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Addressing violence against women in HIV testing and counselling: A meeting report

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The WHO would like to thank each of the meeting participants for sharing their vast experience and valuable work in the areas of HIV testing and counselling and violence against women. This report was prepared by Suzanne Maman and Elizabeth King of the University of North Carolina, Chapel Hill, United States of America, Avni Amin and Claudia Garcia-Moreno from GWH, and Donna Higgins and Amolo Okero from HIV at WHO. This report summarizes discussions held at the meeting and resulting conclusions. It does not represent official WHO policy.

Executive summary

The growing access to anti-retrovirals (ARVs) and the recognition of the potential benefits of people knowing their HIV status has prompted a stronger interest in making HIV testing more widely available. At the same time, there is increasing recognition that the HIV epidemic intersects in different ways with the epidemic of violence against women and girls. For example, in studies among women in sub-Saharan Africa, fear of partner's negative reaction, including abandonment, violence, rejection, loss of economic support and accusations of infidelity were the most commonly reported barriers to HIV testing and disclosure of HIV status.

Therefore, the World Health Organization (WHO) departments of Gender, Women and Health (GWH) and of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) co-convened an international meeting to discuss how HIV testing and counselling programmes can take into account and address as necessary intimate partner violence and other concerns related to women.

The meeting brought together practitioners, researchers and policymakers to: review existing information and experiences in addressing the impact of violence against women in HIV testing and counselling; identify promising strategies; and to develop related recommendations to guide programmes and policies in light of current strategies to expand access to testing and related services.

Emerging themes from this consultation included addressing the fear of or experience with violence:

1. As a barrier to women accessing HIV testing and counselling services;
2. In the counselling that is provided to women on how to disclose their HIV status to their sexual partners or other members of their social networks;
3. In the risk reduction counselling provided to women; and
4. As part of the post-test support needs of women.

Meeting participants reviewed specific programme approaches to address violence through HIV testing and counselling programmes. They proposed recommendations focusing on the four themes, and identified opportunities to address the fear of or experience with violence through the HIV testing and counselling process. They also provided suggestions for further research.

In order to address the fear of or experience with violence as a barrier to accessing HIV testing and counselling services, participants recommended that the first step is to raise awareness of the linkages between HIV and violence at different levels, such as among health care providers

and government health officials. Existing training modules for HIV testing and counselling should address violence through case studies focusing on barriers that women living in violent relationships face in accessing HIV testing services, disclosing their HIV test results to their partners, negotiating HIV risk reduction, and accessing post-test support and care. In settings where time and resources constrain the expansion of existing HIV counselling training, a supplemental training for HIV counsellors, with a focus on gender dimensions, including violence, was recommended. Participants also recommended that the HIV testing and counselling process could serve as an opportunity for women and HIV counsellors to discuss women's vulnerability to violence.

Responses to violence against women could be incorporated in HIV testing and counselling protocols. There are efforts under way to re-examine the models of HIV testing and counselling and adapt them to the diversity of settings, and to target them to specific populations. Participants identified two specific opportunities to address violence against women in the protocols, namely counselling on disclosure and risk reduction. It was recommended that HIV counsellors should engage in a discussion with women during the HIV testing and counselling process about fear of or experience with violence as a factor in their decision to disclose their HIV status to their partner. In cases where violence is a risk factor for women who disclose, then alternative models of disclosure, such as mediated disclosure, could be offered. In the risk-reduction planning that HIV counsellors do with clients during post-test counselling sessions, there must be an assessment of the extent to which women feel able to negotiate safer sex. Participants recommended that violence be addressed in relation to the post-test support needs of women who live in violent relationships. Counsellors need to be prepared to offer women ongoing support options, by referring them to existing support services for victims of violence. In settings where these do not exist or are inadequate, there is a need to build post-test support systems, including peer support models. The meeting report describes concrete examples of programmes that have implemented the above recommended strategies.

The meeting helped to identify two broad areas that require operational research. First, there is a need for more knowledge about women's experiences in HIV testing and counselling, including under provider-initiated models. The implications for women of different HIV testing and counselling models, including the provider-initiated model, warrant more thorough investigation in order to be understood better.

Second, there is a need for more operational research to assess the effectiveness of tools to improve outcomes of and support women through the disclosure and risk reduction counselling process. Attention should be paid to understanding how the scale-up of provider-initiated HIV testing and counselling can support women living with intimate partner violence to safely disclose their HIV status and reduce barriers in accessing appropriate and effective post-test services.

Key recommendations made by the meeting participants to address violence against women in HIV testing and counselling programmes

1. **Address violence as a barrier to women accessing HIV testing and counselling services by**
   - Raising awareness of the links between HIV and violence among programme managers, counsellors and clients.

2. **Address violence as a barrier to HIV disclosure, and as an outcome of disclosure for some women by**
   - Implementing tools that counsellors can use to identify and counsel women who fear violence and other negative outcomes following HIV status disclosure.
   - Offering alternative models for HIV disclosure, including mediated disclosure with the help of counsellors.

3. **Address violence as a barrier to women implementing risk-reduction strategies by**
   - Assisting women to develop strategies to protect themselves when negotiating safer sexual relationships.

