobilization to combat GBV, to coordination of activities among stakeholders at multiple levels.

BACKGROUND

Gender-based Violence

> *Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm...It includes that violence which is perpetuated or condoned by the state.*[1]

Research has shown that globally, at least one out of every three women has been beaten, coerced into sex, or otherwise abused in her lifetime—usually the abuser is someone known to her.[2] According to the World Report on Violence and Health, 40–70 percent of all women who are murdered are killed by a (male) intimate partner.[3]

While men, boys, and other vulnerable groups also experience gender-based violence (GBV), women are disproportionately affected. This is the result of social and cultural norms that often subordinate women. For example, many laws and customary practices create and perpetuate women's unequal status. This can be seen when examining women's legal, social, and economic status, including norms such as polygamy, female genital cutting (FGC), and lack of inheritance rights. Societal attitudes also perpetuate GBV. Some of these attitudes that justify GBV include the idea that men have the right to control wives' or partners' behavior and can discipline them. Attitudes also include believing that there are just causes for violence. As a result, GBV survivors often are blamed for the violence they have experienced—both by men and by women themselves.

Studies have shown that high levels of violence perpetrated against women can directly and indirectly expose them to HIV.[4] Violence can increase the likelihood of HIV infection for women in the following ways:

- Forced or coercive sex with an HIV-infected partner (without condom)
    - Girls who experience rape are more vulnerable to acquiring HIV because girls' vaginal tracts are immature and tear easily during sex[5]
- Women's inability or limited ability to negotiate condom use with abusive partners
    - Abusive men are more likely to engage in high-risk behavior, such as having multiple partners[6]

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[1] United Nations Population Fund Gender Theme Group. 1998. *Violence against Girls and Women: A Public Health Priority.* UNFPA Gender Theme Group, Interactive Population Center.
[2] General Assembly. 2006. *In-Depth Study on All Forms of Violence against Women: Report of the Secretary General*. A/61/122/Add.1. 6 July 2006.
[3] Krug, E.G., L. L. Dahlberg, J. A. Mercy, A.B. Zwi, and R. Lozano. 2002. *World Report on Violence and Health*. Geneva: World Health Organization.
[4] See WHO and Global Coalition for Women and AIDS. Not dated. "Violence against Women and HIV/AIDS: Critical Intersections. Intimate Partner Violence and HIV/AIDS." *Information Bulletin Series,* Number 1. Available at: http://www.who.int/gender/violence/en/vawinformationbrief.pdf.
[5] WHO and Global Coalition for Women and AIDS. Not dated. "Violence against Women and HIV/AIDS: Critical Intersections. Intimate Partner Violence and HIV/AIDS." Information Bulletin Series, Number 1. Available at: http://www.who.int/gender/violence/en/vawinformationbrief.pdf.
[6] Heise, L., M. Ellsberg, M. Gottemoeller. 1999. "Ending Violence against Women." *Population Reports,* Series L, No. 11. Baltimore, Maryland: Johns Hopkins University School of Public Health, Population Information Program.

- Experience of physical or sexual abuse during childhood leads to risky behaviors
    - Abused girls are more likely to have sex at an early age, have multiple sex partners, use alcohol or drugs, or engage in transactional sex[7]
- Exploitation of girls and women by men (often older), which can include transactional sex and trafficking
    - Violence and the threat of violence are used as means of control; keeps women from leaving relationships
    - Girls who marry at a young age to older men are at a higher risk for acquiring HIV
    - Some men believe the myth that having sex with virgins will cure HIV
- Fear of violence impedes/prevents women from accessing services
    - Women may not seek HIV testing
    - Women may not disclose their HIV status to partner, for fear of being blamed for bringing HIV into the household[8]
- Partners may limit women's ability to access treatment due to household and economic control
- Women who may obtain antiretroviral (ARV) medication often are forced to give it to their partners[9]

Training Religious Leaders and Women of Faith on GBV and HIV

Women of faith have called attention to gender-based violence in their communities, citing a need for religious leaders to raise awareness of the issue and address it. Religious leaders and women of faith are well positioned to identify, validate, and promote best practices on preventing and reducing GBV as it relates to HIV. Under the USAID | Health Policy Initiative Task Order 1, Futures Group and Religions for Peace initiated a multi-religious activity to prevent and reduce GBV and HIV for women and girls and other vulnerable groups. This activity included the following objectives:

- Strengthen the capacity of religious communities and networks to respond to GBV as it relates to HIV;
- Equip religious communities with tools to deepen their awareness and understanding of GBV; and
- Enhance faith-based activities regarding GBV.

As part of the overall activity, Futures Group and Religions for Peace (RFP) conducted a regional training on GBV and HIV for women of faith and male religious leaders (drawn from Religions for Peace's [RFP] African Women of Faith Network and National Inter-Religious Councils). Participants came from eight countries (Democratic Republic of Congo, Ghana, Kenya, Liberia, South Africa, Tanzania, Uganda, and Zambia) to attend the training in Nairobi, Kenya. This manual was piloted at the regional training and has

[7] WHO and Global Coalition for Women and AIDS. Not dated. "Violence against Women and HIV/AIDS Information Sheet." Available at: http://www.who.int/hac/techguidance/pht/InfosheetVaWandHIV.pdf.
[8] International Community of Women Living with HIV/AIDS (ICW) and the Global Coalition on Women and AIDS. 2006. Violence against HIV-Positive Women. London: ICW. Available at: http://www.aidsallianceindia.net/Publications/Violence_Against_Women_ICW_Jun06.pdf.
[9] POLICY Project. 2006. *Policy Reform to Meet Access-to-Treatment Goals: HIV-Positive Women's Access to Care, Treatment, and Support (ACTS) in Swaziland.* Washington, DC: POLICY Project.

since been revised to reflect suggestions from participants. For more on the USAID | Health Policy Initiative activity with religious leaders on GBV and HIV, see the project documents, *The Role of Religious Communities in Addressing Gender-based Violence and HIV* and *A Call to Act: Engaging Religious Leaders and Communities in Addressing Gender-based Violence and HIV.*[10] In addition, Religions for Peace produced *Restoring Dignity: A Toolkit for Religious Communities to End Violence Against Women.*[11]

Training Objectives

This manual has been designed to guide trainers in conducting workshops for religious leaders and women leaders of faith on GBV and HIV. It was created specifically for heads of religious organizations, such as inter-religious councils and women's religious organizations. While this material was piloted with leaders, it can be adapted to meet the specific priorities and needs of participants, such as other organization members.

The overall objective of the training is to raise awareness of religious leaders and women leaders of faith about GBV as it relates to HIV and motivate action planning to address the issues in their own organizations or communities. At the end of the workshop, participants should be better able to

- Identify different types, causes, and consequences of GBV;
- Understand the link between GBV and HIV;
- Name approaches for addressing GBV through religious organizations, institutions, and/or communities; and
- Initiate dialogue on how religious leaders and women leaders of faith can mainstream GBV into faith-based interventions.

Agenda

Day 1: Workshop Overview
Exploring Gender-based Violence

Day 2: Linking GBV and HIV
Multi-Religious Approach to GBV and HIV

Day 3: Approaches to Mobilizing Communities of Faith to Address GBV

[10] Herstad, Britt. 2009. *The Role of Religious Communities in Addressing Gender-based Violence and HIV.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1; Herstad, Britt. 2009. *A Call to Act: Engaging Religious Leaders and Communities in Addressing Gender-based Violence and HIV.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.
[11] Religions for Peace. 2009. *Restoring Dignity: A Toolkit for Religious Communities to End Violence Against Women.* New York: Religions for Peace.

DAY 1

Workshop Objective

Raise awareness of religious leaders and women of faith about GBV as it relates to HIV and inspire action planning to address the issues in their own communities.

Workshop Overview (75 minutes)

Learning Objectives

At the end of this session, participants should be better able to

- Understand purpose and objectives of workshop
- Familiarize yourself (facilitator and training participants) with other participants and their backgrounds

Preparation

- Workshop objective and Day 1 agenda on flipchart or PowerPoint (PPT)
- Instructions for "Shared faith values" activity on flipchart
- Write faith words on cards (one word per card), such as truth, compassion, temperance, peace, love, endurance, gentleness, goodness, and faith. Cut the word cards in half. Make sure there are enough half-cards for each participant.

Materials

- Handout—Workshop agenda (see Annex I for sample agenda, page 53)
- Handout—Prayers and reflections (see Annex II for sample prayers and reflections, page 55)
- Handout—Day 1 Evaluation (page 18)

Welcome (5 minutes)

Training organizers and/or training facilitators should introduce themselves at this time, welcome the participants, and thank them for attending the training.

Silent reflection (5 minutes)

Since it is important to emphasize the centrality of religion to this training, the workshop will begin with a moment of silent reflection.

1. Introduce the silent reflection, noting that participants reflect a variety of religious identities and a silent reflection allows them to meditate according to their own beliefs.
2. After the silent reflection, draw attention to the need for mutual respect for religious and cultural diversities throughout the course of the training. Tell the participants that they will be sharing their different religious identities every morning through a moment of reflection.
3. Ask participants to think of multi-religious prayers, rituals, or other ways in which they'd like to share their faith with the group in the following days. Tell them you will be asking for volunteers the next few mornings.

Activity 1: Shared Faith Values—Participant Introductions (45 minutes)

1. Introduce the activity—review instructions on flipchart.
   Interview instructions for "5-minute interview"
   - Name (the name they prefer to be called by during the workshop)
   - Religious affiliation
   - Place of work
   - Why they are committed to the issues of GBV and/or HIV
   - One expectation of the workshop
2. Hand out one half-card to each participant.
3. Explain that they will need to locate the person with the other half of their card. When they have found their "other half," they will take turns interviewing their partner according to the instructions.
4. Monitor time and make sure they switch to the other partner.
5. After 15 minutes, invite partners to introduce each other to the group and share the word that binds them, and their expectations.
6. Record participant expectations on the flipchart.
7. After everyone has been introduced, initiate a brief discussion of the words on the cards. Ask participants to identify the significance of the word in relation to their own faith traditions.

Activity 2: Workshop Agenda (20 minutes)

1. If necessary or relevant, provide information on how this training fits into a larger initiative, project, or context.
2. Review the workshop objective and agenda, displaying flipchart and/or PPT.
3. Review participant expectations mentioned in the "shared faith values" activity. Any expectations outside the scope of the workshop should be written on the flipchart under the heading "parking lot."
4. Ask participants if they have any questions on the workshop's objective or agenda.

Exchange of peace

1. Lead participants in greeting their neighbors by saying "peace."

SESSION 1: EXPLORING GENDER-BASED VIOLENCE (4 HOURS 45 MINUTES)

Learning Objectives

At the end of this session, participants should be better able to

- Define GBV and related terms
- Clarify how personal values impact understanding of GBV
- Demonstrate a basic understanding of GBV prevalence
- Recognize how the thoughts, beliefs, and actions of others influence and perpetuate GBV as the norm in communities

Preparation

- GBV definition on flipchart
- Select statements (2–3) for use with "Vote with Your Feet" activity
- PPT on Prevalence of GBV (This and other PowerPoints related to this document can be found at: http://www.healthpolicyinitiative.com).
- Draw ecological model on flipchart, as seen in handout (page 14)
- Photocopy and cut out character statements found at the end of this section (page 15)
- *If using a video, cue video to appropriate spot*

Materials

- Flipcharts and markers
- Tape for hanging flipcharts
- Handout—Gender Definitions (page 10)
- Handout—Prevalence of Gender-based Violence (page 12)
- Handout—Ecological Model of GBV (page 14)
- Handout—Character Statements (page 15)
- PPT on Prevalence of GBV

Activity 1: Defining Gender-based Violence and Related Terms (45 minutes)

1. Write GBV as a header on the flipchart and ask the participants what they associate with that term. (What comes to mind?)
2. Record key phrases that come up on the flipchart.
3. Distribute the handout of key GBV terms and definitions.
4. Review phrases identified by participants and key terms on the handout (page 10), emphasizing how the concept of gender-based violence evolved and how it differs from violence against women.

> Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm...It includes that violence which is perpetuated or condoned by the state.
>
> –United Nations Population Fund Gender Theme Group, 1998

Explain to the group that justifications for violence frequently are based on gender norms. Review the following points:

- Gender norms are the socially assigned roles and responsibilities of women and men.
- Cultural and social norms often socialize males to be aggressive, powerful, unemotional, and controlling. This contributes to a social acceptance of men as dominant.
- Similarly, expectations of females are that they be passive, nurturing, submissive, and emotional. This reinforces women's roles as weak, powerless, and dependent on men.
- The socialization of both men and women has resulted in an unequal balance of power, an unequal power relationship between women and men.

