

VIOLENCE & HIV/AIDS: VIOLENCE AGAINST WOMEN AND GIRLS AS A CAUSE AND CONSEQUENCE OF HIV/AIDS

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INTRODUCTION

The worldwide HIV/AIDS epidemic has had and continues to have negative effects on human development. In parts of the world that have been most affected by HIV infections, such as sub-Saharan Africa, the epidemic has had the devastating effects of reducing life expectancy, reducing productivity, deepening poverty, decimating populations, increasing levels of dependency, weakening institutional structures, and undermining national systems.¹

The grave consequences of HIV infections extend beyond the individuals living with the virus, as HIV/AIDS affects their families and greater communities.² Specifically, women, as primary caretakers of families and communities, and as frequent subjects of stigma, discrimination, violence, and unequal access to health care and medication, are particularly vulnerable to the effects of the HIV/AIDS epidemic.³

The Joint United Nations Programme on HIV/AIDS estimated that 30-36 million people worldwide were living with AIDS in 2007.⁴ Globally, women constitute approximately 50% of individuals living with HIV/AIDS.⁵

Women in some countries and in certain age groups are disproportionately affected by the HIV virus.⁶ Globally, 95% of daily new infections occur in developing countries,⁷ and approximately 45% are among young people 15-24

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1. DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 17 (2009).

2. AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 3 (2004) [hereinafter AMNESTY INT'L 2004].

3. *Id.* at 3-13.

4. JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], 2008 REPORT ON THE GLOBAL AIDS EPIDEMIC 32 (2008), available at http://data.unaids.org/pub/GlobalReport/2008/JC1510_2008GlobalReport_en.zip [hereinafter UNAIDS 2008].

5. *Id.* at 33.

6. *See id.* at 33-42.

7. Robin Shattock, *Sexual Trauma and the Female Genital Tract*, in WOMEN, SEXUAL VIOLENCE AND HIV 7, 7 (2005).

years of age.⁸ It is estimated that, worldwide, young women are 1.6 times more likely to be living with HIV/AIDS compared to young men.⁹ In sub-Saharan Africa, women constitute nearly 60% of HIV infections,¹⁰ and 75% of HIV infections in the 17-24 year-old age group.¹¹ In parts of southern Africa, young women are 4-5 times more likely than young men to be infected with HIV.¹²

The research statistics consistently reveal women's disproportionate vulnerability within the broader HIV/AIDS epidemic,¹³ and there is a parallel growing body of research that attributes such vulnerability to specific risks faced by women.¹⁴ Of these identified risks, the underlying risk of pervasive gender inequalities rooted in many cultures, which manifests in violence against women and girls, has been recognized to increase the susceptibility of women to HIV/AIDS.¹⁵

Violence against women and girls and HIV/AIDS are co-existent epidemics that have devastating health and development consequences,¹⁶ and their relationship is best understood as a bi-directional and mutually-reinforcing one. Violence against women and girls causes HIV infections, and it is also a consequence of HIV infections.¹⁷

This Note focuses on the epidemic of violence against women and the epidemic of HIV/AIDS as two mutually-reinforcing epidemics. The Note identifies and examines the network of major factors within the twin epidemics: the biological nature of men and women; experiences of sexual violence; having intimate partners; the practices of condom use; history of childhood sexual abuse; having multiple sexual partners; engaging in sexual relations with older men; and the disclosure of HIV serostatus.

The Note further addresses violence against women and girls in times of armed conflicts. Due to the unique nature of conflict settings and its implications on risk factors associated with violence against women and girls

8. UNAIDS 2008, *supra* note 4, at 33.

9. JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], U.N. POPULATION FUND [UNFPA] & U.N. DEV. FUND FOR WOMEN [UNIFEM], WOMEN AND HIV/AIDS: CONFRONTING THE CRISIS 1 (2004), available at http://www.unfpa.org/upload/lib_pub_file/308_filename_women_aids1.pdf.

10. JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], 2008 REPORT ON THE GLOBAL AIDS EPIDEMIC 33 (2008), available at http://data.unaids.org/pub/GlobalReport/2008/JC1510_2008GlobalReport_en.zip [hereinafter UNAIDS 2008].

11. JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], 2004 REPORT ON THE GLOBAL AIDS EPIDEMIC 22 (2004), available at http://www.unaids.org/bangkok2004/GAR2004_pdf/UNAIDSGlobalReport2004_en.pdf.

12. AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 3 (2004) [hereinafter AMNESTY INT'L 2004].

13. See UNAIDS 2008, *supra* note 10.

14. AMNESTY INT'L 2004, *supra* note 12, at 3.

15. WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 1 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

16. DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 17 (2009).

17. See FOUND. FOR AIDS RES., WOMEN, SEXUAL VIOLENCE AND HIV: AN AMFAR SYMP. (2005) [hereinafter AMFAR SYMP.].

and HIV infections, this is done in an independent section. In the final section, the Note proposes some policy recommendations based upon its findings.

I. VIOLENCE AND HIV – TWO MUTUALLY REINFORCING EPIDEMICS

Worldwide, women and girls are placed at elevated risks for HIV infections due to exposure to violence.¹⁸ In studies conducted in South Africa, Rwanda, and Tanzania, women who had been victims of violence were up to 3 times more likely to contract the HIV virus than women who had not experienced violence.¹⁹

The significant connection between the violence against women and girls epidemic and the HIV/AIDS epidemic has been well-established, but the network of causal or temporal links between the two is complex—including considerations such as biological, socio-cultural, economic and behavioral factors, structural and institutional factors, health consequences, and policy and development implications—and not yet understood in its entirety.²⁰ Yakin Ertürk, the United Nations Special Rapporteur on Violence Against Women, has stated, “multiple factors associated with women’s subordinate position increase the risk of HIV infection. Among them are: illiteracy and poverty, conflict situations, lack of sexual autonomy, rape by intimate partners or strangers, multiple sexual partners, trafficking for sexual exploitation, genital mutilation and other harmful practices, prostitution, and child marriage.”²¹

There are numerous links between violence and HIV infections that help explain women and girls’ particular vulnerability within the HIV/AIDS epidemic. Within the context of violence against women and girls, the HIV virus is transmitted to women and girls directly through biological means, and indirectly through socio-cultural, economic, and behavioral means.²² For example, Wyatt and colleagues found that, among racial and ethnic minority

18. FERDINAND, *supra* note 16, at 13-15; see AMNESTY INT’L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 4 (2004) [hereinafter AMNESTY INT’L 2004].; WHO, INTIMATE PARTNER VIOLENCE, *supra* note 15, at 1.

19. On the usage of “victim:” some individuals who have been assaulted prefer to refer to themselves as survivors, whereas others feel that avoidance of the word “victim” denies the damage that has been done to them. The Note adopts the term victim(s) throughout the text to refer to individuals who have experienced physical, sexual, or intimate partner violence. See Kristin L. Dunkle et al., *Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa*, 363 LANCET 1415 (2004); Suzanne Maman et al., *HIV-Positive Women Report More Lifetime Partner Violence: Findings From a Voluntary Counseling and Testing Clinic in Dar es Salaam, Tanzania*, 92 AM. J. PUB. HEALTH 1331 (2002); Ariane van der Straten et al., *Sexual Coercion, Physical Violence and HIV Infection Among Women in Steady Relationships in Kigali, Rwanda*, 2 AIDS & BEHAV. 61 (1998).