4. **Address post-test support needs of women in violent relationships by**
   - Referring women to peer or other groups for ongoing psychosocial support.
   - Developing referral agreements with organizations that offer services for women living with violence.
   - Building support systems for women, including peer support models, where these services do not exist.

INTRODUCTION

The growing access to anti-retrovirals and the recognition of the potential benefits of people knowing their HIV status has prompted a stronger interest in making HIV testing more widely available. At the same time, there is growing recognition that the HIV epidemic intersects in different ways with the epidemic of violence against women and girls, including in the context of HIV testing and counselling. The World Health Organization (WHO) departments of Gender, Women and Health (GWH) and of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) therefore, co-convened an international consultation to identify strategies to address violence against women and other contextual factors affecting HIV testing and counselling programmes. The meeting built on the previous work undertaken by GWH to review the rates, barriers and outcomes of HIV status disclosure for women.[1] It brought together a group of practitioners, researchers and policy-makers working on HIV testing and counselling, and on violence against women to review experiences and develop recommendations that might guide health workers to address violence against women through HIV testing and counselling programmes.

The specific objectives of this consultation were to:

1. Identify and review promising strategies or good practices to support women who may fear or experience violence as a consequence of HIV testing and/or HIV status disclosure; and
2. Develop recommendations to guide programmes and policies related to HIV testing and counselling, in light of current strategies to expand access to these and related services.

Small group discussions were organized to help identify concrete strategies for HIV testing and counselling programmes to take into account violence against women and other contextual factors affecting women.

HIV status disclosure, in the context of this report, is the process that people who have been tested for HIV may undergo when sharing information about their HIV status with other people, particularly those in their sexual network. An important focus of this consultation was women's HIV status disclosure (for both – those who test positive and negative) to their sexual partners.

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[1] See World Health Organization (WHO). Gender dimensions of HIV status disclosure to sexual partners: Rates, barriers and outcomes (GWH Review Paper). 2004. Geneva, Switzerland, World Health Organization.
http://www.who.int/gender/documents/en/genderdimensions.pdf

This report summarizes the discussions and final recommendations from the meeting participants. Section 1 reviews the evidence of the association between HIV testing and serostatus disclosure and women's experiences of violence, describes current strategies to expand access to HIV testing and counselling, and discusses the implications of these various strategies for women.

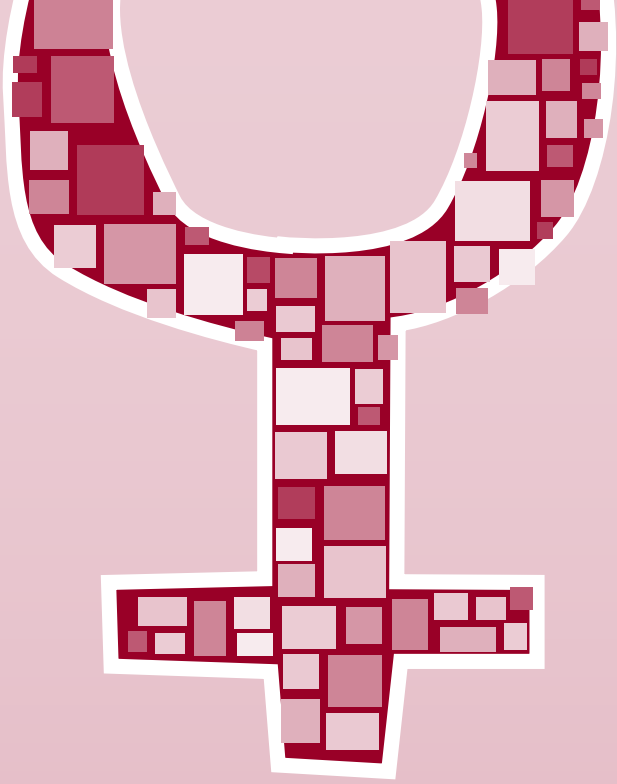
Section 2 describes specific programme approaches to address violence through HIV testing and counselling programmes, including strategies to achieve the following:

1. Engage male partners in the HIV testing and counselling process through couple counselling;
2. Train and build the capacity of HIV counsellors and other appropriate health care providers[2] to recognize and counsel women at potential risk of violence;
3. Integrate HIV testing services into other health-related services, such as those provided to women who have experienced sexual assault;
4. Create peer support programmes to support women through the HIV testing and counselling process; and
5. Integrate HIV testing and counselling programmes within services for women who have experienced intimate partner violence.

Finally, section 3 reflects conclusions and identifies specific recommendations made by the meeting participants to address violence against women:

1. As a barrier to women accessing HIV testing and counselling services;
2. In the counselling that is provided to women on how to disclose their HIV status to their sexual partners or other members of their social networks; and
3. In the risk reduction counselling provided to women.
4. As part of the post-test support needs of women.

[2] HIV testing and counselling is also offered by health care providers other than HIV counsellors. Henceforth, any reference to HIV counsellors includes other appropriate health care providers.