- In many societies, children learn that men are dominant and that violence is an acceptable means of asserting power and resolving conflict.
- Women as mothers and mothers-in-law unknowingly perpetuate violence by socializing boys and girls to accept men's dominance and to meet their demands.
- Mothers and fathers teach their daughters to accept the roles that society assigns them.

Activity 2: Personal Beliefs/Reflections on GBV—"Vote with Your Feet" (45 minutes)

1. Tell the participants that we are going to discuss some statements about GBV. Explain to them that in this activity they are going to explore their own views and beliefs about gender-based violence.
2. Inform them that you are going to read a statement about GBV (statements follow these instructions), and they need to decide if they agree or disagree. Designate one side of the room for those who agree and the other for those who disagree. Tell the participants that when they decide, they should move to the side of the room matching their response. Ensure them that this is just to generate discussion and that there is no "right" or "wrong" answer.
3. Read each statement twice to ensure all participants have heard it. After the participants make their choice, ask one side why they are standing there. Generate responses and probe further with additional questions. When you are through with one group, ask the other group the same question.
4. Close the activity by explaining that we want to understand the variety of personal and institutional beliefs/norms/values related to GBV through the participants' personal reflections. Part of this includes individuals and cultures holding contradictory values—being aware of these contradictions is important when working on GBV. Even though we may be familiar with GBV and the importance of addressing it, some of the issues may be difficult for us to work on. Looking at our socialization and how our cultures feel about violence toward women and girls may influence the way we address this issue in our faith activities or whether we even address it at all.

Examples of Statements (read only 2 or 3)

1. In some instances, women provoke violent behavior.
2. Gender-based violence is too culturally sensitive an issue to be discussed in HIV projects.
3. Men sometimes have good reasons to use violence against their wives.
4. Religious texts or teachings contribute to men's violence against women.
5. Religious organizations are mandated or called to address gender-based violence.
6. It is not appropriate for religious leaders to discuss matters relating to women and sexuality.

Activity 3: Prevalence of GBV (45 minutes)

1. Tell the participants we will be using a PPT presentation. Bring the "Prevalence of Gender-based Violence" PPT up.
2. Begin the presentation with the following points:
    - Millions of girls and women suffer from violence and its consequences because of their sex and their unequal status in society.
    - Gender-based violence is a serious violation of women's human rights.

- While men also are victims of violence, the violence against women is characterized by its high prevalence in the family, its acceptance by the society, its seriousness, and its long-term impact on women's health and well-being.
- Data on the prevalence of GBV can be difficult to collect and compare. Ask the participants if they know why this is the case, keeping the following points in mind:
  - Definitions vary
  - Data or information collectors are not always adequately trained
  - Questions are not always asked in a way that people clearly understand
  - Questions are written in a way that may confuse respondents
  - GBV is underreported because of culture and societal norms around disclosure

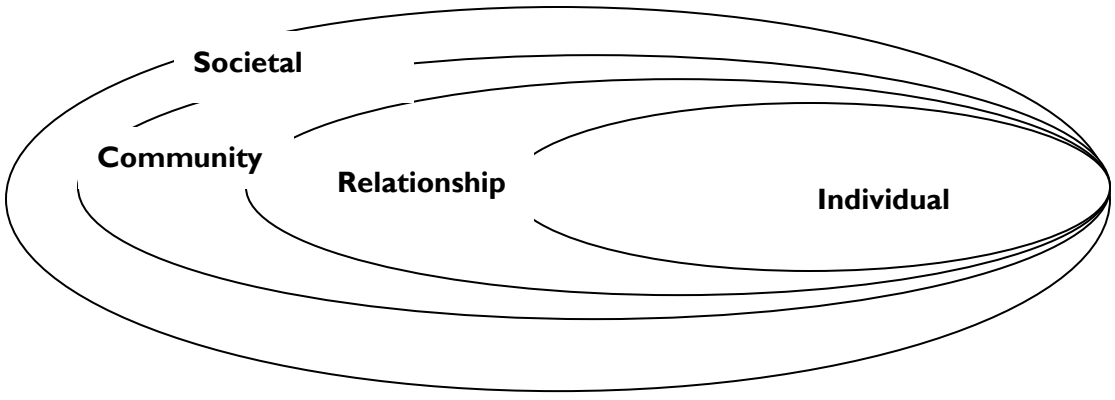
3. Begin the PPT presentation of Prevalence of Gender-based Violence.
4. At the end of the presentation, facilitate a brief discussion on the prevalence data presented and what the group thinks the impacts are/could be. Distribute handouts with the prevalence data.

Facilitator's Note: For the PPT presentation and handout (page 11), use data specific to the region from the most recent Demographic and Health Survey (www.measuredhs.com) or other relevant surveys.

Activity 4: Factors in Perpetuating Violence (60 minutes)[12]

1. Explain that GBV can be perpetuated by any number of actors—partners, family, community, and the State. However, these individuals also can play a role in *preventing* GBV. In fact, all individuals in the community can play a role in addressing GBV.
2. Present the following conceptual model, also known as the ecological model (adapted from Heise, 1998). Explain that researchers developed this model to conceptualize varying factors at each level in the model—individual, relationship, community, and societal—that cause and allow GBV to take place.

   Model:



[12] Adapted from "Circles of Influence" in Raising Voices. Forthcoming in 2009. PREP Module of *The Sasa! Activist Kit.* Kampala: Raising Voices.

Define each level in the model as follows:

- Individual: Biological and personal history factors of GBV victims and perpetrators.
- Relationship: Proximal social relationships (most importantly, those between intimate partners and within families).
- Community: The context in which social relationships are embedded, including peer groups, schools, workplaces, and neighborhoods.
- Societal: Larger factors that create an acceptable climate for violence and reduce inhibitions against it.

3. Ask participants for examples of what they think are factors in perpetuating violence at each level and list them next to the corresponding circle on the flipchart. (See the handout on the ecological model for examples but do not distribute it until the end of the exercise [page 13].) Facilitate a brief discussion on how the factors and each level are linked with one another, recognizing that each level influences the other. Emphasize that understanding GBV requires drawing on each type of explanations.

Facilitator's Note: The ecological model (see page 14) can sometimes cause debate over how each factor is categorized, and what should be considered a factor or not. If so, you may emphasize to participants that the model is not necessarily perfect or exact but rather is intended to conceptualize the various influences on GBV and in this way help design interventions that prevent violence.

4. In the next exercise, go on to explain that we will explore how the thoughts, beliefs, and actions of others create community norms and how these norms influence change in the community. Norms are unwritten rules in a society that guide how people behave. Norms can and do change over time.
5. Randomly distribute character statements (page 15), one to each participant. (If there are fewer than 30 participants, eliminate statements so that the number of statements matches the number of participants. Be sure that Benji's and Betty's statements remain in the pile.)
6. Ask those whose statements were labeled I/R for individual or relationship to get into one group; those with statements labeled C for community in another; and those with S for society in a last group. Tell the groups to have each person in their group read his/her respective character statement to the rest of the group; discuss how the characters may perpetuate violence, according to the statements; and finally, how each character could instead play a supportive role. Give each group some flipchart paper and ask them to write their "level" (individual, relationship, etc.) at the top and then record how each character perpetuates violence. Give each group 15 minutes to discuss. Inform the groups that one person will have to present back to the larger group.
7. Bring the groups back together and ask each group to briefly report their outcomes. After all groups have presented, ask the larger group for comments and questions.
    a. What did you think about the exercise?
    b. Was it difficult to identify the impacts, and if so, why?
    c. Were there differences in the discussion based on culture or geographical origin of participants?
    d. Were there any surprises?

Facilitator's Note: This type of discussion may result in disagreements among the participants. You should be prepared to address any conflict that arises, noting that these are just made-up examples to initiate discussion. This exercise is meant to encourage participants to reflect on the different levels at which violence is perpetuated.

Suggested or Optional Activity

For this activity, the facilitator should look at a range of audiovisual materials on GBV and ideally, faith communities, to share with the training participants. A film or another resource can be used to get participants to identify GBV and HIV and discuss what communities—especially their faith communities—can do in such situations. The facilitated discussion should focus on being specific and concrete about what their communities actually can do.

Example

Activity 5: Film—SASA! A Film about Women, Violence, and HIV (90 minutes)

Accessible at: www.raisingvoices.org/women/Sasa_film.php for download or to order

1. Inform the participants that we are going to watch a film on gender-based violence and HIV. This will be an introduction to the focus of tomorrow's topics and themes.
2. Tell them to keep in mind the previous discussion about different forms of GBV, sites of violence, and consequences of the violence.
3. Show the video. After watching the film, divide the participants into three groups and assign each of the groups three of the following questions to discuss:
    - What is your initial reaction to the film?
    - Could you relate to Mama Joyce's and Josephine's stories? Did they remind you of something you have experienced or witnessed in your communities?
    - The film talks about power and about how men generally have more power than women in relationships and communities. What do you think of this analysis?
    - How were women in the film using their power positively? How were men in the film using their power positively?
    - Why is support important? Whom do you think needs support—only women, or men as well?
    - There were many examples of support in the film. Which do you think would work in your community? What are some other ideas?
    - What do you think prevents people from taking action to prevent violence? What prevents you? How can we overcome these barriers?
    - The film gives many suggestions for taking action. How could you take action?
    - There is a real urgency to prevent violence against women and HIV. What can you do NOW?
    - What do you think of what the religious leaders said in the film?
    - In your faith communities, what would women's options have been?
4. Bring the large group back together and have the small groups report out. Then, ask for additional comments or questions.

Facilitator's Note: Ask the participants to focus on the last question and to be very concrete and realistic about what their faith communities can offer to women experiencing violence.

Activity 6: Daily Evaluation (5 minutes)

1. Hand out the Day 1 evaluation (page 18) and ask the participants to fill it out.
2. Collect the evaluations.

END OF DAY 1

DAY I HANDOUTS

GENDER DEFINITIONS

Gender: A sociocultural construct that refers to power differences between males and females within a culture. These differences manifest themselves in roles, responsibilities, expectations, privileges, rights, limitations, opportunities and access to services.

Gender-based Violence (GBV): Gender-based violence is violence involving men and women, in which the female is usually the victim, and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm… It includes that violence which is perpetuated or condoned by the state.[13]

Research has shown that nearly one in four women report sexual violence by an intimate partner in their lifetime. Women face this and other types of violence as a result of their subordinate status in society. Many laws and customary practices perpetuate women's subordinate legal, social, and economic status. These laws and practices include polygamy, virginity testing, and FGC, among others. GBV highlights the relationship between women's subordinate status in society and their increased vulnerability to violence. Key points include the following:

- Gender norms and inequality condone and perpetuate gender-based violence.
- Gender influences patterns of violence among men versus violence against women.
- Gender-based violence is used to support unequal gender roles.

Violence against women includes but is not limited to the following:

a. Physical, sexual, and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, FGC, and other traditional practices harmful to women, non-spousal violence, and violence related to exploitation.
b. Physical, sexual, and psychological violence occurring within the general community, including rape; sexual abuse; sexual harassment and intimidation at work, in educational institutions, and elsewhere; trafficking in women; and forced prostitution.
c. Physical, sexual, and psychological violence perpetrated or condoned by the State, wherever it occurs.

Other acts of violence against women include violation of the human rights of women in situations of armed conflict, in particular murder, systematic rape, sexual slavery, and forced pregnancy.

Acts of violence against women also include forced sterilization and forced abortion, coercive/forced use of contraceptives, female infanticide, and prenatal sex selection.

— *Excerpted from United Nations 4th World Conference on Women, Beijing, China, 1995*

[13] United Nations Population Fund (UNFPA) Gender Theme Group, 1998.

Forms of Intimate Partner Violence and Modes of Expression

Form of violence	Mode of expression
Physical	Slaps, punches, attack with a weapon, femicide.
Sexual	Rape, coercion and abuse, including use of physical and verbal threats or harassment to have sex, unwanted touching or physical advances, forced participation in pornography or other degrading acts, such as anal sex.
Psychological/emotional	Belittling the woman, preventing her from seeing family friends, intimidation, withholding resources, preventing her from working, or confiscating her earnings.

PREVALENCE OF GENDER-BASED VIOLENCE

How common is gender-based violence? This question is difficult to answer conclusively for a number of reasons. First, comparative data are difficult to collect since estimates vary according to how researchers define violence, the questions they ask, the timeframes they explore, and the sample characteristics. Second, most surveys underestimate prevalence, as survivors may not report violence because of fear, shame, and lack of adequate services. See the following website for a brief on data collection related to GBV: http://www.popcouncil.org/mediacenter/newsreleases/sfp32_1ellsberg.html

To access GBV-related data, there are two websites for international data. See Demographic and Health Surveys, http://www.measuredhs.com/topics/gender/dv_overview.cfm, for countries that have included a domestic violence module in their survey. See also the World Health Organization's *Multi-country Study on Women's Health and Domestic Violence against Women* http://www.who.int/gender/violence/who_multicountry_study/en/index.html.