20. See AMFAR SYMP., *supra* note 17; WHO, INTIMATE PARTNER VIOLENCE, *supra* note 15, at 1.

21. U.N. Econ. & Soc. Council [ECOSOC], Comm’n on Hum. Rts., *Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women*, 16, U.N. Doc. E/CN.4/2004/66 (Dec. 26, 2003) (prepared by Yakin Ertürk).

22. JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], 2008 REPORT ON THE GLOBAL AIDS EPIDEMIC 63-93 (2008), available at http://data.unaids.org/pub/GlobalReport/2008/JC1510_2008GlobalReport_en.zip [hereinafter UNAIDS 2008].; see also AMFAR SYMP., *supra* note 17; WORLD HEALTH ORG. [WHO], DEP’T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 1 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

women in the United States, those who had more sexual partners, were unemployed, had more sexually transmitted infections, had a more severe history of physical and sexual trauma, and were less educated were more likely to be living with HIV/AIDS.²³

Biological factors are at play in cases of sexual violence for the transmission of the HIV virus. These factors include the level of the HIV virus in the semen, the presence of other sexually transmitted diseases, the maturity of the female genital organs, the form of sexual contact, and the age of the victim.²⁴ Socio-cultural considerations include harmful traditional practices, social stigma, discrimination and marginalization associated with HIV/AIDS, lack of education, gender inequality, and the lack of empowerment of women and girls.²⁵ Economic issues include poverty, food insecurity, and general instability and displacement during times of armed conflict.²⁶ Behavioral aspects include the abuse of alcohol and illegal drugs, sexual risk-taking, having multiple partners, engaging in transactional sex, and partnering with older men.²⁷

The following sections identify and examine the major biological, socio-cultural, economic, and behavioral factors within the twin epidemics:

- Biological nature of men and women
- Sexual violence
- Intimate partners
- Condom use
- Childhood sexual abuse
- Multiple sexual partners
- Sexual relations with older men
- Disclosure of HIV serostatus

23. Gail E. Wyatt et al., *Does History of Trauma Contribute to HIV Risk for Women of Color? Implications for Prevention and Policy*, 92 AM. J. PUB. HEALTH 660, 664-65 (2002).

24. Robin Shattock, *Sexual Trauma and the Female Genital Tract*, in WOMEN, SEXUAL VIOLENCE AND HIV 7, 7-8 (2005); see FOUND. FOR AIDS RES., WOMEN, SEXUAL VIOLENCE AND HIV: AN AMFAR SYMP. (2005) [hereinafter AMFAR SYMP.].

25. See UNAIDS 2008, *supra* note 22, at 63-92; AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 5-7 (2004) [hereinafter AMNESTY INT'L 2004]; see also Rachel Jewkes et al., *Sexual Violence*, in WORLD HEALTH ORG., WORLD REPORT ON VIOLENCE AND HEALTH 147, 162 (2002); Quarraisha Abdool Karim et al., *Reducing the Risk of HIV Infection Among South African Sex Workers: Socioeconomic and Gender Barriers*, 85 AM. J. PUB. HEALTH 1521, 1524 (1995); see generally WORLD HEALTH ORG., WORLD REPORT ON VIOLENCE AND HEALTH (2002) [hereinafter WHO WORLD REPORT]; Dooley Worth, *Sexual Decision-Making and AIDS: Why Condom Promotion Among Vulnerable Women is Likely to Fail*, 20 STUD. FAM. PLAN. 297, 306 (1989).

26. DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 10-11 (2009); see generally WHO WORLD REPORT, *supra* note 25, at 158.

27. See WHO, INTIMATE PARTNER VIOLENCE, *supra* note 22, at 2; WHO WORLD REPORT, *supra* note 25; see Kristin L. Dunkle et al., *Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa*, 363 LANCET 1419 (2004); see also Nabila El-Bassel et al., *Partner Violence and Sexual HIV-Risk Behaviors Among Women in an Inner-City Emergency Department*, 13 VIOLENCE & VICTIMS 377, 377 (1998); Seth C. Kalichman et al., *Sexual Coercion, Domestic Violence, and Negotiating Condom Use Among Low-Income African-American Women*, 7 J. WOMEN'S HEALTH 371, 372 (1998); Suzanne Maman et al., *HIV-Positive Women Report More Lifetime Partner Violence: Findings From a Voluntary Counseling and Testing Clinic in Dar es Salaam, Tanzania*, 92 AM. J. PUB. HEALTH 1331 (2002).

A. Biological nature of men and women as risk factor

Women and girls are more likely than men to contract HIV through unprotected sexual intercourse for three primary reasons: women and girls are physiologically more susceptible to the HIV virus than men, the semen contains higher levels of HIV than vaginal fluids, and women and girls are more vulnerable to sexual coercion and violence.²⁸ In the context of sexual violence against women and girls, the HIV virus is transmitted when the vulnerable mucous barriers inside and outside the genital tract break down.²⁹ HIV transmission only requires a non-apparent micro-abrasion to give the virus access to susceptible cells.³⁰ Physiologically, women have a greater mucous surface than men, which provides a greater area for injury and sites of entry for the HIV virus to enter the bloodstream, resulting in women being two to four times more susceptible to HIV infections through sexual intercourse.³¹

Several additional factors contribute to the risk of HIV transmission: the infected partner/perpetrator's stage of infection, type of sexual exposure, presence of the women's pre-existing sexually transmitted infections, and age of the women.³²

The infectiousness of the partner or perpetrator is a critical factor in determining the risk of HIV transmission. The partner or perpetrator is most infectious during the period of acute infection—when the viral load in the semen is the highest—creating the highest biological risk of HIV transmission.³³

The type of sexual exposure (vaginal, anal, or oral) is also a critical element in determining the risk of HIV transmission through sexual intercourse.³⁴ Transmission rate is highest for anal intercourse, followed by vaginal intercourse; oral intercourse has the lowest risk of HIV transmission.³⁵ Shattock reported an eight to ten times “more efficient transmission” for anal intercourse compared to vaginal intercourse.³⁶

28. AMNESTY INT'L 2004, *supra* note 25, at 3-4; Shattock, *supra* note 24, at 7-8; see JOINT U.N. PROGRAMME ON HIV/AIDS [UNAIDS], GENDER AND AIDS ALMANAC (2001), available at http://data.unaids.org/Topics/Gender/genderandaidsalmanac_en.pdf.

29. WOMEN, HEALTH & DEV. PROGRAM, PAN-AMERICAN HEALTH ORG. [PAHO], FACTSHEET: GENDER AND HIV/AIDS (2002) [hereinafter PAHO, FACTSHEET]; Shattock, *supra* note 24, at 7-8.