SECTION 1:

Background

1.1. Overlapping epidemics: HIV and violence

The HIV epidemic continues to grow with an estimated 39.5 million people living with HIV globally. Women are especially vulnerable to HIV and globally, they comprise 48% of people living with HIV *(1)*. Young women (15–24 years) are particularly vulnerable, comprising 75% of 15–24 year-olds living with HIV in sub-Saharan Africa. In parts of the Caribbean and Africa, they are up to six times more likely to be living with HIV than young men of the same age group *(2)*. Violence against women is now recognized as a public health emergency affecting women's health. As shown by the WHO multi-country study on women's health and domestic violence, violence against women by an intimate partner is widely prevalent and a major contributor of ill-health among women. The WHO study was conducted in 10 countries with over 24000 women representing diverse cultural settings: Bangladesh, Brazil, Ethiopia, Japan, Namibia, Peru, Samoa, Serbia and Montenegro, Thailand, and the United Republic of Tanzania. The study found that in the majority of the sites, the proportion of ever-partnered women who had ever experienced physical or sexual violence, or both by an intimate partner in their lifetime, ranged from 29% to 62%. The study also found that in the majority of the sites, sexual abuse by a partner was reported by between 10% and 50% of the women interviewed (3). This high rate of forced sex is particularly alarming in light of the HIV epidemic, providing an impetus to examine not only the links between violence against women and HIV, but also identify strategies to jointly address violence against women and HIV.

The epidemics of HIV and violence against women overlap in at least five ways. First, violence limits women's ability to engage in HIV preventive behaviours *(4, 5)*. Second, women who have experienced early physical and/or sexual abuse are more likely to engage in behaviours that place them at greater risk of HIV *(6, 7, 8)*. Third, women who experience violence are more likely to be in partnerships with men who are themselves at elevated risk for HIV infection *(9)*. Fourth, fear of violence and other negative social outcomes operate as critical barriers to women's ability to access HIV prevention tools and services, including HIV testing and counselling *(10, 11)*. Finally, there is evidence that fear of violence is a major barrier to testing and to disclosure of HIV status to sexual partners for many HIV positive women. Violence is also an outcome of disclosure among some women *(12)*. The current consultation focused on the associations between violence – fear of or experience with violence – and uptake of HIV testing and counselling, and HIV status disclosure, as well as on violence as an outcome of HIV status disclosure among some women.

The consultation built on previous work that WHO/GWH undertook to review the rates, barriers and outcomes of HIV status disclosure among women tested for HIV. The 2004 WHO systematic review of the scientific literature on the gender dimensions of HIV status disclosure found that the rates of disclosure to sexual partners in available published studies varied between 42%–100% (average 71%) in studies from the United States and 16%–86% (average 52%) in studies from the developing world. The lowest rates of disclosure were reported in studies conducted among women who tested for HIV in the context of antenatal care in sub-Saharan Africa. The most common barriers to disclosure reported by women were related to fear of partner's reaction. Women primarily feared abandonment and loss of economic support from a partner as well as violence and accusations of infidelity. Fear of violence was mentioned by women as a barrier to disclosure in about one quarter of all studies included in the review. For example, in two studies from the United Republic of Tanzania, fear of violence was reported by 16% and 19% of women; and in one study from Kenya, fear of violence was reported by 51% of women. In the majority of the studies, most women reported positive outcomes of disclosure, such as increased support, acceptance

and kindness, decreased anxiety, and strengthening of relationships. Violence as an outcome of disclosure was reported by a small proportion of those women who disclosed. For example, in studies from sub-Saharan Africa, among women who had disclosed their HIV status, between 3.5% and 14.6% reported disclosure-related violence, with the highest rates reported among women who tested for HIV in the context of antenatal care *(12)*.

1.2. Expanding access to HIV testing and counselling

HIV testing and counselling is an effective HIV prevention approach *(13)*. It is also a critical gateway to treatment and care services for people living with HIV or AIDS (PLHIV). For more than twenty years, people have learned their HIV status mainly through voluntary client-initiated services (also commonly known as voluntary counselling and testing or VCT). In the VCT model, clients seek out HIV counselling and testing services, receive HIV pre-test counselling, provide informed consent, are tested for HIV, and then receive HIV test results during a post-test counselling session. Client-initiated HIV testing services are often provided in free-standing HIV counselling and testing clinics.

The move towards universal access to HIV prevention, treatment and care by 2010 has prompted some new thinking about HIV testing. In the past few years, a consensus has emerged among public health and human rights experts, as well as affected communities, that people living with HIV and their families benefit significantly from becoming aware of their HIV infection. This convergence of opinion is driven principally by the recent and continued expansion of access to antiretroviral therapy (ART). Some also believe that increasing the numbers of people who know their HIV status through expanded access to testing will result in a decrease in HIV-related stigma and a 'normalization' of the HIV epidemic *(14)*.

To promote greater access to HIV testing and counselling, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and WHO are encouraging expansion of testing and counselling models to include an increase in VCT programmes and provider-initiated testing and counselling. Under provider-initiated models, providers initiate HIV testing with clients or patients in health care settings servicing populations thought to be at elevated risk of HIV infection, such as STI and TB clinics, as well as in antenatal care services, and in clinical and community-based health services in places where HIV prevalence is high. WHO and UNAIDS endorse only provider-initiated models that adhere to the core principles of HIV testing and counselling, namely that the services must be with the informed and voluntary consent of the clients, they must be confidential, and they must be accompanied by counselling *(15)*. The central difference between this model and the VCT model is that the testing and counselling is initiated by the health care provider and not by the client.