In addition, the following report on GBV includes both data from the United States and other countries: *Ending Violence against Women*, Population Reports, December 1999: http://www.infoforhealth.org/pr/l11edsum.shtml.

When looking for other country-specific data, contact local organizations working on GBV, as they may have additional information and data.

Prevalence Estimates of Different Forms of GBV Worldwide[14]

Type of violence	Prevalence
Physical	From 10% to more than 69% of women worldwide report being hit or physically harmed by an intimate partner at some point in their lives.
Sexual	Nearly one in four women report sexual violence by an intimate partner in their lifetime.
Forced sexual initiation	Rates of "forced" sexual debut range from 7% in New Zealand to 46% in the Caribbean.

[14] IGWG of USAID. 2008. *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers.* Second Edition. Washington, DC.

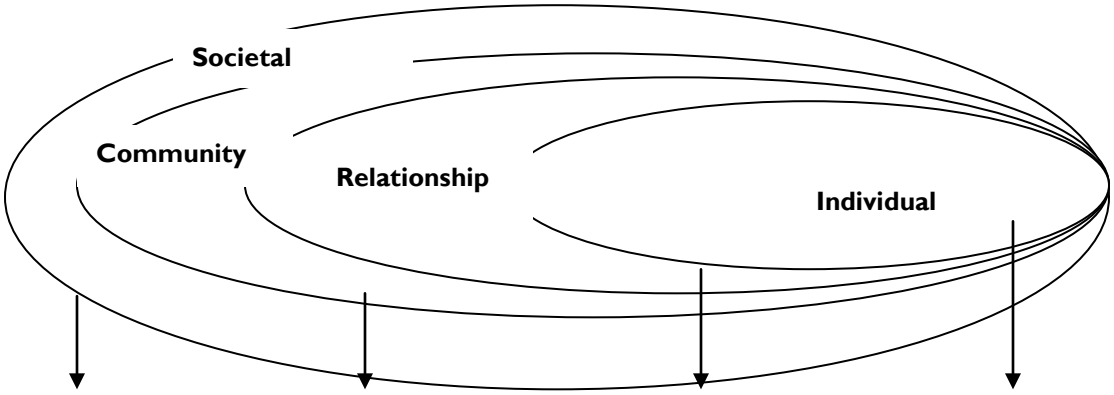
Percentages of Ever-married or Ever-partnered Women Ages 15–49 Who Have Experienced Physical or Sexual Violence by any Husband/Partner Ever and in the 12 Months Preceding the Survey, by Country[15]

Ever-married/partnered women		
Country	**Percentage who have ever experienced violence by a spouse/partner**	**Percentage who have experienced violence by a spouse/partner in the past 12 months**
Azerbaijan 2006	13.5 *(n=3,847)*[2]	10.2 *(n=3,691)*[3]
Bolivia 2003	53.3 *(n=12,005)*	not available
Cambodia 2005	13.7 *(n=2,037)*	8.7 *(n=2,037)*
Colombia 2005[1]	39.0 *(n=25,279)*	not available
Dominican Republic 2007	17.2 *(n=7,719)*	11.7 *(n=7,719)*
Egypt 2005	33.7 *(n=5,613)*	21.7 *(n=5,613)*
Haiti 2005	20.0 *(n=2,420)*	16.8 *(n=2,420)*
India 2005–2006	37.2 *(n=66,658)*[2]	23.9 *(n=63,966)*[3]
Kenya 2003	42.9 *(n=3,856)*	28.2 *(n=3,856)*
Peru 2004	42.3 *(n=2,861)*	14.5 *(n=2,861)*
Rwanda 2005	33.8 *(n=2,338)*	25.6 *(n=2,338)*
Uganda 2006	59.1 *(n=1,598)*[2]	45.0 *(n=1,518)*[3]

[1] Does not ask about sexual violence explicitly; [2] includes widows; [3] excludes widows.

[15] IGWG of USAID. 2008. *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers.* Second Edition. Washington, DC. Sources: Various Demographic and Health Surveys, 1998–2007. www.measuredhs.com.

ECOLOGICAL MODEL OF GBV



• Traditional gender norms that give men economic and decisionmaking power in the household • Social norms that justify violence against women • Women's lack of legal rights (including access to divorce) • Lack of criminal sanctions against perpetrators of GBV (impunity) • High levels of crime • Armed conflict	• Weak community sanctions against GBV • Lack of shelters or other forms of assistance/sanctuary • Poverty • Traditional gender roles for women in transition • Normative use of violence to settle all types of dispute • Social norms that restrict women's public visibility • The safety of public spaces	• Marital conflict • Family dysfunction • Male dominance in the family • Economic stress • Early age at marriage • Large number of children • Friction over women's empowerment • Family honor considered more important than the health and safety of the victim	• A history of violence in the perpetrator's or victim's family of origin (including intimate partner violence and child abuse) • Male alcohol use • Male personality disorders (particularly in low prevalence settings) • Young age (both women and men)

Individual level: biological and personal history factors among both victims and perpetrators.

Relationship level: proximal social relationships, most importantly those between intimate partners and within families.

Community level: the community context in which social relationships are embedded, including peer groups, schools, workplaces and neighborhoods.

Societal level: larger societal factors that "create an acceptable climate for violence, reduce inhibitions against violence."

CHARACTER STATEMENTS

1. **(I/R)** My name is Betty. I am married to Benji. We used to be okay, but nowadays Benji shouts at me a lot and even sometimes hits me. It's especially bad when he's been drinking. I fear him and so do my children. But my mother endured the same fate as well.

---

2. **(I/R)** My name is Benji. I am married to Betty. For some time now things at home have not been so good. My wife annoys me, and I have no choice but to shout at her. Sometimes I even beat her. I guess this is what happens in marriage.

---

3. (**I/R)** I am Benji's parent. We were raised knowing that men can discipline women. This is how things should be.

---

4. **(I/R)** I am a friend of Benji. We go to the drinking joint together. I see how you drink and then go home angry. But it is normal for men.

---

5. **(C)** I am an elder. You respect me and follow my advice. Men have to make all the decisions for a family.

---

6. **(C)** I am your relative. I ensure that you respect the family customs.

---

7. **(C)** I am your in-law. You are now part of our family where women stay quiet and don't complain.

---

8. (**C)** I am a friend of Betty. You and I discuss everything together. My relationship is similar to yours—men are head of the house, we have to endure.

---

9. (**C)** I am your neighbor. I hear your fights at night but say nothing. It isn't my business.

---

10. (**C)** I am an adolescent. I keep silent—what can I do?

---

11. (**C)** I am a priest/imam. I keep silent. God/Allah will take care of things.

---

12. (**C)** I am a health care provider. I take care of injuries but don't ask anything. It is not my business.

---

13. (**C)** I am a food seller. I see her bruises but keep silent.

---

14. (**C)** I am a police officer. Men sometimes can't avoid using some small violence at home. It is a domestic issue.

---

15. (**C)** I am a farmer. I think a woman is not equal to a man. A woman should obey her husband.

---

16. (**C)** I am a taxi driver. I think violence should be used against a woman once in a while. Otherwise women start thinking they can do anything.

---

17. (**C)** I am a market seller. Women and men are not equal. If a man wants to show that he has more power, then that is a woman's fate.

---

18. (**C)** I am a local leader. Violence in relationships is a domestic issue — I don't have time for it!

---

19. (**C)** I am a pharmacist. You buy things from me and ask for my advice. I think women must be patient and endure.

---

20. (**C)** I am a teacher. Making jokes about girls is just for fun, it doesn't do any harm.

---

21. (**C)** I am your doctor. I advise you on many issues but don't see how violence and HIV/AIDS are connected.

---

22. (**C)** I am a social welfare officer. I see violence in the community but I mostly focus on children, as violence between women and men is pretty normal.

---

23. **(S)** I am a judge. Sometimes women file cases just for simple violence. I dismiss the cases.

---

24. **(S)** I am a parliamentarian. There are no laws in my country specifically about domestic violence—that's a private matter!

---

25. **(S)** I am a radio announcer. You hear my messages every day. We joke about women and violence – what's the harm?!

---

26. **(S)** I am a United Nations official. I monitor countries' progress on international conventions, but I don't see the connection between violence against women and HIV/AIDS.

---

27. **(S)** I am a Minister of Health. I decide which services are available at the health centers. Women's rights issues don't belong in clinics – we prescribe drugs!

---

28. **(S)** I am a newspaper editor. I show explicit photos of women in my paper because it sells!

DAY 1 EVALUATION

1. Evaluate the degree to which the session objective was achieved. Please circle a number (1 indicating "not achieved" and 5 indicating "achieved").

   1----------2----------3----------4----------5

2. Rate the usefulness of the session to your work as a faith leader. Please circle a number (1 indicating "not useful" and 5 indicating "useful").

   1----------2----------3----------4----------5

3. Which activity contributed most to your learning?

4. Which activity contributed least to your learning?

5. Additional comments or suggestions:

DAY 2

SESSION 2: LINKING GBV AND HIV (4 HOURS)

Learning Objectives

At the end of this session, participants should be better able to

- Identify ways in which women are vulnerable to HIV
- Understand how GBV can increase women's vulnerability to HIV
- Identify specific populations particularly vulnerable to GBV

Preparation

- Day 2 agenda on flipchart or PPT
- PPT presentation on "Women and HIV," which can be downloaded from: www.healthpolicyinitiative.com .
- List five categories on flipchart: social/cultural, economic, legal, religious, and physiological
- Write questions on flipchart

    1. How does GBV increase women and girls' vulnerability to HIV?
    2. How does GBV affect women's ability to access the following services/programs?
        a. prevention
        b. testing and treatment
        c. care and support
        d. women's leadership/greater involvement of people living with or affected by HIV or AIDS (GIPA)

       How might these services/programs expose women to GBV?
    3. How does being HIV-positive affect women's experience of GBV and ability to access support for GBV?

- List vulnerable populations (refugees, internally displaced person, trafficked and/or migrant girls and women, children, women and girls living in conflict settings, sex workers, girls and women who undergo harmful traditional practices) on a flipchart
- *If using a video, cue video to appropriate spot*

Materials and Handouts

- Flipcharts and markers
- Tape for hanging flipcharts
- Handout—Activity Instructions: Links between GBV and HIV (page 28)
- Handout—Links between GBV and HIV (page 29)
- Handout—Vulnerable Populations to GBV and HIV (page 35)
- PPT presentation on Women and HIV (PPT can be found at: http://www.healthpolicyinitiative.com)

Reflection (5 minutes)

Ask a participant to lead the group in a reflection. You can use examples included in Annex II.

Welcome and Recap (10 minutes)

1. Welcome the participants back. Ask them to recap key issues of the previous day.
2. Review the agenda for Day 2 on flipchart or PPT.

Activity 1: Women's Vulnerability to HIV (45 minutes)

1. Begin the PPT presentation entitled "Women and HIV."
2. At the end of the presentation, ask the participants what they think the impacts of women's vulnerability to HIV are or could be. Distribute handouts of the PPT presentation.

Facilitator's Note: Try to gather data specific to the region and focus the presentation on these data. The data can be obtained from the most recent Demographic and Health Survey (http://www.measuredhs.com/topics/gender/dv_overview.cfm). Make sure data are up-to-date and sources are cited (see the handout on page 11 for further details).

3. After the discussion on prevalence, divide the participants into five groups, telling them you will be discussing gender-based factors that make women vulnerable to HIV.
4. Assign the groups one of the following categories:
    - Social/Cultural
    - Economic
    - Legal
    - Religious
    - Physiological
5. Ask the groups to discuss the factors within that category that make women vulnerable to HIV. They will have 15 minutes to do this and then they will report back to the larger group.

Sample answers

- **Social/Cultural**—Women are not always able to make their own decisions, and may be subject to forced marriages, female genital cutting, etc. Idea of ritual cleansing where men who believe they are HIV infected have sex with virgins to rid themselves of the infection.
- **Economic**—Women are not always allowed to own property or may have fewer opportunities for paid work. Women in poverty may then be forced to engage in prostitution or sexual transactions for food or money.
- **Legal**—In many places, there are no laws to protect women from rape and other forms of violence. Where there are laws, many women do not know about them or the legal system may make it difficult for women to find justice.
- **Religious**—Religious beliefs related to the use of condoms can put women at risk of acquiring HIV through unprotected sex. Polygamy also can be a factor, as having multiple partners places women at increased risk for acquiring HIV.
- **Physiological**—The physical makeup of the female genitalia puts women at a higher risk of acquiring HIV than men.