30. Robin Shattock, *Sexual Trauma and the Female Genital Tract*, in WOMEN, SEXUAL VIOLENCE AND HIV 7, 7-8 (2005).

31. AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 3-4 (2004) [hereinafter AMNESTY INT'L 2004]; PAHO, FACTSHEET, *supra* note 29.

32. AMNESTY INT'L 2004, *supra* note 31, at 3-4; DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 7-15 (2009); see PAHO, FACTSHEET, *supra* note 29; Shattock, *supra* note 30, at 7; WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 2 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

33. Shattock, *supra* note 30, at 7.

34. See PAHO, FACTSHEET, *supra* note 29; WHO, INTIMATE PARTNER VIOLENCE, *supra* note 32, at 2.

35. See WHO, INTIMATE PARTNER VIOLENCE, *supra* note 32, at 2; Shattock, *supra* note 30, at 7.

36. Robin Shattock, *Sexual Trauma and the Female Genital Tract*, in WOMEN, SEXUAL VIOLENCE AND HIV 7, 8 (2005).

The risk of HIV transmission is exacerbated by the existence of previously existing sexually transmitted infections of the receptive partner.³⁷ The risk of transmission increases with pre-existing sexually transmitted diseases because the immune system is compromised and cells are, therefore, more susceptible to the HIV virus.³⁸ Even when the receptive partner is previously infected with HIV/AIDS, her condition can be worsened with the infection of a different strain of the HIV virus, further devastating her health condition.³⁹

The age of the receptive women or girls during sexual intercourse also plays a role in the risk of HIV transmission.⁴⁰ The immaturity of the reproductive tracts of young women and girls makes them more susceptible to HIV infections, and more prone to injuries, both of which increase the risk of HIV transmission.⁴¹ Older women, on the other hand, may also be more susceptible to HIV and other sexually transmitted infections due to estrogen deficiency, which causes increased fragility in the vaginal and cervical tissues.⁴²

B. Sexual violence as risk factor

Sexual violence against women and girls causes direct physical harm, emotional trauma, stigma, and social marginalization for its victims.⁴³ Sexual violence is also a direct vehicle for the transmission of the HIV virus and other sexually transmitted infections.⁴⁴ By virtue of sexual violence being a forced and non-consensual sexual act, the likelihood of HIV transmission increases through the heightened possibility of physical injury to women and girls' reproductive tracts, and therefore, enabling a pathway of entry for the HIV virus.⁴⁵

Within the context of sexual violence, several additional factors increase the risk of HIV transmission: bite injuries, multiple offenders, repeated violence, vaginal and anal penetration, genital trauma and/or vagina or anal tears, the

37. See WOMEN, HEALTH & DEV. PROGRAM, PAN-AMERICAN HEALTH ORG. [PAHO], FACTSHEET: GENDER AND HIV/AIDS (2002) [hereinafter PAHO, FACTSHEET]; WHO, INTIMATE PARTNER VIOLENCE, *supra* note 32, at 2.

38. Shattock, *supra* note 36, at 8.

39. NAT'L SEXUAL VIOLENCE RESOURCE CTR., SEXUAL VIOLENCE AND HIV/AIDS: A TECHNICAL ASSISTANCE GUIDE FOR VICTIM SERVICE PROVIDERS 15 (2008).

40. DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 9 (2009); PAHO, FACTSHEET, *supra* note 37; see Shattock, *supra* note 36, at 7-8.; WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 1 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

41. PAHO, FACTSHEET, *supra* note 37; Shattock, *supra* note 36, at 7-8; WHO, INTIMATE PARTNER VIOLENCE, *supra* note 40, at 2.

42. See Faryal Mahar & Jackie Sherrard, *Sexually Transmitted Infections*, in SEXUAL HEALTH AND THE MENOPAUSE 55 (John M. Tomlinson ed. 2005).

43. WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, SEXUAL VIOLENCE IN CONFLICT SETTINGS AND THE RISK OF HIV 1 (2005), available at www.who.int/gender/en/infobulletinconflict.pdf [hereinafter WHO, SEXUAL VIOLENCE IN CONFLICT SETTINGS].

44. *Id.*; FERDINAND, *supra* note 40, at 14-15.

45. AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 3-4 (2004) [hereinafter AMNESTY INT'L 2004]; FERDINAND, *supra* note 40, at 14-15.

presence of sperm or semen in or around the vagina or anus, and offender(s) who is/are injecting drug user(s).⁴⁶

Shattock reported that research studies have observed drastically higher chances of genital trauma for rape victims compared to non-victims—87-92% for rape victims, 10% for non-victims.⁴⁷ Evidence also indicated that rape victims had more sites of injury compared to non-victims.⁴⁸ Furthermore, victims of sexual violence were subjected to anal penetration in 13-20% of reported cases, and 73% suffered anal tears or abrasions.⁴⁹

Vaginal and anal trauma is a direct passageway for the transmission of HIV, and the forceful nature of sexual violence exacerbates the risk for physical injury, and thereby increases the risk for HIV transmission.⁵⁰ Silverman and colleagues found that women and girls who had been subjected to sexual exploitation and were subsequently repatriated to Nepal had a HIV prevalence rate of 38%.⁵¹ In a similar study in India, among women and girls who had been trafficked and subjected to sexual violence, 22.9% were found to be infected with HIV.⁵²

Studies of sexual violence victims have revealed a host of associated risk factors that further increase the risk for HIV infection. Maman and colleagues reported that several studies conducted in the United States indicated that the experience of sexual violence is associated with early sexual initiation, anal sex, “sex with unfamiliar partners, and low rates of condom use.”⁵³ Thus, not only is sexual violence a direct cause of HIV infections, it is also a risk factor for other associated behaviors that increase the risk of HIV transmission.

C. Intimate partners as risk factor

Violence perpetrated by an intimate partner is a pervasive problem worldwide: 10-69% of women have been physically abused by an intimate partner, and 6-47% of women have been sexually assaulted by an intimate partner.⁵⁴ The World Health Organization has recognized that, without

46. AMNESTY INT’L 2004, *supra* note 45, at 4-6; CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP’T OF HEALTH & HUM. SERVS., ANTIRETROVIRAL POSTEXPOSURE PROPHYLAXIS AFTER SEXUAL, INJECTION-DRUG USE, OR OTHER NONOCCUPATIONAL EXPOSURE TO HIV IN THE UNITED STATES 7, 15 (2005).

47. Robin Shattock, *Sexual Trauma and the Female Genital Tract*, in WOMEN, SEXUAL VIOLENCE AND HIV 7, 8 (2005).

48. *Id.*

49. *Id.*

50. *Id.*

51. Jay G. Silverman et al., *HIV Prevalence and Predictors of Infection in Sex-Trafficked Nepalese Girls and Women*, 298 JAMA 536, 538 (2007).

52. Jay G. Silverman et al., *HIV Prevalence and Predictors Among Rescued Sex-Trafficked Women and Girls in Mumbai, India*, 43 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 588, 590 (2006).

53. Suzanne Maman et al., *The Intersections of HIV and Violence: Directions for Future Research and Interventions*, 50 SOC. SCI. & MED. 459, 474 (2000).