1.3. Implications of the different HIV testing and counselling approaches for women affected by violence

Given the role that fear of and experience with violence play in influencing women's uptake of HIV testing services and the occurrence of violence reported by some women following disclosure of HIV status, it is important that these issues are addressed by HIV testing and counselling services and providers. In addition, HIV testing and counselling programmes provide one of several possible entry points for identifying and providing support to women who are in violent relationships. As indicated by WHO's systematic review of rates, barriers and outcomes of HIV status disclosure, a small proportion of women report violence

as an outcome of disclosure *(12)*. These data do not obviate the need to continue to expand access to HIV testing and counselling services. However, these findings suggest that as testing becomes more common, a large number of women may avoid learning their HIV status or once known may not disclose positive results – thereby minimizing benefit – or may actually experience violence upon disclosing their HIV status. Moreover, as data from the WHO multi-country study on women's health and domestic violence indicate, expansion of HIV testing and counselling services is taking place in settings where there is a high prevalence of intimate partner violence *(3)*. In such settings, the fear of or experience with violence may not only deter the uptake of HIV testing and counselling, but also pose a barrier to disclosure and to risk reduction and prevention more broadly.

As national programmes and international organizations review and revise policies on HIV testing and counselling, there is an opportunity to address the specific needs of women, particularly those living in violent relationships. Therefore, it is critical that existing VCT models as well as new approaches to expand HIV testing and counselling services are cognizant of and pay particular attention to the situation of women and the inequalities that may make them vulnerable to HIV, as well as to abuse. As all models of HIV testing and counselling are strengthened and updated in different settings, operational research on the key issues identified below needs to be conducted to inform the roll-out of expanded HIV testing. At the same time, it is important to recognize that as HIV testing and counselling programmes struggle with the burden of providing services to an increasing number of clients, they constitute only one possible entry point for responding to the needs of women living in violent relationships.[3] Any efforts to address violence against women must be accompanied by a broader set of actions that go beyond HIV testing and counselling programmes. These include, for example, efforts to change social norms to make violence against women unacceptable, give women legal rights and protection from violent partners, and empower women to have access to and control over financial and other resources so that they can leave abusive relationships.

Women accessing HIV testing services face various obstacles. In many settings, women often have limited autonomy and decision-making authority regarding access to health services. As a result, models of HIV testing and counselling that rely on clients' initiative to seek out services may present substantial barriers for women. Fear of HIV-related stigma, discrimination and violence has been found to be a significant barrier to women accessing HIV testing under client-initiated models *(10, 11, 16)*. On the other hand, women often come into contact with health services during pregnancy and childbirth. Pregnancy is also a time when many providers initiate HIV testing and counselling with women because of the ability to provide ARVs for the prevention of HIV transmission from a woman to her infant and for the mother, when needed. Prevention of mother-to-child transmission (PMTCT) of HIV is a key opportunity to expand access to HIV testing and counselling, and provider-initiated testing and counselling is a key component of PMTCT. While more women may undergo HIV testing under the provider-initiated models, the proportion of women returning for their HIV test results is still low. Research among pregnant women suggests that some do not want to know their HIV test results because they fear discrimination, abandonment, stigma and discrimination from their sexual partners, peers, family, and from the health care establishment *(17, 18, 19, 20)*.

[3] While HIV testing and counselling service providers may be limited in their ability to intervene or prevent violence from occurring, as a minimum they need to abide by the basic premise of "do no harm" and to assist women in safely disclosing their HIV status.

All models of HIV testing and counselling recommended by UNAIDS and WHO are required to uphold the core principles (or 3 Cs) of HIV testing and counselling, namely voluntary consent, confidentiality and counselling (15). The process of informed consent for an HIV test is complex. To make a truly informed and voluntary choice about HIV testing, women must receive and understand the information about the HIV test and its possible consequences, and perhaps more importantly, must feel empowered to make a genuine choice about whether or not to have a test. Given the unequal power dynamics that exist between women and their health care providers in many settings, women may not feel empowered to make a truly informed and voluntary choice, or may prefer that the provider make a decision on their behalf. The fear or experience of violence is likely to make it even more difficult for women to give fully informed consent as they not only have to contend with making a decision for themselves, but also have to consider the possibility of negative reactions from their partner. Empirical evidence is needed to inform the development of messages and best practices to enable women, including those living in abusive relationships, to give truly informed and voluntary consent and assist them in safely disclosing their HIV status.