Facilitator's Note: If you need to explain the response around physiological factors, you can note that women's risk of acquiring sexually transmitted infections (STIs) during unprotected sex is two to

four times that of men. Researchers believe that women are biologically more susceptible to HIV infection from heterosexual sex than men. The female genital tract has a greater exposed surface area than the male genital tract. Thus, women may be prone to greater risk of infection with every exposure. Younger women may be even more vulnerable because they have less mature tissue, which tears more easily. Sources: http://www.globalhealthreporting.org and www.unfpa.org.

Activity 2: Links between Gender-based Violence and HIV (75 minutes)[16]

1. Explain to the group that we now want to focus on the links between GBV and HIV—particularly on consequences of GBV for women in the context of HIV. Ask participants the following: When you think of the consequences of GBV for women, in the context of HIV, what comes to mind? Generate initial responses in the large group.

   Explain that the links between GBV and HIV often include, for example:
   - GBV increases women's vulnerability to HIV
   - GBV can affect women's ability to access HIV prevention, treatment, care and support services, and GIPA
   - Being HIV positive can intensify women's experiences of GBV and their ability to access support for GBV

Facilitator's Note: If it does not come up in discussion, note that GBV includes fear of GBV, as well as actual instances of violence.

2. Explain that we want to focus further on the consequences of GBV for women, in the context of HIV. To do so, we want to consider these different links, along with HIV in the context of the links.

   Review these questions on a flipchart (and also include on the handout):

   A. How does GBV increase women's and girls' vulnerability to HIV?
   B. How does GBV affect women's ability to access the following services/programs?

      i. prevention
      ii. testing and treatment
      iii. care and support
      iv. women's leadership/GIPA

   Also consider the following question: How might these services/programs expose women to GBV?

   C. How does being HIV positive affect women's experience of GBV and ability to access support for GBV?

3. Tell the group to divide into four small groups for this activity and distribute the instructions on the handout (page 28). Tell them they have 15 minutes to discuss their assigned questions.

[16] Adapted from Anne Eckman, as included in the Global Women's Leadership in HIV/AIDS Workshop in Washington, DC, July 2007.

Assign the questions as follows:

Group 1: Question A
Group 2: Question B, i & ii (prevention, testing and treatment)
Group 3: Question B, iii & iv (care and support, GIPA)
Group 4: Question C

4. Ask the participants to record their responses on flipchart paper and be prepared to share with the larger group.

5. After 15 minutes, call time and ask each group to briefly report out (4 minutes each).

6. After each group has reported, facilitate a discussion, asking the group the following (15 minutes):

   A. Was this exercise easy or difficult? Why?
   B. Is anything missing?
   C. Were there any surprises in your own group's discussions? The other groups' findings?
   D. What patterns and trends do you see?
   E. How does being perceived as being HIV positive or disclosing a positive status affect women's experiences of violence?

Facilitator's Note: Ensure that participants address the impact of the fear of violence; e.g., a woman will not disclose her status because of the fear of violence.

   F. Is there anything more you would like to add?
   G. Distribute the handout that reviews different links between HIV and GBV (page 29).

Activity 3: Types of Populations Vulnerable to Gender-Based Violence and HIV (60 minutes)

1. Explain that vulnerable populations in this case are those segments of society that face the highest risks of experiencing some form of gender-based violence. Add that vulnerable groups are found in all nations of the world, regardless of the country's level of development and modernization. Display the printed flipchart listing vulnerable populations.

   Vulnerable populations include

   - Refugees
   - Internally displaced persons
   - Trafficked and/or migrant girls and women
   - Children
   - Women and girls living in conflict settings
   - Sex workers
   - Girls and women forced to undergo harmful traditional practices

2. Go around the room and assign participants a different population (you may choose to only focus on a few population groups). Ask them to gather in groups based on the population they were assigned.

3. Ask participants to identify how their population group might be particularly vulnerable to both GBV and HIV.

4. Give flipcharts and markers to each group to record the required information. Each group should choose a recorder and presenter. Give each group 30 minutes.
5. After 30 minutes, ask the groups to make their presentations. As each group makes its presentation, ask the rest of the participants to make comments and raise any questions they might have. Debrief the participants by asking the following questions:
    - What do you think about each group's findings?
    - What are commonalities between the groups?
    - Did we leave out anything?
    - Were there differences in the discussion based on culture or geographical area?
    - What types of GBV are most commonly seen in your culture or geographic area?
6. Distribute the handout on vulnerable populations (page 35).

Suggested or Optional Activity

If participants have indicated a particular interest in a specific vulnerable population or need to discuss it further, the facilitator can arrange a session on that issue. This example focuses on conflict settings, via the IRIN video Our Bodies…Their Battleground: Gender-based Violence during Conflict. *The video is accessible at http://www.irinnews.org/filmtv.aspx#.*

Example
Activity 4: GBV in Conflict Settings (45 minutes)

1. Explain that we'd like to take some time to look specifically at women in conflict settings.
2. Show the video *Our Bodies…Their Battleground: Gender-based Violence during Conflict.*
3. After the video, divide participants into small groups and ask them to identify the risk factors for women related to violence and HIV.
4. After 20 minutes, ask groups to reconvene and review responses.
5. Synthesize responses, mentioning that, in conflict settings, acts of violence against women include the violations of women's human rights, such as murder, systematic rape, sexual slavery, and forced pregnancy. Women in these settings, therefore, face the risk of being infected by STIs and, increasingly, HIV infections. These increased risks are due to three factors
    - Direct transmission of STIs and HIV through rape.
    - Being placed in situations where women may be forced to exchange sex for survival.
    - Experiencing increased levels of overall violence makes it difficult for women to negotiate safe sex in their relationships.
6. Follow up on the role of religions related to GBV and HIV in conflict settings by asking the participants the following questions:
    - Do their religious organizations have any practical experience with assisting refugees, especially survivors of gender-based violence?
    - What are the challenges for religious organizations in working on this issue?
    - What are the opportunities for religious organizations in working on this issue?

SESSION 3: MULTI-RELIGIOUS APPROACH TO GBV AND HIV (3.0 HOURS)

Learning Objectives

At the end of this session, participants should be better able to understand the representation of GBV and HIV in religious texts.

Preparation

- Agenda for Day 3 on flipchart

Materials and Handouts

- Flipcharts and markers
- Tape for hanging flipcharts
- Handout—Activity Instructions for "Analyzing Faith Beliefs Related to GBV and HIV" (page 36)
- Handout—Case Study: A Woman at Closed Crossroads (page 37)
- Handout—Day 2 Evaluation (page 38)

Activity 1: Analyzing Faith Beliefs Related to GBV and HIV (90 minutes)

1. Ask participants to break into small groups based on religion. If there are too many participants of one faith, find a way to separate them into smaller groups. There should be about four members per group.
2. Tell participants that we are interested in discussing our own religious beliefs and how they relate to the issues at hand.
3. Tell participants that we are going to ask them to examine their own religious texts and/or beliefs and discuss the following with one another:
    a. The ways in which these texts/beliefs **perpetuate gender-based violence**.
    b. The ways in which these texts/beliefs call believers to **address gender-based violence and/or HIV**.
4. Before that, you can go over an example with them, using one of the following texts:

    "The Lord, peerless is He, hath made woman and man to abide with each other in the closest companionship, and to be even as a single soul. They are two helpmates, two intimate friends, who should be concerned about the welfare of each other." Bahá'í Principles

    "And among His signs is this: that He created for you mates from among yourselves so that you may dwell in tranquility with them. He has put love and mercy between your hearts; in that are signs for those who reflect." (Qur'an 30:21)
    "…either remain together on equitable terms, or separate with kindness…" (Qur'an 2:229)
    "…live with them on a footing of kindness and equity…" (Qur'an 4:19)

    "Keep on loving each other as brothers. Do not forget to entertain strangers, for by so doing some people have entertained angels without knowing it. Remember those in prison as if you were their fellow prisoners, and those who are mistreated as if you yourselves were suffering." (Bible, Hebrews 13:1-3)

"Men are the maintainers of women because Allah has made some of them to excel others and because they spend out of their property; the good women are therefore obedient, guarding the unseen as Allah has guarded; and (as to) those on whose part you fear desertion, admonish them, and leave them alone in the sleeping-places and beat them; then if they obey you, do not seek a way against them; surely Allah is High, Great." (Qur'an 4:34)

Facilitator's Note: This verse from the Qur'an (4:34) is highly controversial. As the facilitator, you should study or discuss this ahead of time with an Islamic scholar, if possible, and be prepared to facilitate conversation about the interpretation of the verse. You may not want to use this one as an example, as it may be more appropriate to have the Muslim group discuss among themselves, due to the amount of time it may take.

5. Tell the participants they will have 40 minutes to identify **two** examples for both a. and b.
6. During the 40 minutes, visit each group to see how they are doing. Make sure they are focusing on GBV and not just gender or women's roles or status.
7. After 40 minutes, ask the groups to present their examples to the whole group for discussion.
8. Record their responses on flipcharts and facilitate a discussion on themes, commonalities, or differences.
9. Ask participants the following:
    a. Did your group disagree on any of the examples you discussed?
    b. Have you heard your religious leaders use these texts as illustrations in discussing GBV and HIV?
    c. How can these examples facilitate discussion of these issues with your own religious organizations or communities?

Facilitator's Note: Ensure that participants cite the religious texts and record them as references for future use when planning activities.

Activity 2: Religious Community Responses to GBV (90 minutes)

Case Study: A Woman at Closed Crossroads

1. Distribute the case study (handout, page 37) to participants.
2. Give them 10 minutes to read the case study and the questions on the handout.
    - Why is the woman said to be at a "closed crossroads?"
    - What forms of GBV are evident in this case?
    - What reasons explain this woman's position?
    - Explain the vulnerability of this woman and her daughters to other forms of GBV and HIV.
    - How could the religious communities address this woman's problems or assist her and her family?
    - What could your religious community do?
3. After 10 minutes, facilitate a discussion of the questions, focusing on the last two about religious community responses.

Activity 3: Daily Evaluation (5 minutes)

1. Hand out the Day 2 evaluation (page 38) and ask the participants to fill it out.
2. Collect the evaluations.

END OF DAY 2

DAY 2 HANDOUTS

ACTIVITY INSTRUCTIONS: LINKS BETWEEN GBV AND HIV

Key Questions

A. How does GBV increase women's and girls' vulnerability to HIV?
B. How does GBV affect women's ability to access the following services/ programs?
    i. prevention
    ii. testing and treatment
    iii. care and support
    iv. women's leadership/GIPA

Also: how might these services/programs expose women to GBV?

C. How does being HIV-positive affect women's experience of GBV and ability to access support for GBV?

Group Assignment

Group 1: Question A
Group 2: Question B, i & ii (prevention, testing and treatment)
Group 3: Question B, iii & iv (care and support, GIPA)
Group 4: Question C

A. Discuss your assigned questions.

B. Use flipchart to record your responses as follows.

C. Be prepared to share your group's flipchart.

LINKS BETWEEN GBV AND HIV[17]

I. Are GBV and HIV related?

Research demonstrates an overlap in prevalence of HIV and violence. People who experience violence are more likely to be HIV positive than those who do not (Dunkle et al., 2004; Greenwood et al., 2002 in Campbell, 2005; Wyatt et al., 2002 in AMFAR, 2005).

- A study in Tanzania found that young women (under age 30) who were HIV positive were 10 times more likely to report having experienced violence than HIV-negative young women (Maman et al., 2002).
- A South African study among 1,366 women attending health centers concluded that women who were beaten by their husbands or boyfriends were 48 percent more likely to become infected with HIV/AIDS than women in nonviolent relationships. Women who were emotionally or financially dominated by their partner were 52 percent more likely to be infected than those who were not (Rothschild et al., 2006).

II. How does GBV affect women's vulnerability to HIV and ability to prevent HIV or (re)infection with other sexually transmitted infections?

Sexual violence can increase physiological risk of transmission. The most direct way that GBV increases risk for HIV is physically: sexual violence can increase physiological risk of HIV by causing abrasions or cuts that facilitate entry of the virus into the body (Wood and Jewkes, 1997 in AMFAR, 2005).

Violence may also weaken women's immune systems. Emerging research also shows that violence against women may weaken their immune systems, putting them at risk for HIV and other health problems (Woods et al., under review, in Campbell, 2005).