54. WORLD HEALTH ORG. [WHO], DEP’T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 2 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE]. In the 2005 World Health Organization Multi-Country Study on Women’s Health and Domestic Violence Against Women, surveying 15 sites in 10 countries, the lifetime

exception, intimate partner violence occurs in all countries and all cultures, and at all levels of society; it has also illustrated the disproportionate effects of intimate partner violence on various populations.⁵⁵

Intimate partner violence increases the risk of HIV transmission.⁵⁶ Having a partner who is infected with HIV or at high risk for HIV infections is a common risk factor for women, and this risk is especially acute for women who experience violence at the hands of their intimate partners.⁵⁷ In South Africa, a study reported a strong association between experience of violence and increased risk of HIV infection among women.⁵⁸ Fonck and colleagues conducted a study in Kenya where they found that HIV-positive women were almost 2 times more likely to be victims of intimate partner violence.⁵⁹ The study also found an association between the experience of intimate partner violence and the existence of other risk factors such as early sex, multiple sexual partners, history of low or inconsistent condom use, and existing sexually transmitted infections.⁶⁰ Similarly, a study in the United States of African-American and Hispanic adolescent women found a correlation between increased experiences of intimate partner violence and higher probability of inconsistent condom use.⁶¹

D. Condom use as risk factor

While it is certain that women's risk of contracting HIV is greater when engaging in sexual intercourse with HIV-positive men without preventative measures, such as the use of condoms,⁶² research to date is inconclusive as to the impact of violence on women's ability to negotiate condom use.⁶³ Pettifor and colleagues reported from a study in South Africa that women who experienced sexual violence with their most recent partners were almost 6 times more likely

prevalence of physical violence by intimate partners ranged from 13% to 61%, and the lifetime prevalence of sexual violence by intimate partners ranged from 15% to 71%. CLAUDIA GARCÍA-MORENO, ET AL., WORLD HEALTH ORG., WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN xii, 3 (2005).

55. Lori Heise & Claudia García-Moreno, *Violence by Intimate Partners*, in WORLD HEALTH ORG., WORLD REPORT ON VIOLENCE AND HEALTH 87, 89 (2002).

56. DINYA LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 14 (2009).

57. AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 5-6 (2004) [hereinafter AMNESTY INT'L 2004]; see WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, ADDRESSING VIOLENCE AGAINST WOMEN IN HIV TESTING AND COUNSELING: A MEETING REPORT 16-18 (2006), available at http://www.who.int/gender/documents/VCT_addressing_violence.pdf.

58. Kristin L. Dunkle et al., *Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa*, 363 LANCET 1415, 1415 (2004).

59. Karoline Fonck et al., *Increased Risk of HIV in Women Experiencing Physical Partner Violence in Nairobi, Kenya*, 9 AIDS AND BEHAV. 335, 337 (2005).

60. *Id.* at 337-38.

61. Anne Teitelman et al., *Sexual Relationship Power, Intimate Partner Violence, and Condom Use Among Minority Urban Girls*, 23 J. INTERPERSONAL VIOLENCE 1694, 1707 (2008).

62. AMNESTY INT'L 2004, *supra* note 57, at 6.

63. WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 1 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

to use condoms inconsistently compared to those who had not experienced sexual violence.⁶⁴ The same study found that women with inconsistent condom use were almost 1.6 times more likely to be infected with HIV compared to those who used condoms consistently.⁶⁵

Some research studies indicate that, in the face of violence, women's ability to negotiate condom use is compromised.⁶⁶ Qualitative studies from several countries have suggested that women find it more difficult to suggest or insist on condom use when facing violence or the threat of violence.⁶⁷ A study conducted in the United States of African American women found that victims of intimate partner violence were 4.2 times more likely to be verbally abused and 9.2 times more likely to be threatened with physical abuse when suggesting condom use to their intimate partners compared to women who had not experienced intimate partner violence.⁶⁸

In contrast, a study in South Africa found that women who had experienced intimate partner violence were 1.51 times more likely to suggest condom use to their current partners compared to women who had not been physically abused.⁶⁹

E. Childhood sexual abuse as risk factor

Experiences of sexual violence during childhood have been found to be associated with higher risk for HIV infections, as well as for a host of other risky behaviors—drug abuse, having multiple sexual partners, engaging in transactional sex, having male partners at risk for HIV, engaging in unprotected sex—that are themselves risk factors for heightened risk for HIV transmission.⁷⁰ Studies have consistently found that women often experience their first sexual

64. Audrey E. Pettifor et al., *Sexual Power and HIV Risk, South Africa*, 10 EMERGING INFECTIOUS DISEASES 1996, 1999 (2004).

65. *Id.* at 2001.

66. See WHO, INTIMATE PARTNER VIOLENCE, *supra* note 63.

67. See Vivian F. Go et al., *When HIV-Prevention Messages and Gender Norms Clash: The Impact of Domestic Violence on Women's HIV Risk in Slums of Chennai, India*, 7 AIDS & BEHAV. 263, 263 (2003); HUM. RTS. WATCH, JUST DIE QUIETLY: DOMESTIC VIOLENCE AND WOMEN'S VULNERABILITY TO HIV IN UGANDA (2003).

68. Gina M. Wingood & Ralph J. DiClemente, *The Effects of an Abusive Primary Partner on the Condom Use and Sexual Negotiation Practices of African-American Women*, 87 AM. J. PUB. HEALTH 1016, 1017 (1997).

69. Rachel Jewkes et al., *Gender Inequalities, Intimate Partner Violence and HIV Preventive Practice: Findings of a South African Cross-Sectional Study*, 56 SOC. SCI. & MED. 125, 130 (2003).

70. See Lillian S. Bensley et al., *Self-Reported Childhood Sexual and Physical Abuse and Adult HIV-Risk Behaviors and Heavy Drinking*, 18 AM. J. PREVENTIVE MED. 151 (2000); Mardge Cohen et al., *Domestic Violence and Childhood Sexual Abuse in HIV-Infected Women and Women at Risk for HIV*, 90 AM. J. PUB. HEALTH 560 (2000); DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 14-15 (2009); Nancy J. Thompson et al., *The Relationship of Sexual Abuse and HIV Risk Behaviors Among Heterosexual Adult Female STD Patients*, 21 CHILD ABUSE & NEGLECT 149 (1997); WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE]; Sally Zierler et al., *Adult Survivors of Childhood Sexual Abuse and Subsequent Risk of HIV Infection*, 81 AM. J. PUB. HEALTH 572 (1991).

encounter as one of violence and coercion.⁷¹ Worldwide, it was found that for 7 to 48% of women between the ages of 10-24 years, their first sexual encounter was forced.⁷²

In a study of individuals infected with HIV/AIDS in the United States, Kalichman and colleagues reported that 68% of the women had been sexually abused at least once since the age of fifteen.⁷³ The study also found that the HIV-positive individuals who had a history of childhood sexual abuse were more likely to engage in unprotected sex compared to those without experiences of childhood sexual abuse.⁷⁴