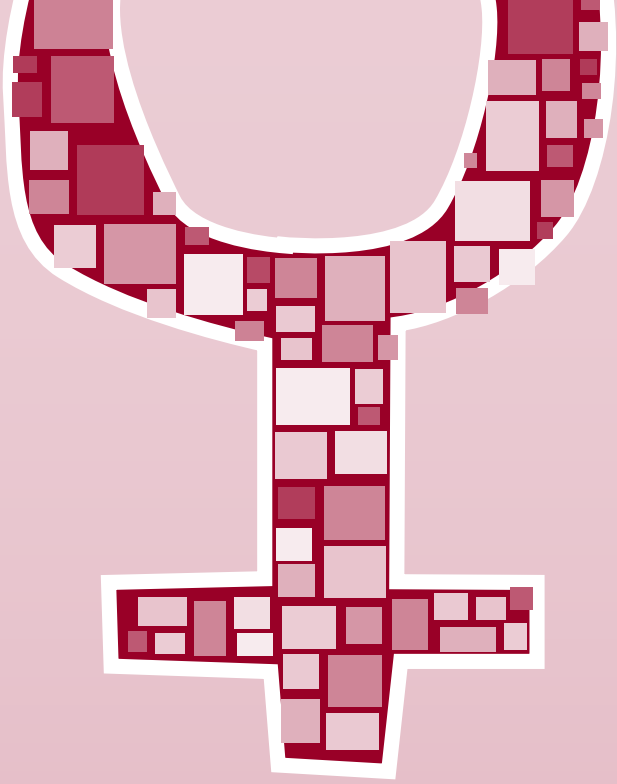
All models of HIV testing and counselling recommended by UNAIDS and WHO stress the importance of confidentiality. The importance of ensuring the confidentiality of HIV testing and counselling is underscored for women who live in violent relationships. The literature highlights that some women make the decision to test for HIV without the consent or knowledge of a partner *(11)*. HIV testing and counselling services should take all possible measures to eliminate the possibility that a partner might learn of a woman's decision to take an HIV test, or the result without her consent. In practice, it may be more difficult to ensure confidentiality of HIV testing and counselling in approaches such as door-to-door testing and mobile testing in communities, which are being promoted now to expand access to HIV testing.

The VCT and the provider-initiated approaches to HIV testing differ in the extent of counselling they offer to clients. The VCT model involves a two-point counselling process, including individual pre- and post-test counselling for all clients. The UNAIDS and WHO policy states that in the case of provider-initiated offer[4] of testing and counselling "the standard pre-test counselling used in VCT services is adapted to ensure informed consent, without a full education and counselling session *(15)*." In some settings, for example in antenatal care clinics, the individual pre-test counselling session has been replaced with a group information session. The staffing and time requirements for a group pre-test information session are less intensive than individual sessions. This is an important consideration for clinics with a high patient load and limited staff availability. Individual pre-test counselling sessions serve as an opportunity for counsellors to help clients think through the implications of an HIV-positive test result, and begin to help plan for HIV disclosure. It also is an opportunity to discuss a person's risk behaviors. Group information sessions may be sufficient for clients to make a decision about whether or not to take an HIV test, provided that enough information is given to enable clients to make an informed choice about taking the test, and confidentiality is maintained. UNAIDS and WHO recommend that all clients, HIV-positive and negative, undergo individual post-test counselling.

There are also implications for post-test support that might be available to clients undergoing

[4] The 2004 UNAIDS and WHO policy on HIV testing and counselling will be superseded by the new WHO guidance on Provider-Initiated Testing and Counselling (PITC), which is forthcoming in 2007. At the time of this consultation (January 2006), the guidance on provider-initiated testing and counselling was based on the 2004 policy statement, which is used as the reference in this meeting report.

HIV testing and counselling. Referral to post-test support services is a key element of all HIV testing and counselling programmes. The lack of ongoing support services or referral options for women living in violent relationships poses a challenge for all health services including HIV testing and counselling programmes. This challenge may be exacerbated if emphasis is placed on expanding the number of women tested for HIV, without simultaneous efforts to expand the support services available to women, as well as HIV and violence prevention programmes directed at men. WHO recommends that the scale-up of testing and counselling should be accompanied by a concomitant expansion of other facilities for HIV prevention, treatment, and care. How to mobilize the resources to build the care and support infrastructure at the same time as the HIV testing and counselling infrastructure is a challenge that lies ahead for all settings experiencing a rapid expansion of programmes.



SECTION 2:

Approaches that address HIV testing and violence against women

The current consultation arose from efforts to answer the following questions:

1) What is the experience of programmes that are jointly addressing violence and HIV testing and counselling?

2) What challenges do these programmes face in implementing their services?

3) What strategies have they used to overcome these challenges?

4) What are alternative approaches that could be used to address violence in the context of HIV testing and counselling?

Representatives of programmes that are jointly addressing the problems of HIV and violence highlighted their approaches, identified lessons learned, and formulated recommendations for strategies that could be used by HIV testing and counselling programmes to address violence against women. The section below summarizes the different programme strategies presented. Strategies can be broadly categorized as those: a) addressing violence against women in HIV testing and counselling programmes, b) addressing HIV-related needs among women who experience violence.

2.1. Addressing violence against women in HIV testing and counselling programmes

2.1.1. Couple counselling

Couple-based HIV testing and counselling has been widely promoted to overcome some of the challenges that women face in accessing HIV testing services and disclosing HIV test results to partners *(13, 21)*. In sub-Saharan Africa, while up to 60% of new HIV infections are acquired from a spouse, it is estimated that only 1% of couples living together have been tested together *(22)*. Given the barriers that women face in accessing HIV testing services on their own, the assumption is that if men are encouraged to bring their female partners with them for HIV testing and counselling, this may help overcome some of the barriers to testing and HIV status disclosure for women. It may also encourage men to take more responsibility for sexual behaviour that places both partners at risk *(19)*. The experiences from programmes that offer couple-based counselling suggest that counselling couples rather than individuals may result in greater subsequent behaviour change, and therefore better HIV prevention outcomes. These programmes also suggest that a focus on couples may help overcome barriers to disclosure, and mitigate negative outcomes as a result of disclosure. There is a need, however, for more assessment of couple-based counselling programmes in order to determine their level of uptake and effectiveness in terms of disclosure and access to post-test services.