Experience of GBV, especially childhood sexual abuse, can lead to risk-taking behaviors, including risky sex and intravenous drug use ([Abdool, 2001; Choi et. al., 1998; Gilbert, El-Bassel, Rajah et al., 2002; Wyatt et. al., 2002 in Campbell, 2005]; and [Maman et al., 2000; Bensley et al., 2000; Thomson et al., 1997; Zierler et al., 1991 in AMFAR, 2005]).

Violence or fear of violence impedes negotiating safer sex. There are numerous studies showing the difficulties of negotiating safe sex behavior for abused partners (Davila and Brackley, 1999; Wingood and Clemente, 1997 in Campbell, 2005) (Karim et al., 1995 and Worth, 1989 in AMFAR, 2005). The challenge of HIV-positive women to negotiate safer sex/preventive behaviors for themselves and their partners may be even greater.

Sexual coercion, especially widespread among young women, limits safer sex options. Women and girls experience an alarming rate of coerced sex (Krug et al., 2002; Pettifor et al., 2004 in AMFAR; Koenig et al., 2004). For example, a study in the Rakai District of Uganda found that one in four women experience sexual coercion at some point in their lives, coercion ranging from threats and threatening gestures, to pushing and holding down the female partner, to beating or threatening her with a weapon. Young women (up to 34 years of age) were found to be significantly more likely to experience coerced sex than older women (35 years and older) (Koenig et al., 2004). Between 4 percent (in New Zealand) and 58 percent (in the Caribbean) of women and girls report that their first sexual encounter was forced (Krug et al., 2002).

[17] Adapted from Anne Eckman, as included in the Global Women's Leadership in HIV/AIDS Workshop in Washington, DC, July 2007.

Abusive men may have greater risk of exposure to HIV and other STIs, putting female partners at risk. Data exists suggesting that abusive men are more likely to have other sexual partners unknown to their wives (Garcia-Moreno and Watts, 2000 in Campbell, 2005).

Isolation decreases access to information and services. Experiencing GBV, particularly domestic violence, can be an isolating experience for women, as such abuse takes place in the broader context of power and control over her. This isolation is likely to decrease women's access to information and services for prevention of HIV, as well as access to other women for support.

III. How does GBV affect women's access to HIV testing, treatment, care and support—and their ability to exercise leadership?

A. GBV related to HIV testing and disclosure

Testing seen as a potential sign of women's infidelity, and gender-based violence is a feared consequence. Men and women in a study in Tanzania reported that getting tested for HIV revealed lack of faith in a relationship, mistrust of a partner, and acknowledgement of one's own risky sexual behaviors. Similarly, this study also found that women's fear of negative reactions, including violence from their partner is a major barrier to getting tested (Maman et al., 2001).

Studies also show that women fear violent reactions from their partners after testing, regardless of their serostatus. In the study from Tanzania cited above, 17 percent of the HIV-positive women chose not to tell anyone that they were tested, versus 7 percent of HIV-negative women. Fifty-two percent of those who chose not to share their results said they feared violent reactions from their partner. While the majority (74%) of the women who did share their test results with their partners were met with understanding and support, blame and violence did occur (Maman et al., 2001).

Gender-based violence is a feared consequence of disclosure and is a result of disclosure for some women. In a review of 17 studies conducted in developing countries to assess the outcomes of disclosing HIV serostatus, 10 reported violence directed toward women as a reaction to disclosure at rates ranging from 3.5 percent to 14.6 percent (Medley et al., 2004). Similarly, a study conducted in the United States found that 18 percent of HIV-positive women reported disclosure-related violence, including verbal abuse and physical assault (Wyatt et al., 2002 in AMFAR, 2005).

Fear of GBV related to serostatus also affects women's infant feeding options. HIV-positive women may also fear disclosure and violence when enacting safer feeding practices to avoid transmitting HIV to their infants (ICW factsheet).

B. GBV and access to treatment and services.

Experiencing GBV may decrease HIV-positive women's access to services and adherence to treatment programs. For example, a study found that "abused women were reluctant to keep appointments if they were afraid of their partners, if they were depressed, feeling ill or 'too worn down,' or if they were ashamed of being abused. Abusive partners were sometimes reported to sabotage women's efforts to seek care, keep appointments, or take medications" (Lichtenstein, 2006 in Harvard, 2006).

Further, where there are fees for services, experience or fear of GBV may hinder women from accessing the money to pay the fees (ICW/GCWA, "Care and Treatment").

C. GBV and HIV care and support

GBV affects women's overall well-being, which poses a heavy burden on being able to live positively. Some effects of GBV include the following:

Fatal Outcomes	Non-Fatal Outcomes		
	Physical injuries and chronic conditions:	Sexual and reproductive sequelae:	Psychological and behavioral outcomes:
• Femicide • Suicide • AIDS-related mortality • Maternal mortality	• Fractures • Abdominal/thoracic injuries • Chronic pain syndromes • Fibromyalgia • Permanent disability • Gastrointestinal disorders • Irritable bowel syndrome • Lacerations and abrasions • Ocular damage	• Gynecological disorders • Pelvic inflammatory disease • Sexually transmitted infections, including HIV • Unintended pregnancy • Pregnancy complications • Miscarriage / low birth weight • Sexual dysfunction • Unsafe abortion	• Depression and anxiety • Eating and sleep disorders • Drug and alcohol abuse • Phobias and panel disorder • Poor self-esteem • Post-traumatic stress disorder • Psychosomatic disorders • Self harm • Unsafe sexual behavior

Source: Bott et al., 2005.

D. Positive women's leadership/participation

The isolation that abused women experience (Heise et al., 1999) is likely to inhibit their participation in public programs. This is a hindrance to encouraging HIV-positive women to lead and participate in health and other programs in the community.

GBV is also an issue within organizations. Women experience sexual discrimination, sexual harassment, sexual assault and even homicide at work (FVPF); this violence and harassment may be even further compounded by being HIV positive. GBV also has an effect on victims' job attendance and performance (FVPF); combined with HIV this may greatly affect an employee's performance. These issues around GBV in the workplace and HIV and GBV's effects on workers must be recognized and addressed by organizations (FVPF).

E. Cross-cutting theme: Programs' effect on women's experience of GBV

Some HIV programs may enact GBV against HIV-positive women, or may unintentionally put women at risk of GBV.

Enacted GBV is evident with sexual and reproductive health and rights of positive women. Some providers may believe that positive women should not be sexually or reproductively active—this belief can lead to violence and coercion such as

- Verbal abuse, denial of service, and humiliating treatment in delivery settings from providers of HIV-positive pregnant women (on the grounds that women have no right to be pregnant). (ICW Visibility, Voices and Visions: A Call for Action from HIV-positive women to policymakers, 2004)

Programs (especially in the context of prevention, testing, and PMTCT) may unintentionally place women at risk of GBV. For example, programs that encourage women to suggest condom use without taking into account a women's potential experience of GBV may place women at risk of GBV. As noted above,

women fear and may experience GBV as a result of disclosure of testing or a positive serostatus; as such, programs that do not account for women's realities of GBV may expose them to gender-based violence.

IV. How does GBV affect the lives of women living with HIV (beyond being a barrier to accessing prevention, testing treatment, care and support, and GIPA)?

Women living with HIV may experience GBV as a result of their status, and may experience harsher effects of GBV. Since GBV results from unequal power relations, the stigma and discrimination of being HIV positive and a woman may increase gender power imbalances and increase positive women's risk of experiencing GBV.

GBV may also be enacted in the form of economic violence, wherein spouses or families deprive positive women of housing, property, or food and nutrition (WHO, 2004; HRW, 2003; HRW, 2003a). This is gender-based violence because it is directed toward women because they are women.

Experiencing GBV as an HIV-positive woman may make it even more difficult to access support to leave an abusive situation. This higher risk of GBV among HIV-positive women may also compound barriers to gaining access to already-limited support (i.e., being able to leave an abusive situation, find shelter with others, access income/resources). Women may fear losing their children, with discrimination faced by HIV in addition to threats of control by a partner and partner's family. Also, internalized stigma and discrimination may mean that women living with HIV feel ashamed of themselves and their status, and may thus have even less confidence or sense of self-worth to leave an abusive situation.

References:

Abdool Q, Karim. 2001. "Barriers to preventing human immunodeficiency virus in women: experiences from KwaZulu-Natal, South Africa." *Journal of American Medical Women's Association* 56(4): 193–196.

AMFAR. 2005. "Gender-Based Violence and HIV Among Women: Addressing the Evidence." Issue Brief 3. Washington, DC: AMFAR.

Bensley LS, J. Van Eenwyk, K.W. Simmons. 2000. "Self-reported childhood sexual and physical abuse and adult HIV-risk behaviors and heavy drinking." *Am J Prev Med* 18(2): 151–8.

Choi, K.H.; D. Binson, M. Adelson, and J. Catania,. 1998. "Sexual Harassment, Sexual Coercion and HIV Risk among U.S. Adults 18–49 years." *AIDS and Behavior.* 2: 33–40.

Davila, Y. R. and M. H. Brackley. Mexican and Mexican American women in a battered women's shelter: Barriers to condom negotiation for HIV/AIDS prevention. *Issues Mental Health Nursing* 1999; 20(4): 333–355.

Dunkle, K., R. Jewkes, R. Brown, G. Gray, J. McIntyre, and S. Harlow. 2004. "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa." *The Lancet* 363: 1415–1421.

Family Violence Prevention Fund (FVPF). "The Facts on the Workplace and Violence Against Women." San Francisco, CA: FVPF.

Garcia-Moreno, C. and C. Watts. 2000. Violence against women: Its importance for HIV/AIDS prevention. *AIDS* 24(3): S253–S265.

Gilbert, L., N. El-Bassel, V.Rajah, J. Foleno, V. Fontdevila, B.Frye, and L Richman. The Converging Epidemics of Mood-Altering Drug Use, HIV, HCV, and Partner Violence: A Conundrum for Methadone Maintenance Treatment. *The Mount Sinai Journal of Medicine* 67 (5 and 6): 452–463, 2002.

Harvard School of Public Health. 2006. "HIV/AIDS and Gender-Based Violence Literature Review." Boston, MA: Harvard School of Public Health, Program of International Health and Human Rights.

Heise, Lori, Mary Ellsberg, and Megan Gottemoeller. 1999. "Ending Violence Against Women." *Population Reports* XXVII, Number 4, Series L, Number 11.

Human Rights Watch. 2003. *Just Die Quietly: Domestic violence worsens vulnerability to AIDS in Uganda*. New York: Human Rights Watch.

Human Rights Watch. 2003a. *Double Standards: Women's Property Rights Violations in Kenya* New York: Human Rights Watch.

International Community of Women Living with HIV (ICW). Visibility, Voices and Visions: A Call for Action from HIV positive women to policy makers, 2004.

International Community of Women Living with AIDS (ICW) and Global Coalition on Women and AIDS (GCWA). "Access to Care, Treatment and Support." London: ICW.

Karim QA, Karim SS, Soldan K, Zondi M. 1995. "Reducing the risk of HIV infection among South African sex workers: Socioeconomic and gender barriers." *Am J Public Health* 85(11): 1521–5.

Koenig, Michael, Iryna Zablotska, Tom Lutalo, Fred Nalugoda, Jennifer Wagman and Ron Gray. 2004. "Coerced First Intercourse and Reproductive Health Among Adolescent Women in Rakai, Uganda." *International Family Planning Perspectives* 30(4).

Krug, EG, et al. 20002. WHO *World Report on Violence and Health.* Geneva: World Health Organization.

Lichtenstein, B. 2006." Domestic Violence in Barriers to Health Care for HIV-Positive Women." *AIDS Patient Care and STDs* 20(2): 122–32.

Maman, S., J.K. Mbwambo, N.M. Hogan, G.P. Kilonzo, J.C. Campbell, E. Weiss, M.D. Sweat. 2002. "HIV-positive women report more lifetime partner violence: findings from a voluntary counseling and testing clinic in Dar es Salaam, Tanzania." *Am J Public Health.* 92(8): 1331–7.

Maman, S., J. Mbwambo, N.M. Hogan, G.P. Kilonzo, and M.D. Sweat. 2001. "Women's barriers to HIV-1 testing and disclosure: challenges for HIV-1 voluntary counseling and testing." *AIDS Care* 13(5): 595–603.

Maman, Suzanne, Jessie Mbwambo, Margaret Hogan, Gad Kilonzo, Michael Sweat, and Ellen Weiss. 2001. *HIV and Partner Violence: Implications for HIV Voluntary Counseling and Testing Programs in Dar es Salaam Tanzania*. Washington, DC: The Population Council, Inc.