Another study conducted in the United States on adolescent girls found that those who had a history of sexual abuse or had witnessed family violence were 3-4 times more likely to report risky sexual behaviors such as having unprotected sex, engaging in sexual activities after drug use, and having sex with multiple partners compared to peers not exposed to such violence.⁷⁵

Similarly, a study in Nicaragua revealed a positive correlation between the severity of sexual abuse and the impact of such abuse.⁷⁶ The study reported that women who experienced severe sexual violence as children or adolescents began engaging in sexual activities more than 2 years earlier and had more sexual partners compared to women who had experienced moderate sexual abuse or had not experienced sexual abuse.⁷⁷

F. Multiple sexual partners as risk factor

Engaging in sexual activities with multiple partners increases the risk for HIV infection. Within the context of violence, both the perpetrating men and receptive women may have multiple partners, which contribute to the heightened risk of HIV infection. Studies have suggested that women victims of sexual violence are more likely to engage in risky sexual behaviors such as having multiple sexual partners or engaging in transactional sex.⁷⁸ Dunkle and colleagues conducted a study in South Africa, and found that women victims of intimate partner violence were about 2 times more likely to engage in

71. Ferdinand, *supra* note 70, at 9; see Claudia García-Moreno, *Sexual Violence*, 37 IPPF MED. BULL. 1, 1-2 (2003); CLAUDIA GARCÍA-MORENO, ET AL., WORLD HEALTH ORG., WHO MULTI-COUNTRY STUDY ON WOMEN'S HEALTH AND DOMESTIC VIOLENCE AGAINST WOMEN (2005); see also WHO, INTIMATE PARTNER VIOLENCE, *supra* note 70.

72. WHO, INTIMATE PARTNER VIOLENCE, *supra* note 70, at 2.

73. Seth C. Kalichman et al., *Emotional Adjustment in Survivors of Sexual Assault Living with HIV/AIDS*, 15 J. TRAUMATIC STRESS 289, 292 (2002).

74. *Id.* at 294-95.

75. Dexter R. Voisin, *The Relationship Between Violence Exposure and HIV Sexual Risk Behaviors: Does Gender Matter?* 75 AM. J. ORTHOPSYCHIATRY 497, 502-03 (2005).

76. See Ann Olsson et al., *Sexual Abuse During Childhood and Adolescence Among Nicaraguan Men and Women: A Population-Based Anonymous Survey*, 24 CHILD ABUSE & NEGLECT 1579 (2000).

77. *Id.*

78. See WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

transactional sex compared to those who had not experienced violence.⁷⁹ Furthermore, the study found that women who engaged in transactional sex were 1.85 times more likely to be infected with HIV compared to those who had not engaged in transactional sex.⁸⁰

Another study conducted in South Africa reported that male perpetrators of sexual violence were approximately 2 times more likely to have engaged in sexual activities with multiple partners than men who had not engaged in sexual violence.⁸¹ In a study in India, Martin and colleagues concluded that married men who engage in sexual violence against their wives were more likely to have sexual partners outside of marriage, become infected with sexually transmitted infections including HIV, and subsequently place their wives at heightened risk for HIV infections.⁸²

G. Sexual relations with older men as risk factor

The World Health Organization, in a review of more than 40 studies conducted in sub-Saharan Africa, found that a significant portion of women and girls engage in sexual relations with men 5-10 years older than themselves.⁸³ Studies suggest that these relationships with older men place the women and girls at heightened risk of HIV transmission because older men have a higher prevalence of HIV infection,⁸⁴ and are more likely to use violence against intimate partners.⁸⁵ Relationships with older men also result in power imbalances, limiting the ability of females to negotiate safe sex practices such as condom use and contraceptive use.⁸⁶

H. Disclosure of HIV serostatus as risk factor

While for some women, disclosure of HIV serostatus to their partners results in sympathetic and understanding reactions, for many women,

79. Kristin L. Dunkle et al., *Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa*, 363 LANCET 1415, 1418 (2004).

80. *Id.* at 1417.

81. Naeemah Abrahams et al., *Sexual Violence Against Intimate Partners in Cape Town: Prevalence and Risk Factors Reported by Men*, 82 BULL. OF WORLD HEALTH ORG. 330, 335 (2004).

82. See Sandra L. Martin et al., *Sexual Behaviors and Reproductive Health Outcomes: Associations with Wife Abuse in India*, 282 JAMA 1967 (1999).

83. See WHO, INTIMATE PARTNER VIOLENCE, *supra* note 78.

84. See Rachel Jewkes et al., *HIV and Gender-Based Violence: Associations Found in Young Women in Rural South Africa* (2004) (unpublished paper presented at Dangerous Intersections: Current and Future Research Perspectives on HIV and Violence Against Women conference at Johns Hopkins University), *cited in* WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS (2004), *available at* <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

85. See Rachel Jewkes, Personal Communication (Nov. 2004), *cited in* WHO, INTIMATE PARTNER VIOLENCE, *supra* note 84.

86. See NANCY LUKE & KATHLEEN M. KURZ, INT'L CTR. FOR RES. ON WOMEN, CROSS-GENERATIONAL AND TRANSACTIONAL SEXUAL RELATIONS IN SUB-SAHARAN AFRICA: PREVALENCE OF BEHAVIOR AND IMPLICATIONS FOR NEGOTIATING SAFER SEXUAL PRACTICES (2002).

disclosure produces hostile and negative responses.⁸⁷ In addition to the social stigma that is often attached to victims of sexual violence and HIV,⁸⁸ women often risk further discrimination and social exclusion when they decide to disclose their positive HIV serostatus.⁸⁹

Due to fear of violence, marginalization, rejection, and accusations of infidelity from their partners, families, and communities, 16-86% of women choose not to disclose their HIV serostatus to their partners.⁹⁰ Among the various barriers to disclosure, studies in Tanzania and Kenya suggested that the fear of violence was a major factor, which was reported by 16.1% and 51% of women, respectively.⁹¹

The fear of violence has also been found to be a barrier to women being tested for HIV.⁹² A study in Uganda, reported by Human Rights Watch, found that women were sometimes forbidden by their husbands from seeking HIV testing, and when they were not explicitly forbidden, they were afraid to ask for money or permission to obtain HIV testing or related information.⁹³

When disclosure leads to violence, it creates a cycle of risks of violence and risks of HIV transmission that is difficult to break. A study conducted in the United States found that 45% of women were subjected to emotional, physical, or sexual violence after being diagnosed with HIV, and 4% of the women were subjected to physical violence at the hands of their intimate partners after disclosure of their HIV serostatus.⁹⁴

The risk of violence due to disclosure of HIV serostatus is linked to other factors, including prior history of abuse, drug use, lower socioeconomic status, and younger age, all of which contribute to a heightened risk for HIV infection.⁹⁵ Non-disclosure can also place women at increased health risks due to lack of

87. See Amy Medley et al., *Rates, Barriers and Outcomes of HIV Serostatus Disclosure Among Women in Developing Countries: Implications for Prevention of Mother-to-Child Transmission Programmes*, 82 BULL. WORLD HEALTH ORG. 299 (2004).