EXAMPLE 1

AIDS Information Centre (AIC), Uganda: Couple counselling and testing

Description of the programme: The AIDS Information Centre (AIC) was established in 1990 by a consortium of government, nongovernmental organizations (NGOs) and various development partners. The services were initially established to respond to the growing public demand for HIV testing services. The programme started with one free-standing site in Kampala, and has now grown to eight stand alone centres and 163 AIC supported integrated service centres throughout Uganda. The AIC mission is to prevent the spread of HIV and mitigate its impact by being a model of excellence in the provision and scaling up of VCT, HIV-related information and education, and promotion of care and support.

Strategies used to address HIV and violence jointly: One approach that the AIC has taken to support clients and potentially minimize the risk of negative social outcomes of HIV status disclosure is couple counselling, and post-test support for HIV discordant couples. The AIC has focused on couple counselling as its primary strategy to address some of the challenges faced by women in accessing HIV testing services and disclosing HIV test results to their sexual partners. Over fifty percent of the clients who receive services at AIC, receive them as part of a couple. To ensure that women who come to the centres as part of a couple are not being coerced into doing so, the counsellors meet with the men and the women separately for the pre-test counselling session. The counsellors conduct the risk reduction assessment, talk to the clients about their readiness to test, and assess their understanding of the test results. If the clients decide to test, then they are tested on site. The couple receives the results in individual post-test counselling sessions. If the couple wants to come together and disclose results to one another in the presence of the counsellor, they have that option at the end of their individual post-test counselling session. A majority of couples who use the services together opt for this kind of joint session.

The special needs of discordant couples have also been an important focus of the AIC couple counselling initiatives. AIC staff have noted that the threat of violence and other negative social outcomes including abandonment is particularly salient for women who are the HIV-infected partner in a discordant couple. The AIC has established discordant couple clubs to provide ongoing support. They established four such couple clubs and by 2004, 145 couples had been recruited at one branch, out of which 75 were active participants. Counsellors reported that the formation of these discordant couple clubs have helped couples to remain in a stable partnership, and have reduced the violence reported by women in discordant couples. Formal evaluation of this approach is essential.

For further information see: http://www.aicug.org/

Lessons learned from the AIC programme:

- It is important to meet the man and the woman in the couple separately for pre-test counselling sessions and to provide an option for mediated disclosure at the end of the individual post-test counselling sessions.
- Focusing on the needs of HIV serodiscordant couples – where some women may have a higher likelihood of experiencing violence – is a strategy that needs to be considered.

Questions remaining related to couple counselling and post-test support:

- Are couple counselling and testing approaches, including those that have post-test support for discordant couples, effective in mitigating negative social outcomes, including violence for women?
- What is the feasibility of using this approach as countries move towards rapidly expanding access to HIV testing and counselling services?

2.1.2. Capacity-building for HIV counsellors to address violence

Another strategy to address concerns about violence within the context of HIV testing and counselling is to build capacity of the counselling staff to identify and appropriately counsel women experiencing violence. The rationale for this approach is based on the fact that for HIV testing and counselling programmes to respond to women's needs, it is essential that providers understand the links between violence against women (VAW) and HIV, the relevance of these associations to their own work, and how they can practically respond to these concerns. Issues that need to be kept in mind in considering these programme examples in the context of scaling up is that HIV counsellors and other health care providers are faced with enormous workloads, work under very tight time constraints, and often do not have adequate training to respond to some of the most basic needs that arise within HIV counselling sessions. Adding appropriate counselling on violence against women to their current workloads may be challenging.

Nonetheless there are programme examples from several settings that build this perspective among HIV counsellors. This can be either integrated into core training related to HIV counselling, or added on as a separate module beyond the basic HIV counselling training. As testing and counselling services are scaled up, these experiences provide important insights to draw on for capacity-building of counsellors. While the potential for experiencing violence as an outcome of disclosure could be raised at several points throughout the counselling process, counselling skills on addressing violence are particularly important when discussing possible HIV disclosure plans and risk reduction strategies. Evidence suggests that fear of and experience with violence play a significant role in women's decisions regarding both HIV status disclosure to sexual partners and their ability to adopt HIV risk reduction strategies.

EXAMPLE 2

Centre for the Study of Violence and Reconciliation (CSVR), South Africa

Description of the programme: Since 2001, the Centre for Violence and Reconciliation in South Africa has been involved in training, advocacy, research and the development of information and education materials to train health care workers and HIV counsellors who are working with women who have experienced stranger rape or intimate partner violence.

Strategies used to address HIV and violence jointly: The centre has conducted a number of training programmes including a training programme for HIV counsellors to identify instances of domestic violence in three voluntary counselling and testing sites. They have also implemented two training workshops for 19 organizations that work on violence against women to help them integrate a focus on HIV, and they have conducted a series of year-long interventions training nurses to "screen" for intimate partner violence.