Maman, S. et al. 2000. "The intersections of HIV and violence: Directions for future research and interventions. *Social Science and Medicine* 50(4): 459–78.

Medley A, et al. 2004. “Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries: Implications for prevention of mother-to-child transmission programmes.” *Bull World Health Organ*. 82(4): 299–307

Pettifor A., et al. 2004. *HIV and Sexual Behaviour Among Young South Africans: A National Survey of 15-24 Year Olds.* Johannesburg, South Africa: Reproductive Health Research Unit of the University of Witwatersrand.

Rothschild, Cynthia, Mary Anne Reilly, and Sarah A. Nordstrom. 2006. “Strengthening Resistance: Confronting Violence against Women and HIV/AIDS.” New Brunswick, NJ: Center for Women’s Global Leadership.

Thompson, N.J. et al. 1997. “The relationship of sexual abuse and HIV risk behaviors among heterosexual adult female STD patients.” *Child Abuse Negl* 21(2): 149–56.

Wingood, G.M.; R.J. DiClemente. The Effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African-American Women. *American Journal of Public Health.* 1997; 87: 1016–1018.

Wood, K. and R. Jewkes.1997. “Violence, Rape, and Sexual Coercion: Everyday Love in a South African Township.” *Gender and Development.* 5(2): 41–6.

Woods, A. B., G. Page, P. O’Campo, L. Pugh, D. Ford, and J.C. Campbell. (In review). The Mediation Effect of Post-Traumatic Stress Disorder Symptoms on the Relationship of Intimate Partner Violence and IFN-γ Levels.

World Health Organization. 2004. “HIV/AIDS: Meeting the Challenge.” New Delhi: WHO Regional Office for Southeast Asia.

Worth, D. 1989. “Sexual decision-making and AIDS: Why condom promotion among vulnerable women is likely to fail.” *Stud Fam Plann* 20(6 Pt 1): 297–307.

Wyatt, D. Chin and N. Presley. 2002. “Does a history of trauma contribute to HIV risk for women of color? Implications for prevention and policy.” *Am.J.Public Health* 92(4): 660–665.

Zierler S, et al. 1991. “Adult survivors of childhood sexual abuse and subsequent risk of HIV infection.” *Am J Public Health* 81(5): 572–5.

VULNERABLE POPULATIONS TO GBV AND HIV

Vulnerable populations are those that can easily be attacked by some danger. In the context of GBV and HIV, these are populations in some sort of disadvantaged situation who therefore are easily manipulated, forced, or coerced into sexual activities that expose them to the risk of HIV infection. They can include those taken advantage of by people they trust or by others authorized by society, religion, or the state to protect them. These groups include the following:

- Refugees fleeing their countries as a result of civil strife or war
- Persons displaced by natural disasters, ethnic cleansing, or civil strife
- Trafficked and/or migrant girls and women
- Children
- Women and girls living in conflict settings
- Girls and women forced to undergo harmful traditional practices, such as female genital
- cutting, child marriages, widow inheritance, or payment of dowry
- Commercial sex workers

Women in these vulnerable populations are at particular risk for gender-based violence and HIV infection.

Refugees	**Conflict situations**	**Camps for internally displaced populations**	**Sex workers**	**Girls**
Women and girls are sometimes forced to exchange sex for food.	Women and girls can be subjected to rape, including gang rape, forced marriages, sexual slavery, and other forms of violence.	Camps can foster alcohol abuse, poverty, and inactivity, all of which are factors contributing to GBV.	Women and girls are not always in positions to negotiate safe sex, especially when circumstances are the result of trafficking or extreme poverty.	Women who were abused in childhood may be at risk for GBV later in life.

ANALYZING FAITH BELIEFS RELATED TO GBV AND HIV

1. Break into small groups based on religion. If there are too many participants of one faith, separate into smaller groups. There should be about four members per group.

2. Using your own religious materials, examine your religion's texts and/or beliefs and discuss the following with your group:

   - The ways in which these texts/beliefs **perpetuate gender-based violence**; and
   - The ways in which these texts/beliefs call believers to help **address gender-based violence and/or HIV.**

3. As a group, select 2–3 examples for both a. and b. and discuss. You will have 40 minutes for this part of the activity.

4. Prepare to report back to the larger group.

5. After the report, there will be a large group discussion on the following questions:

   - Did your group disagree on any of the examples you discussed?
   - Have you heard your religious leaders use these texts as illustrations in discussing GBV and HIV?
   - How can these examples facilitate discussion of these issues with your own religious organizations or communities?

CASE STUDY: A WOMAN AT CLOSED CROSSROADS

A woman who is a mother of three girls has been unable to provide her husband with a son. While she is happy with her daughters, her husband is upset that he does not have a son. He wants a son to carry on the family. Frustrated with the situation, the husband frequently hits his wife and yells at her for not being a good wife. When drunk, he often yells and hits his daughters as well.

One day, the husband tells her he is divorcing her for a woman who is pregnant with his child. He expects her to have a son. He tells her he never wants to see her again and she should go back to her family. The woman has no choice but to leave her husband and return to her father's home, where before his death, he had allocated her two acres of land. Her brothers were not happy that she had inherited this land, arguing that women are not capable of managing the land. When they see her returning home, they do not allow her to stay in their homes with them. They also threaten to remove her from the land.

At the same time, her next door neighbor, a very rich man, keeps letting his cows wander from his compound and destroy her vegetables and other produce. The woman reports the matter to the local Chief, who refuses to listen to her, saying that women can never be owners of land according to local customs. She wants to take the case to court but cannot afford the services of a lawyer and does not know if she had a legal standing.

In the meantime, her local church, in which her rich neighbor is a prominent elder, refuses to baptize her children and bars her from receiving Holy Communion on the grounds that she is a divorced woman. Church elders often ignore her at worship.

Her daughters have been expelled from school, as they had been enrolled in the name of their grandfather as a cover for building funds and other costs. The church also bars her from joining and participating in the activities of the church's women group, even though she was a strong and capable youth leader before her marriage. The church elder is considering not baptizing her youngest daughter until her marital status is clear.

Discussion Questions

1. Why is the woman said to be at a "closed crossroads?"
2. What forms of GBV are evident in this case?
3. What reasons explain this state of affairs?
4. Explain the vulnerability of this woman and her daughters to other forms of GBV and HIV.
5. How could the religious communities address this woman's problems and assist her and her family?
6. What could your religious community do?

DAY 2 EVALUATION

1. Evaluate the degree to which the session objective was achieved. Please circle a number (1 indicating "not achieved" and 5 indicating "achieved").

   1----------2----------3----------4----------5

2. Rate the usefulness of the session to your work as a faith leader. Please circle a number (1 indicating "not useful" and 5 indicating "useful").

   1----------2----------3----------4----------5

3. Which activity contributed most to your learning?

4. Which activity contributed least to your learning?

5. Additional comments or suggestions:

DAY 3

SESSION 4: MOVING FORWARD—APPROACHES TO MOBILIZING COMMUNITIES OF FAITH TO ADDRESS GBV (5.5 HOURS)

Learning Objectives

At the end of this session, participants should be better able to

- Identify effective advocacy approaches to secure the support of faith leaders in addressing GBV and HIV.
- Design an action plan that serves to mobilize communities of faith to address GBV and HIV.

Preparation

- Day 3 agenda on flipchart or PPT
- PPT on "The Advocacy Process," which can be found at: www.healthpolicyinitiative.com .

Materials

- Flipcharts and markers
- Tape for hanging flipcharts
- Handout—A Young Girl's Marriage (page 43)
- Handout—What Religious Communities Can Do to Address GBV (page 44)
- Handout—Guiding Principles in GBV Programming (page 48)
- Handout—Sample Matrix for Action Planning (page 50)
- Handout—Day 3 Evaluation (page 51)
- Handout—Overall Evaluation (page 52)
- PPT on Advocacy Process

Reflection (5 minutes)

Ask a participant to lead the group in a reflection. You can use examples included in Annex II.

Welcome and Recap (10 minutes)

1. Welcome the participants back. Ask them to recap key issues of the previous day.
2. Review the agenda for Day 3.

Activity 1: Advocacy Overview (65 minutes)

1. Explain to the participants that you are going to review the advocacy process, which can be used to gain support for addressing GBV and HIV. Note that this is an overview and you understand that many of them probably have initiated their own advocacy activities already.
2. Present "The Advocacy Process" PPT to the participants. Divide the participants into small groups with about 5 people per group. Distribute the "Young Girl's Marriage" handout (page 43) and ask them to read it and discuss the following concepts:

- What the women were advocating for
- How they were successful
- How the religious leader undertook advocacy

3. With the small groups still together, briefly review their responses to these questions, asking participants also to discuss how this example of advocacy relates to what was presented in the PPT.
4. Ask the small groups to discuss briefly their own advocacy success stories, if they have any, using "A Young Girl's Marriage" as an example. The success story can be related to any topic—it does not have to focus on GBV or HIV.
5. After 10 minutes, have one person per group share her/his story with the larger group. Emphasize how he/she undertook advocacy and what may have been achieved.

Activity 2: Action Planning: How FBOs can Address GBV and HIV (3.5 hours)

1. Divide the participants into groups to begin action planning. If this is a regional training, you can divide them into groups by country. If this is a country-specific training, you can divide them based on individuals who may be working with each other to implement action plans (by religion or by location, for example).
2. Distribute the handouts on what religious communities can do and guiding principles in GBV programming (pages 43–49), telling participants that we are going to look at concrete things we can do in our own communities to address GBV and HIV.
3. Ask the groups to review the handouts. After 5 minutes, ask the participants which actions stand out, and why.
4. Distribute the handout on action planning (page 50). Briefly review the handout with the whole group and ask for questions.
5. When you are done discussing the handouts, ask the groups to brainstorm their own action planning related to GBV and HIV, deciding on a focus or objective. Explain what level of support you (or the overall project) will be able to offer them. Once they have an objective, they should develop detailed action plans in their groups. They will have 90 minutes for this.
6. While the groups are brainstorming and planning, walk around and check in with them. Ask if they need any help or feedback. Remind groups that they must focus on activities they can realistically implement, such as setting up referral systems with community resources.
7. After 90 minutes, ask participants to make presentations in plenary on various activities and to discuss what role they can play in those activities and the kind of support they expect from others. Ensure that participants develop a practical and feasible strategy that clearly marks the roles and responsibilities of everyone involved in the action plan. They also should integrate a possible timeline and a monitoring and evaluation plan into the action plan.
8. Ask the group to provide feedback for each presentation.

Facilitator's Notes:

- Encourage participants to look at their current activities and consider adding a GBV component to them, if possible. For example, existing HIV programs could be altered to include a GBV component.

- If participants choose to undertake trainings in their action plans, help them think clearly about the training as part of a process that includes working with communities to address the issue there.
- The facilitator should prepare a sample/model action plan beforehand to demonstrate to the participants.

Activity 3: Close and Evaluation (45 minutes)

1. Ask the participants if they have final questions or comments. Ask them what key points they learned from this workshop, and generate responses.
2. Make final remarks and ask participants to please complete the workshop evaluations (pages 51–52) before they leave. Distribute the evaluations and collect as they leave.
3. Thank the group for their enthusiasm, energy, and participation.

END OF DAY 3

DAY 3 HANDOUTS

A YOUNG GIRL'S MARRIAGE

This is the story of a young girl in Tanzania who was to be married off by her father so that he could get money to educate his other children. Her father arranged her marriage to a 45-year old man, who agreed to pay a bride price of 45 cows. As part of the marriage celebration, the father planned a feast and invited guests from the village to come celebrate and witness the girl's marriage to the man.

In this village, a few women were upset that this young girl was going to marry this man. They believed she should be going to school rather than marrying the man. They knew that this man had kept company with many women and believed that the young girl would face many difficulties if she married him.

Knowing that their local Bishop was going to attend the feast and knew the girl's father well, the women decided to approach the Bishop to discuss their concerns about this marriage. They met with him a week before the feast and argued that the girl also deserved an education and was too young to marry this man. They explained the health consequences that the girl could face in marrying this man.

The Bishop understood the women's argument but was not sure he wanted to get involved in the family's business. Young girls often married older men in their village. He said he would think about the matter but was not sure he would try to do anything about it. The women took his answer and because they felt so strongly, returned to him every day for the rest of the week to speak about the matter.

The day before the feast, the Bishop decided he agreed with the village women. He went to the girl's father and spoke to him about the girl. He knew the father faced economic difficulties and could not afford to educate or support the girl. He offered to assist the family in placing the girl in a boarding school. The father was not sure his daughter deserved this, but the Bishop convinced him that she should go to this school.