88. See NAT'L SEXUAL VIOLENCE RESOURCE CTR., *SEXUAL VIOLENCE AND HIV/AIDS: A TECHNICAL ASSISTANCE GUIDE FOR VICTIM SERVICE PROVIDERS* 15 (2008).

89. See DINYS LUCIANO FERDINAND, *DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN* 37 (2009).

90. See P. Keogh et al., *The Social Impact of HIV Infection on Women in Kigali, Rwanda: A Prospective Study*, 38 SOC. SCI. & MED. 1047 (1994); Amy Medley et al., *supra* note 87, at 299; WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, FAM. AND CMTY. HEALTH, *GENDER DIMENSIONS OF HIV STATUS DISCLOSURE TO SEXUAL PARTNERS: BARRIERS AND OUTCOMES* (2003), available at <http://www.who.int/gender/documents/en/genderdimensions.pdf> [hereinafter WHO, GENDER DIMENSIONS].

91. Amy Medley et al., *supra* note 88, at 301-02.

92. See WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, *INTIMATE PARTNER VIOLENCE AND HIV/AIDS* 3 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

93. See HUM. RTS. WATCH, *JUST DIE QUIETLY: DOMESTIC VIOLENCE AND WOMEN'S VULNERABILITY TO HIV IN UGANDA* (2003).

94. Andrea Carlson Gielen et al., *Women's Lives after an HIV-Positive Diagnosis: Disclosure and Violence*, 4 MATERNAL & CHILD HEALTH J. 111, 116 (2000).

95. *Id.* at 117-18.

access to medical treatments and psychosocial support, particularly when the women are at risk for further infections.⁹⁶

II. VIOLENCE AND HIV IN CONFLICT SETTINGS

The high prevalence of violence against women and girls during armed conflicts is attributed to the availability of weapons, increased levels of frustration and tension among men and soldiers, and a breakdown in law and order.⁹⁷ These factors combined with the perpetrators' failure to appropriately handle such dramatic changes during periods of armed conflicts result in the unfortunate amplification of the phenomenon of violence against women and girls. Moreover, it has been reported that sexual violence is accepted more in the context of armed conflicts because sex is regarded as a service that can be acquired by force.⁹⁸

Violence against women and girls has been pervasive in all recent armed conflicts.⁹⁹ A study on the first civil war in Liberia (1989-1996) found that 49% of women 15-70 years of age were subjected to physical or sexual violence by a soldier or fighter during the war.¹⁰⁰ It was estimated that 20,000-50,000 women—approximately 1- 2% of the total pre-war female population—were raped during the 1992-1995 conflict in Bosnia-Herzegovina.¹⁰¹

During times of armed conflicts, women and girls are at particular risk of contracting HIV and other sexually transmitted infections due to the drastic increase in the prevalence of violence against women and girls.¹⁰² The emergency nature of armed conflicts generates major changes in the social and political structures of communities, giving rise to a set of unique risk factors of HIV transmission. Risk factors that fuel women and girls' vulnerability and the spread of HIV in times of armed conflict include: the high frequency of physical and sexual violence against women and girls, forced marriages with enemy soldiers, the occurrence of mass rape, the need to exchange sex for survival, and the loss of access to health care and other support systems.¹⁰³

96. See WHO, GENDER DIMENSIONS, *supra* note 90; WHO, INTIMATE PARTNER VIOLENCE, *supra* note 92.

97. See WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, SEXUAL VIOLENCE IN CONFLICT SETTINGS AND THE RISK OF HIV 1 (2005), available at www.who.int/gender/en/infobulletinconflict.pdf [hereinafter WHO, SEXUAL VIOLENCE IN CONFLICT SETTINGS].

98. HUM. RTS. WATCH, THE WAR WITHIN THE WAR: SEXUAL VIOLENCE AGAINST WOMEN AND GIRLS IN EASTERN CONGO 1, 21 (2002).

99. Including recent conflicts in the Democratic Republic of Congo, Rwanda, Sierra Leone, Liberia, Uganda, Chechnya, Somalia, Burundi and ongoing conflicts in Darfur; see WHO, SEXUAL VIOLENCE IN CONFLICT SETTINGS, *supra* note 97.

100. Shana Swiss et al., *Violence Against Women During the Liberian Civil Conflict* 279 JAMA 625, 627 (1998).

101. U.N. CHILDREN'S FUND (UNICEF), INT'L CHILD DEV. CTR. WOMEN IN TRANSITION, MONEE PROJECT CEE/CIS/BALTICS REG'L MONITORING REP. NO. 6 85 (1999), available at http://www.unicef-irc.org/cgi-bin/unicef/download_insert.sql?PDFName=monee6/index.html&ProductID=36&DownloadAddress=/publications/pdf/monee6/index.html.

102. See WHO, SEXUAL VIOLENCE IN CONFLICT SETTINGS, *supra* note 97.

103. *Id.*

In many armed conflicts, sexual violence against women and girls has deliberately been used as a weapon of war or political power to brutalize and humiliate civilians.¹⁰⁴ In the 1994 Rwanda genocide, rape was used as a form of ethnic cleansing, and an estimated 250,000 women were raped.¹⁰⁵ Of those women who survived the genocide, Amnesty International estimated that 70% contracted HIV.¹⁰⁶ Furthermore, from 1994 to 1997, the prevalence rate of HIV infections in rural areas of Rwanda increased from 1% to 11%.¹⁰⁷

A. "SURVIVAL SEX"

Armed conflicts give rise to a plethora of humanitarian emergencies, including displacement, the loss of families and social support systems, the loss of income, heightened abuse of authority by combatants and other men, heightened discrimination, and high degrees of instability.¹⁰⁸ Due to these dramatic and sudden changes, women and girls are often placed in positions where their only option is to engage in "survival sex."¹⁰⁹

Oftentimes, to acquire the essentials of livelihood, such as safety, shelter, food, and protection for themselves and their families, women and girls must exchange sex.¹¹⁰ Weiser and colleagues reported that a study conducted in Botswana and Swaziland found food insufficiency increases risky behaviors in women, and, therefore, is an important risk factor for HIV transmission.¹¹¹

Women and girls' desperation to survive during armed conflicts render them more vulnerable to sexual exploitation, which increases their risk of unprotected sex, increases the number of sexual partners, increases the frequency of sexual activities, and, consequently, increases the risk for HIV infection.¹¹² The decreased or total absence of access to medical services during times of conflict also exacerbates the negative health implications of "survival sex."¹¹³

104. *See Id.*

105. AMNESTY INT'L, RWANDA: "MARKED FOR DEATH", RAPE SURVIVORS LIVING WITH HIV/AIDS IN RWANDA 1, 3 (2004); *see also* HUM. RTS. WATCH, STRUGGLING TO SURVIVE: BARRIERS TO JUSTICE FOR RAPE VICTIMS IN RWANDA (2004).

106. AMNESTY INT'L, *supra* note 105, at 3.

107. *See* WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, SEXUAL VIOLENCE IN CONFLICT SETTINGS AND THE RISK OF HIV 1 (2005), *available at* www.who.int/gender/en/infobulletinconflict.pdf [hereinafter WHO, SEXUAL VIOLENCE IN CONFLICT SETTINGS].