Process evaluation findings of the screening programme: The organization conducted a process evaluation to describe the factors that influenced the nurses' effectiveness at screening women for violence within the HIV testing and counselling services. Overall, the evaluation revealed significant problems in instituting the screening guidelines. A few key findings are highlighted below:

1. Nurses were reluctant to engage with the emotional impact of domestic violence and so tended to avoid discussing it with clients. Staff often felt helpless in relation to domestic violence, were fearful of strong emotional responses from clients, and were themselves traumatised by the stories they heard;
2. Nurses were reluctant to take on the additional responsibility and demands of screening for domestic violence; and
3. Generally, nurses worked in high pressure environments with limited time and heavy workloads. The screening procedure required both additional time and paperwork and hence, became an unlikely prospect for nursing staff. The profound lack of appropriate referral services made nursing staff less inclined to implement screening procedures. Patients also perceived a lack of appropriate referral services. In this context both nurses and patients may query the benefit of engaging with issues of domestic violence without the availability of appropriate follow-up.

Conclusions and recommendations: Based on these findings the following recommendations were made:

1. A thorough review of referral services needs to be undertaken prior to implementation of screening procedures, and this information should be made available to health workers.
2. The utility of screening in the absence of suitable referral services needs to be carefully considered.
3. The evaluation suggests that not all staff display the necessary sensitivity or desire to engage with emotional issues relating to domestic violence.
4. Commitment from regional and clinic managers is required, as well as that of health workers.
5. A formal procedure for monitoring the impact of screening for violence needs to be systematically developed and implemented.

For further information see: http://www.csvr.org.za/gender/

EXAMPLE 3

Cell for AIDS Research Action and Training (CARAT), India

Description of the programme: CARAT is involved in capacity-building for the government and NGOs in India. For the past five years they have been implementing training programmes throughout South and Southeast Asia. They have focused on capacity-building related to HIV counselling, sexuality, care and support, and research. They design training workshops to meet the specific needs of organizations and established HIV/AIDS programmes, such as the National AIDS Control Programme, State AIDS Control Programmes, funding organizations and both local and foreign NGOs. The duration of the training workshops vary from between 2 weeks to 2 months, depending on the specific needs of an organization.

Strategies used to address HIV and violence jointly: Since 2001, CARAT has initiated an annual ten-week advanced certificate programme on HIV counselling and psychosocial interventions. This has been a core training activity for the organization. The entire certificate programme is structured into seven modules of 30 hours each. Gender based violence and its link to the HIV epidemic is a central theme of this programme.

Core topics related to violence and HIV covered in the CARAT training: The trainings cover information on the social construction of gender and violence, the gendered nature of the HIV epidemic, and a firm understanding of gender-based violence. They have also covered violence as a public health issue, a review of the legal rights regarding violence and caste, communal violence and HIV. The specific skills that are covered in the training include assessment of violence in pre- and post-test counselling; options for disclosure; couple counselling; case-work and crisis intervention; and referral and networking to address issues affecting women who may be positive or negative. In their training, CARAT also helps to develop skills in family interventions and in setting up support and self-help groups.

For further information see: http://www.tiss.edu/carat/

EXAMPLE 4

Family Health International (FHI), Asia-Pacific Region

Description of the programme: FHI is involved in capacity-building of HIV counsellors in the Asia-Pacific Region. This region presents a number of unique challenges in terms of implementing HIV testing and counselling programmes and training counsellors. For example, in China this includes mass screening and case-finding. In China and Vietnam there are reports of involuntary third-party disclosure within a specified time period, particularly for minors.

Strategies used to address HIV and violence jointly: FHI has developed a number of HIV counselling protocols specific to disclosure and assessing risks following disclosure. One of these protocols is presented in Section 3. In FHI-operated HIV testing and counselling sites, they have also offered a number of different disclosure options to clients including: preparing and supporting the client to self-disclose independently; preparing clients to self-disclose with a counsellor present; having the counsellor disclose in the presence of the client; having the counsellor disclose on behalf of the client (with written permission); and preparing the client to disclose to a relative with or without the support of a counsellor. To prepare the clients for disclosure, FHI-trained counsellors conduct role-rehearsals with the clients with the goal of developing the communication skills to initiate disclosure, manage partner/family reactions and questions, and planning for the next stage of their sexual relationships.

For further information see: http://www.fhi.org/en/HIVAIDS/index.htm

EXAMPLE 5

Rakai Health Sciences Programme, Uganda

Description of the programme: The Rakai Health Sciences Programme was initiated in 1990 as a collaborative initiative between the Uganda Ministry of Health, Makerere University, the Johns Hopkins University and Columbia University. The Rakai Health Sciences Programme is a reproductive health research and service provision programme. The programme activities include epidemiological and behavioural studies to document and increase knowledge about the HIV and STI epidemics; large community randomized intervention trials for HIV prevention, STI control and safe pregnancy; provision of HIV and STI preventive services; provision of HIV and STI treatment services; and community-based health education. Based on results from the cohort data collection in Rakai, the study team found that 30% of women reported experiences of physical threats or abuse from their intimate partner and 24% of women reported sexual coercion by their intimate partner. The team found that a woman's perception that her (male) partner is at risk for HIV is associated with higher rates of domestic violence, and that domestic violence is associated with less discussion about HIV testing and results with a woman's partner. They also concluded that early sexual coercion is linked with higher risk of HIV acquisition later in life.