The following week, the Bishop began to speak about early marriage within the church. He included the topic in his sermon, arguing against the practice. After worship, many villagers stood outside the church and talked about his sermon.

This story was adapted from one told by a Bishop from Tanzania.

Discussion Questions

1. What were the women advocating for?
2. How were they successful?
3. How did the religious leader undertake advocacy?

WHAT RELIGIOUS COMMUNITIES CAN DO TO ADDRESS GENDER-BASED VIOLENCE[18]

1. Commit to making the problem of gender-based violence a critical concern.

- Emphasize the teachings, practices, and organizational structures that promote a woman's right to be free from violence, such as teachings that support equality and respect for women and girls.
- Develop theologically-based materials that emphasize a woman's right to safety and support and a perpetrator's personal responsibility for ending the violence.
- Adopt policies developed by religious leaders that outline appropriate responses to survivors and perpetrators of violence and educate leaders about child abuse reporting requirements, the importance of confidentiality, and other safety issues.
- Support local advocacy programs that provide services to survivors by encouraging faith communities to donate time, money, and other material resources.

2. Ensure that religious, spiritual, and faith-based communities are safe environments to allow survivors of violence to discuss their experiences and seek healing.

- Encourage members and leaders of churches, synagogues, mosques, and other spiritual or faith-based groups to seek training on survivor experiences and on support that will restore and heal the survivor.
- Create opportunities for survivors to discuss their experiences and needs. Form support groups in collaboration with local sexual assault and domestic violence programs for women who desire faith- or spirituality-based healing.
- Encourage members to discuss sexual assault, dating and domestic violence, and stalking within their faith communities in a manner sensitive to their cultures and backgrounds.
- Create or provide materials that address survivors' concerns and offer informed referrals to various advocacy organizations.
- Encourage men, particularly leaders in the community, to speak out and use their influence to communicate intolerance for gender-based violence in all forms.
- Emphasize teachings and practices that promote equality and respect for both women and men.
- Integrate information on gender-based violence into existing activities.

3. Develop strategies to address the needs of all women and girls exposed to violence.

- Include members of specific ethnic and cultural groups in discussions of community efforts addressing violence.
- Seek advice from various age groups within communities on ways to address violence.
- Organize youth ministry and leadership groups to educate young people about the dynamics, impact, and prevention of gender-based violence.

[18] Adapted from the *Toolkit to End Violence against Women.* 2001. The National Advisory Council on Violence Against Women and the Violence Against Women Office. Available at: http://toolkit ncjrs.org/.

- Inform leaders about the particular vulnerabilities of older people and people with disabilities who may be dependent on abusive partners or caregivers.
- Seek appropriate training and legal assistance before advising immigrant victims so as to avoid potentially compromising their citizenship status.

4. Develop and refine guidelines and protocols for responding to gender-based violence related to members of the congregation or community.

- Encourage support for a survivor's continued inclusion in the community of her choice if the perpetrator is from the same community, including respecting emotional and physical safety considerations and no-contact orders.
- Consider the emotional and physical safety of survivors and any dependents affected by violence, including elderly relatives and children.
- Encourage youth workers to receive training on child abuse reporting requirements and local child welfare practices.
- Encourage congregations, religious community centers, and other religious institutions to adopt policies for employees, members, and participants who may be survivors or perpetrators of violence.

5. Create opportunities for youth to develop healthy and appropriate interpersonal relationships in the context of their religious, spiritual, or faith-based traditions.

- Consider conducting background checks of volunteers and staff who work with youth to try to ensure that they have not been perpetrators of physical or sexual violence.
- Invite youth to participate in the design and evaluation of programs that address their needs, such as writing and designing multimedia materials on safety and healthy relationships.
- Train youth to support survivors and to constructively confront peers about gender-based violence.[19]

6. Institutionalize efforts to address gender-based violence by educating, training, and supporting community leaders.[13]

- Develop or expand core curriculums on gender-based violence in the basic education for religious leaders, including theory- and practice-oriented coursework such as counseling or pastoral care.
- Create and support continuing education programs on violence against women.
- Develop and disseminate educational materials, regionally and nationally, about religious programming that addresses gender-based violence.
- Work with religious educational institutions to teach religious leaders how to develop programs that address gender-based violence in religious communities.
- Partner with secular advocacy and direct service programs for consultation, support, or joint programming.

[19] Please note that these types of activities require external expertise or additional technical resources. For training on GBV, see manuals such as Raising Voices' "Rethinking Domestic Violence," available at: http://www.raisingvoices.org/women/domestic_violence.php.

7. Draw on the resources of secular survivor service, advocacy, and perpetrator treatment programs to enhance community responses to gender-based violence.

- Network with survivor service and advocacy programs to locate religious and secular allies on the local, regional, state, and national levels.
- Use the resources of other religious groups and existing GBV survivor advocacy organizations to develop policies, protocols, and educational materials appropriate to specific traditions.
- Learn about local secular community protocols for handling GBV.
- Make appropriate and informed referrals to local secular programs that have the expertise to help survivors or perpetrators, including the legal community, healthcare system, and child welfare system.
- Collaborate with perpetrator treatment programs to hold perpetrators accountable for their violence.

SUMMARY

Become a safe place. Make the church, temple, mosque, or synagogue a safe place for survivors of gender-based violence. Display materials that include local and national hotlines or other resources for GBV.

Educate your faith community. Routinely include instructional information in monthly newsletters, on bulletin boards, and in marriage preparation classes and sponsor educational seminars on GBV.

Speak out. Speak out about gender-based violence in your faith community. A faith leader can have a powerful impact on people's attitudes and beliefs, and his or her leadership is important, particularly on public policy issues, such as funding and changes in criminal law.

Lead by example. Volunteer to serve on the board of directors at the local gender-based violence program or train to become a crisis volunteer.

Offer space. Offer meeting space for educational seminars and weekly support groups.

Partner with existing resources. Include local GBV programs in donations and community service projects. Adopt a shelter for which the church, temple, mosque, or synagogue provides material support or provide similar support to families as they rebuild their lives following a shelter stay. Provide referrals to health and legal centers.

Prepare to be a resource. Seek out training from professionals in the fields of gender-based violence and HIV. Do the theological and scriptural homework necessary to better understand and respond to these issues.

Intervene. If there are suspicions that violence is occurring in a relationship or a family, speak to each person separately. If an individual is being or has been abused, speak to her privately. Help the survivor plan for safety and refer her to available community resources. (Note: To intervene, one must seek out training from professionals in gender-based violence first to ensure that one's involvement does not cause harm to the survivor.)

Support professional training. Encourage and support training and education for faith leaders to increase their awareness of GBV and HIV.

Address internal issues. Encourage continued efforts by religious institutions to address allegations of abuse within their own institutions to ensure a safe resource for survivors and their children.

GUIDING PRINCIPLES IN GBV PROGRAMMING[20]

Work in the area of GBV requires careful consideration of the ethical principles of confidentiality, privacy, informed consent, and issues of disclosure. Given the potential risks to survivors, available data on ‘‘good practice’’ in this field suggest that organizations should follow some basic principles when designing and implementing GBV initiates. In general, the principles of ‘‘doing no harm’’ should guide every decision. More specific principles include:

Ensure that all activities respect survivors' safety and autonomy first and foremost

- Encourage programs and health providers to address GBV with clients only after sensitization, ongoing training, and monitoring, to guarantee providers' appropriate attitudes and actions and clients' privacy and confidentiality.
- Encourage programs and providers to inform women of their options and to allow them to make their own decisions without undue influence from providers.
- If health organizations are not equipped to address violence directly during medical consultations, they should find other ways to assist clients experiencing abuse.
- Whenever possible, involve women and communities in the design, implementation, and evaluation of interventions.

Ensure the relevance and appropriateness of interventions to the local setting

- Conduct a situational analysis before designing any interventions.
- Ensure the cultural appropriateness of interventions, especially when adapting initiatives originally implemented in other settings.
- Support the collection and dissemination of local data for the purposes of sensitization and advocacy.

Employ both public health and human rights perspectives

- Use existing data to highlight the magnitude and the health effects of gender violence.\
- Do not allow ‘‘culture’’ or ‘‘tradition’’ to be used to justify GBV; rephrase the issue as a public health problem and a human rights violation.
- Challenge norms that view domestic violence as acceptable or as a private matter.
- Promote the idea that human rights are inalienable and indivisible, so women should have the right to live free of violence under all circumstances.
- Empower communities to challenge norms that condone violence.

Encourage multisectoral interventions at multiple levels

- Carry out situational analyses to identify local organizations active in GBV and decide strategically on a course of action.

[20] IGWG of USAID. 2008. *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers.* Second Edition. Washington, DC. Sources: Various Demographic and Health Surveys, 1998–2007. www.measuredhs.com.

- Work in collaboration with organizations from various sectors and with programs focusing on other areas.
- Support initiatives at both local and national levels.

Invest in evaluation both for the sake of assessing results and for protecting survivors' safety

- Ensure that programs are based on lessons learned from the field about best practices.
- Monitor and evaluate GBV initiatives as rigorously as possible.
- Involve women and other program beneficiaries in the evaluation process whenever possible.
- Document and disseminate lessons learned as widely as possible.

SAMPLE MATRIX FOR ACTION PLANNING

Activity/program you've proposed	How do you want to conduct the planned activity?	Where and with whom?	Indicators of progress	How can we assess change among the target audience?	Means of verification	Timeframe

DAY 3 EVALUATION

1. Evaluate the degree to which the session objective was achieved. Please circle a number (1 indicating “not achieved” and 5 indicating “achieved”).

   1----------2----------3----------4----------5

2. Rate the usefulness of the session to your work as a faith leader. Please circle a number (1 indicating “not useful” and 5 indicating “useful”).

   1----------2----------3----------4----------5

3. Which activity contributed most to your learning?

4. Which activity contributed least to your learning?

5. Additional comments or suggestions:

OVERALL EVALUATION

1. Were the workshop materials clear and easy to understand?

2. Please tell us what you found most useful in the workshop and why.

3. How will you use the knowledge and skills gained from the workshop in your work?

4. Please comment on the workshop methodology.

5. How might we improve the workshop in the future?

6. Additional comments or suggestions:

ANNEX 1: SAMPLE THREE-DAY TRAINING AGENDA

Day 1	Time
Workshop Overview - Welcome - Silent reflection - Activity 1: Shared Faith Values—Participant Introductions - Activity 2: Workshop Agenda - Exchange of peace	8.30am–9.45am
Session 1: Exploring GBV - Activity 1: Defining GBV and Related Terms	9.45am–10.30am
Tea Break	10.30am–11.00am
Session 1 continued - Activity 2: Personal Beliefs/Reflections on GBV—"Vote with Your Feet" - Activity 3: Prevalence of GBV	11.00am–12.30pm
Lunch	12.30pm–1.30pm
Session 1 continued - Activity 4: Factors in Perpetuating Violence	1.30pm–2.30pm
Tea Break	2.30pm–3.00pm
Session 1 continued - Activity 5: Film (suggested/optional activity) - Activity 6: Daily Evaluation	3.00pm–4.30pm

Day 2	Time
Session 2: Linking GBV and HIV - Reflection - Welcome and recap - Activity 1: Women's Vulnerability to HIV - Activity 2: Links between GBV and HIV	8.30am–10.45am
Tea Break	10.45am–11.15am
Session 2 continued - Activity 3: Types of Vulnerable Populations to GBV and HIV - Activity 4: GBV in Conflict Settings (suggested/optional activity)	11.15am–1.00pm
Lunch	1.00pm–2.00pm
Session 3: Multi-religious Approach to	

GBV and HIV - Activity 1: Analyzing Faith Beliefs Related to GBV and HIV	2.00pm–3.30pm
Tea Break	3.30pm–4.00pm
Session 3 continued - Activity 2: Religious Community Responses to GBV - Activity 3: Daily Evaluation	4.00pm–5.30pm

Day 3	Time
Session 4: Moving Forward—Approaches to Mobilizing Communities of Faith - Reflection - Welcome and recap - Activity 1: Advocacy Overview	8.30am–9.45am
Tea Break	9.45am–10.15am
Session 4 continued - Activity 2: Action Planning—How FBOs can Address GBV and HIV	10.15am–12.45pm
Lunch	12.45pm–1.45pm
Session 4 continued - Activity 2 continued - Activity 3: Close and Evaluation	1.45pm–3.30pm

ANNEX 11: SAMPLE PRAYERS AND REFLECTIONS

ISLAMIC PRAYER

Reflection Prayer

In the name of Allah, the Most gracious the Most merciful

All praise be to you, the cherisher and sustainer of the world.

Most compassionate and merciful.