108. *Id.*

109. *Id.*

110. DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 11 (2009).

111. *See* Sheri Weiser et al., *Food Insufficiency is Associated with High Risk Sexual Behavior Among Women in Botswana and Swaziland*, 4 PLOS MED. 1589 (2007).

112. FERDINAND, *supra* note 110, at 11.

113. *See* WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, SEXUAL VIOLENCE IN CONFLICT SETTINGS AND THE RISK OF HIV 1 (2005), *available at* www.who.int/gender/en/infobulletinconflict.pdf [hereinafter WHO, SEXUAL VIOLENCE IN CONFLICT SETTINGS].

III. POLICY IMPLICATIONS

A. INTERNATIONAL HUMAN RIGHTS STANDARDS AS FOUNDATION

Numerous international instruments have established standards for the protection of various human rights of individuals with HIV/AIDS and victims of violence against women and girls.¹¹⁴ First articulated in the constitution of the World Health Organization in 1946, international human rights law requires all governments to take all appropriate measures to protect “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹¹⁵ Further, Article 41 of the Vienna Declaration and Programme of Action (1993) specifically recognizes women’s entitlement to protection of these same rights, as well as the right to “accessible and adequate health care and the widest range of family planning services.”¹¹⁶

The United Nations Millennium Declaration (2000) also addresses both violence against women and HIV/AIDS epidemics through the Development Goals of “promot[ing] gender equality and . . . empower[ing] . . . women,” and “combat[ing] HIV/AIDS, malaria and other diseases.”¹¹⁷

Highlighting issues at the intersection of violence against women and HIV/AIDS, the Declaration of Commitment on HIV/AIDS (2000) adopted by the United Nations General Assembly Special Session on HIV/AIDS stated, “gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS,” and called on nations to “empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.”¹¹⁸

The Beijing Declaration and Platform for Action (1995) similarly stated that “[t]he social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective.”¹¹⁹ The Beijing Declaration further encouraged governments to “undertake gender

114. See Fourth World Conference on Women, Sept. 4-15, 1995, *Beijing Declaration and Platform for Action*, U.N. Doc. A/CONF.177/20 (Oct. 17, 1995) [hereinafter *Beijing*]; International Conference on Population and Development, Sept. 5-13, 1994, *Cairo Programme of Action (The Cairo Consensus)*, U.N. Doc. A/CONF.171/13 (Oct. 18, 1994); Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, T.I.A.S. No. 20,378, 1249 U.N.T.S. 13; United Nations General Assembly Special Session on HIV/AIDS, June 25-27, 2001, *Declaration of Commitment on HIV/AIDS*, U.N. Doc. A/RES/S-26/2 (Aug. 2, 2001) [hereinafter *Declaration of Commitment on HIV/AIDS*]; International Covenant on Economic, Social and Cultural Rights, *entry into force* Jan. 3, 1976, S. Treaty Doc. No. 95-19, 993 U.N.T.S. 3; Second International Consultation on HIV/AIDS and Human Rights, Sept. 23-25, 1996, *International Guidelines on HIV/AIDS and Human Rights*, U.N. Doc. E/CN.4/1997/150 (1997); United Nations General Assembly 8th Plenary Meeting, Sept. 8, 2000, *United Nations Millennium Declaration*, U.N. Doc A/55/49 [hereinafter *Millennium Declaration*]; World Conference on Human Rights, June 14-25, 1993, *Vienna Declaration and Programme of Action*, U.N. Doc. A/CONF.157/23 (July 12, 1993) [hereinafter *Vienna*].

115. International Covenant on Economic Social and Cultural Rights, *supra* note 114, at 4.

116. *Vienna*, *supra* note 114.

117. *Millennium Declaration*, *supra* note 114.

118. *Declaration of Commitment on HIV/AIDS*, *supra* note 114.

119. *Beijing*, *supra* note 114.

sensitive initiatives that address sexually transmitted diseases, HIV/AIDS and sexual and reproductive health issues.”¹²⁰

These internationally recognized human rights standards and calls for action are the foundation for government responsibilities and obligations worldwide. In light of these tenets, intervention programming of violence against women and girls and HIV/AIDS must be integrated and comprehensive to fully address the two epidemics.

B. THE NEED FOR COMPREHENSIVE INTERVENTION PROGRAMS

“AIDS responses must include programmes to stop sexual violence as an integral part of HIV prevention and treatment programmes,” said Michel Sidibé, Executive Director of The Joint United Nations Programme on HIV/AIDS.¹²¹

HIV/AIDS intervention programs have largely been dominated by the biomedical approach, which focuses on HIV as a biological entity and rarely addresses any social or other factors that underlie the HIV epidemic.¹²² However, given the established links between the epidemics of violence against women and girls and HIV/AIDS, the need to integrate violence against women and girls and HIV/AIDS intervention programming has become necessary to combat their devastating effects.¹²³

Perhaps the most comprehensive approach to addressing sexual violence and HIV/AIDS to date is the recent initiative launched at the Clinton Global Initiative Annual Meeting in New York.¹²⁴ In 2009, the United States Centers for Disease Control and Prevention and the United Nations Children’s Fund, jointly with other public and private organizations, launched a new international initiative to address sexual violence against girls.¹²⁵ The initiative will focus on countries where sexual violence is a key vehicle for the transmission of HIV and other infectious diseases, and will integrate sexual violence intervention strategies into current AIDS responses in order to combat both epidemics.¹²⁶ More importantly, these organizations will join efforts to develop comprehensive responses to sexual violence and HIV prevention and treatment

120. *Id.*

121. Joint U.N. Programme on HIV/AIDS [UNAIDS], *UNAIDS Partners in New Clinton Global Initiative to Address Sexual Violence Against Girls*, http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090925_clinton_sexual_violence.asp. (Sept. 25, 2009).

122. DINYS LUCIANO FERDINAND, *DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 17* (2009); see PAUL FARMER, *INFECTIONS AND INEQUALITIES: THE MODERN PLAGUES* (2001); Bill Rodriguez, *Biomedical Models of HIV and Women*, in *THE GENDER POLITICS OF HIV/AIDS IN WOMEN: PERSPECTIVES ON THE PANDEMIC IN THE UNITED STATES* (N. Goldstein & Jennifer L. Manlowe eds. 1997); WORLD HEALTH ORG. [WHO], *DEP’T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 3* (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, *INTIMATE PARTNER VIOLENCE*].

123. See FERDINAND, *supra* note 122, at 19–21; FOUND. FOR AIDS RES., *WOMEN, SEXUAL VIOLENCE AND HIV: AN AMFAR SYMP.* (2005); WHO, *INTIMATE PARTNER VIOLENCE*, *supra* note 122.

124. See UNAIDS, *supra* note 121.

125. *Id.*

126. *Id.*

in realms beyond the health sector.¹²⁷ Although the strategies proposed by the initiative have been piloted in Swaziland with success, their effectiveness on a larger scale remains to be observed and evaluated.¹²⁸

Several other integrated programming approaches have been implemented, but have not been adequately evaluated for their effectiveness. These approaches include:¹²⁹

- Executing behavior change communication strategies;
- Responding to violence against women through health services;
- Targeting gender attitudes and norms;
- Implementing micro-credit interventions for economic empowerment of women; and
- Strengthening laws and policies related to domestic violence and gender equality.