Almighty Allah we thank you for making the beginning of the workshop sound and good.

We therefore ask you to make the middle of it prosperous and the end of it successful.

This can only be possible with your will because you are the only one who has made it possible for us to meet again in good health this morning.

You are the only one we worship and seek your guidance in our deliberations during this workshop.

Show us the straight way, the way of those whom you have bestowed your grace, not the way of those who have gone astray.

In your name we pray.

Amen.

JEWISH PRAYER: UNIVERSAL PRAYER FOR PEACE

In the name of Almighty God, The Most Gracious, The Most Kind
We, the people come in prayer to the source of all Justice, Truth, and Peace on behalf of our cities, our nation, our world.

We ask you; Help us to accept the challenge of AIDS,
To protect the healthy and calm the fearful,
To give courage to those in pain,
To embrace the dying and comfort the bereaved,
To care for the orphans and support all those in need,
Unite us in your love and free us from fear.

Make us instruments of your Peace
Where there is ignorance and superstition,
Let there be enlightenment and knowledge.
Where there is prejudice and hatred,
Let there be acceptance and love.
Where there is fear and suspicion,
Let there be confidence and trust.
Where there is tyranny and oppression,
Let there be freedom and justice.
Where there is poverty and disease,
Let there be prosperity and health.
Where there is strife and discord,
Let there be harmony and peace.
Our world is sustained by three things: justice, truth, and peace.

May we by our thoughts, works, deeds hasten the time when wrong and violence shall cease,
That there may be justice in the land, truth amongst all its people and peace established throughout the earth.

May peace prevail on earth! Amen.

HINDU PRAYER: UNIVERSAL PRAYER

O adorable Lord of mercy and love,
Salutations and prostrations unto thee;
Thou art omnipresent, omnipotent, and omniscient;
Thou art Satchidananda;
Thou art Indweller of all beings.
Grant us an understanding heart,
Equal vision, balanced mind,
Faith, devotion and wisdom.
Grant us inner spiritual strength to resist temptations

And to control the mind
Free us from egoism, lust, greed, anger, and hatred,
Fill our hearts with divine virtues.
Let us behold thee in all these names and forms;
Let us serve Thee in all these names and forms;
Let us ever remember Thee;
Let us ever sing Thy glories;
Let Thy Name be ever on our lips;
Let us abide in Thee forever and ever.
Shanti! Shanti! Shanti!

CONSULTED DOCUMENTS AND OTHER RESOURCES

Bott, S., A. Guedes, M. C. Claramunt, and A. Guezmes. 2004. *Improving the Health Sector Response to Gender-based Violence: A Resource Manual for Health Care Professionals in Developing Countries.* New York: International Planned Parenthood Federation, Western Hemisphere Region. Available in English and Spanish at: http://www.hrhresourcecenter.org/node/1385.

Campbell, J.C. 2002. "Health Consequences of Intimate Partner Violence." *Lancet* 359: 1331–1336.

Campbell, J. C. and K. L. Soeken. 1999. "Forced Sex and Intimate Partner Violence: Effects on Women's Risk and Women's Health." *Violence against Women* 5(9): 1017–1035.

Ellsberg, M., L. Heise, R. Pena, S. Agurto, and A. Winkvist. 2001. Researching Domestic Violence against Women: Methodological and Ethical Considerations. *Studies in Family Planning* 32(1): 1–16.

Family Violence Prevention Fund. 2005. *Toolkit for Working with Men and Boys.* San Francisco: Family Violence Prevention Fund. Available at: http://toolkit.endabuse.org/Home.html.

The FORUM. 2007. *Addressing the Impact of Gender-Based Violence on Sexual Reproductive Health and HIV/AIDS through Religion, Culture and Human Rights*. Summary Report on Capacity Building and Research Undertaken by Partners, September 2004–February 2007, by The African Forum of Faith-Based Organizations on Reproductive Health and HIV/AIDS.

The Global Coalition on Women and AIDS. N.d. "Intimate Partner Violence and HIV/AIDS. Violence against Women and HIV/AIDS: Critical Intersections." *Information Bulletin Series* Number 1. Available at: http://www.who.int/gender/violence/en/vawinformationbrief.pdf.

The Global Coalition on Women and AIDS. 2003. *Stop Violence against Women Fight AIDS.* Issue 2. Geneva: UNAIDS. Available at: http://womenandaids.unaids.org/themes/docs/UNAIDS%20VAW%20Brief.pdf.

Garcia-Moreno, C, H.A.F.M. Jansen, M. Ellsberg, L. Heise, and C. Watts 2005. *WHO Multi-country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses.* Geneva: WHO. Available at: http://www.who.int/gender/violence/who_multicountry_study/en/index.html.

General Assembly. 2006. *In-Depth Study on All Forms of Violence against Women: Report of the Secretary General*. A/61/122/Add.1. 6 July 2006.

Guedes, A. 2004. *Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: A Literature Review*. Washington, DC: USAID, Bureau for Global Health. Available at: http://www.prb.org/pdf04/AddressGendrBasedViolence.pdf.

Harvard School of Public Health. 2006. *HIV/AIDS and Gender-based Violence (GBV)/Literature Review*. Boston, MA: Department of Population and International Health, Harvard School of Public Health. Available at: http://www.hsph.harvard.edu/pihhr/files/Final_Literature_Review.pdf.

Heise, L., M. Ellsberg, M. Gottemoeller. 1999. "Ending Violence against Women." *Population Reports* Series L, No. 11. Baltimore, Maryland: Johns Hopkins University School of Public Health, Population Information Program.

Herstad, Britt. 2009. *A Call to Act: Engaging Religious Leaders and Communities in Addressing Gender-based Violence and HIV*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Herstad, Britt. 2009. *The Role of Religious Communities in Addressing Gender-based Violence and HIV*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Interagency Gender Working Group (IGWG). N.d. *Gender and HIV/AIDS* training module. Available at: http://www.igwg.org/training/GenderHIVAIDS.aspx.

IGWG. N.d. *Gender-based Violence and Reproductive Health* training module. Available at: http://www.igwg.org/training/genderbasedviolence.aspx.

IGWG of USAID. 2006. *Addressing Gender-Based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers.* Washington, DC.
Available at: http://www.prb.org/pdf05/GBVReportFinal.pdf.

International Community of Women Living with HIV/AIDS (ICW) and the Global Coalition on Women and AIDS (GCWA). *Violence against HIV-positive Women*.
Available at: http:// www.icw.org/files/VAW-ICW%20Fact%20 sheet-06.doc.

Jewkes, R. 2002. "Intimate Partner Violence: Causes and Prevention." *Lancet*, 359: 1423–1429.

Johnston, T. 2003. *Kenyan Women: Lifetimes of Abuse: A Study of Women Reporting Multiple Abuse: A Briefing Book.* Nairobi: Population Communication Africa, in Association with Ford Foundation, the National Council of Women of Kenya (NCWK), and the Canadian International Development Agency's Gender Equity Support Project (CIDA/GESP).

Johnson, T., J. Seth-Smith, and C. Beacham. 2003. *Kenya Gender Facts and Figures: Gender Abuse and Violence*. Population Communication Africa in Association with CIDA/GESP. Nairobi: Government Printer.

Johnston, T. 2002a. *Violence and Abuse of Women and Girls in Kenya: A Briefing Book*. Nairobi: Population Communication Africa, in Association with Ford Foundation, NCWK, and CIDA/GESP.

Johnston, T. 2002b. *Kenyan Men: Violence and Abuse: A Briefing Book*. Nairobi: Population Communication in Africa Association with Ford Foundation, NCWK, and CIDA/GESP.

Johnston, T. 2002c. *Domestic Abuse in Kenya: A Briefing Book.* Nairobi: Population Communication in Africa Association with Ford Foundation, NCWK, and the CIDA/GESP.

Krug, E.G., L. L. Dahlberg, J. A. Mercy, A.B. Zwi, and R. Lozano. 2002. *World Report on Violence and Health*. Geneva: World Health Organization

Maman, S., J. Mnwambo, J. C. Campbell, M. Hogan, G. P, Kilonzo, E. Weiss, and M. Sweat. 2002. "HIV-1 Positive Women Report More Lifetime Experiences with Violence: Findings from a Voluntary HIV-1 Counseling and Testing Clinic in Dar es Salaam, Tanzania." *American Journal of Public Health* 92(8):1331-1337.

Michau, L. and D. Naker (Eds.). 2004. *Preventing Gender-Based Violence in the Horn, East and Southern Africa: A Regional Dialogue*. Raising Voices and UN-HABITAT, Safer Cities Programme.

Available at: http://www.raisingvoices.org/publications.php.

Michau, L. and D. Naker. 2003. *Mobilizing Communities to Prevent Domestic Violence: A Response Guide for Organizations in East and Southern Africa*. Nairobi: Raising Voices.
Available at: http://www.raisingvoices.org/publications.php.

POLICY Project. 2006. *Policy Reform to Meet Access-to-Treatment Goals: HIV-Positive Women's Access to Care, Treatment, and Support (ACTS) in Swaziland*. Washington, DC: POLICY Project.

Raising Voices. "Circles of Influence." 2009. PREP Module of *The Sasa! Activist Kit* Kampala: Raising Voices.

Religions for Peace. 2009. *Restoring Dignity: A Toolkit for Religious Communities to End Violence Against Women.* New York: Religions for Peace.

Reproductive Health Response in Conflict (RHRC). 2004. *Gender-based Violence Tools Manual.*
Available at: http://www.rhrc.org/resources/gbv/gbv_tools/manual_toc.html.

Republic of Kenya. 2004. *National Guidelines on Medical Management of Rape/Sexual Violence.*
Nairobi: Ministry of Health, Republic of Kenya.

Thomson, M., I. Arias, K. Baside, and S. Desai. 2002. "The Association between Childhood Physical and Sexual Victimization and Health Problems in Adulthood in a Nationally Representative Sample on Women." *Journal of Interpersonal Violence* 17(10): 1115–1129.

Toolkit to End Violence against Women. 2001. The National Advisory Council on Violence Against Women and the Violence Against Women Office. Available at: http://toolkit.ncjrs.org/.

United Nations Population Fund Gender Theme Group. 1998. *Violence against Girls and Women: A Public Health Priority*. UNFPA Gender Theme Group, Interactive Population Center.

UN Secretary General. 2003. *Secretary-General's Bulletin: Special Measures for Protection from Sexual Exploitation and Sexual Abuse.* ST/SGB/2003/13. New York: UN Secretary General.
Available at: http://www.unhcr.org/refworld/docid/451bb6764.html.

UN Theme Group on HIV and AIDS. 2006. *Violence against Women and Girls in the Era of HIV/AIDS: A Situation and Response Analysis in Kenya*. Nairobi: UNAIDS Kenya. Available at:
http://data.unaids.org/pub/Report/2006/20060630_GCWA_RE_Violence_Women_Girls_Kenya_en.pdf

UNAIDS, UNFPA, and UNIFEM. 2004. *Women and HIV/AIDS: Confronting the Crisis*. New York. UNAIDS/UNFPA/UNIFEM.
Available at: http://www.unfpa.org/upload/lib_pub_file/308_filename_women_aids1.pdf.

Vann, B. 2002. *Gender-Based Violence: Emerging Issues in Programs Serving Displaced Populations.* New York: The Reproductive Health for Refugees Consortium, Global Gender-Based Violence Technical Support Project.
Available in English at: http://www.rhrc.org/resources/gbv/vann_toc.html.

VSO. 2003. *Gendering AIDS: Women, Men, Empowerment, Mobilization*.
Available at: http://www2.unescobkk.org/hivaids/fulltextdb/aspUploadFiles/gendering_aids_tcm8-809.pdf.

Warshaw, C. and A. L. Gandley. 1998. *Improving the Health Care Response to Domestic Violence: A Response Manual for Health Care Providers*. San Francisco: Family Violence Prevention Fund. Available at: http://endabuse.org/section/programs/health_care/_resource_manual.

WHO/United Nations High Commissioner for Refugees. 2004. *Clinical Management of Rape Survivors: Developing Protocols for use with Refugees and Internally Displaced Persons,* revised edition. Geneva: WHO/UNHCR. Available at: http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/index.html.

World Health Organization (WHO). 2004. *Gender Dimensions of HIV Status Disclosure to Sexual Partners: Rates, Barriers, and Outcomes: A Review Paper*. Geneva: WHO. Available at: http://www.who.int/gender/documents/en/genderdimensions.pdf.

WHO. N.d. *World Health Organization Intimate Partner Violence and Alcohol Fact Sheet.* Available at: http://www.who.int/violence_injury_prevention/violence/world_report/factsheets/ft_intimate.pdf.

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