The reform of current intervention strategies will require the sustained dedication of resources and commitment from actors on various levels, including international agencies, national governments, donors, policy-makers, communities, advocacy groups, and individuals. The reformation of intervention strategies will also require sustained dedication and involvement across various sectors, including health services, education institutions, social services, and the legal sector.

Several key factors have been identified to be crucial to the effectiveness of multi-level and multi-sectoral intervention programs:¹³⁰

- Political will and commitment by national governments to address the two epidemics synergistically;
- Increased levels of international cooperation to address the two epidemics synergistically;
- Public education to encourage greater public and media awareness of the issues;
- Training for public officials (policy makers and law enforcement) on the intersection of the two epidemics;
- Training for medical professionals on the intersection of the two epidemics;
- Dedication of resources to the development, testing, implementation, and evaluation of effective behavioral interventions that address violence as both a cause and consequence of HIV infection;
- Dedication of resources to the development, testing, implementation, and evaluation of effective biomedical

127. *Id.*

128. *Id.*

129. See WORLD HEALTH ORG. [WHO], DEP'T OF GENDER, WOMEN AND HEALTH, INTIMATE PARTNER VIOLENCE AND HIV/AIDS 3 (2004), available at <http://www.who.int/gender/violence/en/vawinformationbrief.pdf> [hereinafter WHO, INTIMATE PARTNER VIOLENCE].

130. See AMNESTY INT'L, WOMEN, HIV/AIDS AND HUMAN RIGHTS 28-31 (2004); DINYS LUCIANO FERDINAND, DEV. CONNECTIONS, A MANUAL FOR INTEGRATING THE PROGRAMMES AND SERVICES OF HIV AND VIOLENCE AGAINST WOMEN 22-23 (2009); FOUND. FOR AIDS RES., WOMEN, SEXUAL VIOLENCE AND HIV: AN AMFAR SYMP. (2005); WHO, INTIMATE PARTNER VIOLENCE, *supra* note 129.

interventions that address violence as both a cause and consequence of HIV infection;

- Dedication of resources to the development, testing, implementation, and evaluation of effective social interventions that address violence as both a cause and consequence of HIV infection;
- Greater levels of participation of women living with HIV/AIDS in the development, testing, implementation, and evaluation of intervention programs;
- Strengthening of medical and health services to address issues of violence against women and girls;
- Strengthening of laws and policies to address gender inequalities, stigma, and discrimination.

IV. RECOMMENDATIONS

International, national, and organizational policies on violence against women and girls and HIV/AIDS must be examined together for their effectiveness in synergistically addressing the two mutually reinforcing epidemics. While further research is needed to fully understand the complexity of their interactions, policies must reflect the certain connections between violence against women and girls and HIV/AIDS based on existing studies, and kept up-to-date with future research.

The following recommendations are presented according to the three broad levels—international, national, and organizational—where policy changes are necessary. It must be noted that actors on these levels must act in tandem to address the epidemics.

A. International policies

As addressed in this Note, various international instruments, such as the Declaration of Commitment on HIV/AIDS and the Beijing Declaration and Platform for Action, have set forth the fundamental human rights of individuals with HIV/AIDS and victims of violence against women and girls, and many have highlighted the link between the two issues. These instruments must be used to facilitate international cooperation, advocacy, and monitoring. More specifically:

- Signatory states to these international instruments must take all appropriate measures to adhere to their obligations set forth therein, and be held accountable through international monitoring and advocacy bodies.
- Non-signatory states must adhere to the human rights standards set forth by international human rights law, and take all appropriate measures to protect these rights.
- The international community must hold states accountable for violations of human rights.
- The international community must provide sustained support for international programs to address the epidemics, such as the

continual support of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

- The international community must provide sustained financial and technical support for international and national measures to address the epidemics.
- International cooperation must assess and address the need for bilateral or multilateral intervention or aid programs.
- International intervention programs must be developed, tested, implemented and evaluated based on available research, and updated to reflect new research findings.

B. National policies

Violence against women and girls as well as HIV/AIDS are addressed differently across national policies. This difference is necessary, given variations in cultural and political factors that give rise to different levels of need. However, to address the two epidemics, national policies must condemn all forms of violence against women and girls, and promote strategies to reduce women's vulnerability to violence and HIV/AIDS.

- National governments must set forth sustained political will and financial resources to address the epidemics.
- National governments must develop legislation and effective monitoring mechanisms to address the epidemics.
- National intervention programs must be developed, tested, implemented and evaluated based on available research, and updated to reflect new research findings.
- National policies, programs, and laws must be consistent with international human rights law.
- National policies, programs, and laws must respond to international guidelines and recommendations, such as the Guidelines on HIV/AIDS and Human Rights set forth by The Joint United Nations Programme on HIV/AIDS.
- National policies, programs, and laws must ensure that victims of violence against women and girls have access to justice.

C. Organizational policies

In addition to efforts on international and national levels, many intervention efforts addressing violence against women and girls and HIV/AIDS are provided by non-governmental organizations and institutions. These organizations play a vital role in all stages of intervention, thus, it is essential that these organizations adopt principles and programs that are compatible with international and national policies.

- Intervention programs must be developed, tested, implemented and evaluated based on available research, and updated to reflect new research findings.
- Intervention programs must be developed, tested, implemented, and evaluated with the involvement of women living with HIV/AIDS.

- Organizational policies and programs must be consistent with international human rights law and standards.
- Organizational policies and programs must respond to international guidelines and recommendations, such as the Guidelines on HIV/AIDS and Human Rights set forth by The Joint United Nations Programme on HIV/AIDS.
- Organizational structures must promote cultures of intolerance towards discrimination against women and girls, and individuals with HIV/AIDS.

CONCLUSION

Violence against women and girls and HIV/AIDS are co-existent epidemics that have devastating health and development consequences, and their relationship must be recognized as a bi-directional and mutually-reinforcing one. A broad network of biological, socio-cultural, and economic factors have been identified that are associated with the twin epidemics, including the biological nature of men and women, the phenomenon of sexual violence, the existence of intimate partners, the practice of condom use, the disclosure of HIV serostatus, as well as experiences of childhood sexual abuse, having multiple sexual partners, having sexual relations with older partners, and the realities of armed conflicts.

The links between the epidemics of violence against women and girls and HIV/AIDS have been firmly established, calling for a reform of current intervention strategies. To synergistically combat the devastating effects of the twin epidemics, an integration of intervention programming for the two epidemics is necessary. Such reform requires the sustained dedication of resources and commitments from various political levels and sectors.

Policy changes on the international, national, and organizational levels are also necessary to address the twin epidemics. While further research is needed to fully understand the complexity of their interactions, policies must be instituted to reflect the established connections between violence against women and girls and HIV/AIDS based on existing studies, and kept up-to-date with future research.