Strategies used to address HIV and violence jointly: To address the high rates of violence reported in the community cohort, the Rakai team developed and implemented workshops to:

1. Train research assistants and counsellors to encourage couple communication about HIV, and couple HIV testing and sharing of results when promoting VCT;
2. Train HIV counsellors to ask questions about partner violence, offer psychosocial support, encourage disclosure when appropriate and make referrals when necessary; and
3. Strengthen capacity at the district level, and establish a community-based network of providers/institutions to handle and refer cases of domestic violence by coordinating seminars for Rakai District's social welfare officers and police.

Two training workshops have so far been implemented. Based on an informal evaluation, they found that while the workshops had led to improvement in counsellors' level of awareness and understanding of domestic violence as a serious problem, there was almost no impact on change in the counsellors' practice.

In response to the disappointing evaluation data, they developed another project: Safe Homes and Respect for Everyone (SHARE) to provide more sustained opportunities for working with counsellors. The SHARE project includes the following components:

1. Training workshops and seminars;
2. Monthly staff development meetings;
3. Using a system of planning and reporting;
4. Using a system for managing cases; and
5. On-site technical visits (by SHARE staff) to provide feedback and guidance.

The SHARE programme is also supporting the establishment of support groups for women (in general) and for HIV positive women by training community-volunteer counsellors who will reach out to women experiencing violence with the aim of helping them overcome barriers to HIV testing.

For further information see: http://www.preventgbvafrica.org/images/program_approaches/hiv/rakai.hiv.pdf

Lessons learned from the training and capacity-building efforts:

- Training for HIV counsellors should adopt a holistic approach that includes topics such as sexuality, care, support and gender equality, including gender-based violence.
- Systems to institutionalize support for counsellors need to be established to help them put into practice what they learn during the training.
- In addition to ongoing training opportunities, it may be useful to build in systems of support for counsellors – including staff development meetings.
- Training workshops should include opportunities to practice role-playing and skills-building exercises.
- Training could include separate modules on key topics, including violence against women, in addition to the core HIV testing and counselling training module.

Questions remaining on training and capacity building:

- As countries move towards rapid scale-up of HIV testing and counselling services and an increasing number of health care providers (including counsellors) are being trained, how can creative training approaches be incorporated most effectively into core training to prepare counsellors to assist women with HIV disclosure and risk reduction, particularly those who are vulnerable to negative outcomes?
- Counsellors are increasingly being asked to address a number of issues beyond those that are directly related to the HIV counselling process (e.g. reproductive health and violence issues). How can counsellors be supported to respond to the needs of women who fear or experience violence, when they frequently experience poor work conditions (e.g. high workloads, lack of capacity and supervision)?
- What other mechanisms can be developed to provide support to clients of HIV testing and counselling services beyond HIV counsellors?

2.2. Addressing HIV among women experiencing violence

Services for women who have been subjected to violence provide another entry point for HIV testing and counselling.

2.2.1. Integrating HIV testing and counselling services for female survivors of sexual assault

Victims of sexual assault present a unique set of challenges in terms of HIV testing and counselling, as well as post-test support. Programmes that respond to the needs of survivors of sexual assault are faced with the challenge of not only helping them cope with their experience of sexual assault, but also delivering services to them such as post-exposure prophylaxis (PEP) and HIV testing and counselling. Programme examples highlighted in this consultation show different approaches to working with female victims of sexual assault in three different settings – Haiti, Rwanda and Kenya.

EXAMPLE 6

Women's Equity in Access to Care and Treatment for HIV (WE-ACTx) and the Rwandan Women's Inter-association Study and Assessment (RWISA), Rwanda

Description of the programmes: It is estimated that between 150,000 and 200,000 women became infected with HIV as a result of rape during the 1994 genocide in Rwanda.

WE-ACTx was founded in 2004 to help women who became infected with HIV during that period to access antiretroviral therapy (ART). WE-ACTx has partnered with NGOs and the government of Rwanda to operate HIV testing/counselling and ART clinics. Staff members at the HIV testing and counselling and treatment clinics are trained in understanding the short- and long-term effects of rape. This includes HIV infection and prevention, providing care and support for women who have suffered rape, pre- and post-test counselling for HIV, providing care and support for People Living with HIV (PLHIV), and income-generating opportunities for clients. Many of the counsellors themselves are survivors of rape and other forms of violence.

RWISA, funded by the US National Institutes of Health in collaboration with the Rwanda Ministry of Health and Rwandan NGOs, is a cohort study of 984 women established to assess the impact of trauma on HIV-related disease progression and responses to treatment. Half of the women enrolled experienced rape during the 1994 genocide. The community, including many women living with HIV, participated in the design of the study and the development of study questions.

Strategies used to address HIV and violence jointly: In order to address some of the barriers that women face in accessing services, WE-ACTx initiated a family-centred approach to HIV testing and counselling, which invites entire families to be tested. WE-ACTx also organized mobile testing sites in order to overcome barriers expressed by women in the community. The test results are provided in a safe environment with a counsellor present. The counsellors assess for domestic violence, provide ongoing support for the client, and make the necessary referrals for medical care. The counsellors also help with disclosure and the risk of domestic violence by creating a safe space for disclosure, and are available during disclosure to support the client. They offer both individual, as well as couple testing. We-ACTx also offers counselling for discordant couples. The organization helps women identify income-generating opportunities, and provides food for women on ARVs – strategies that further support women affected by HIV and by violence.

For further information see: http://www.we-actx.org/

EXAMPLE 7

Haitian Study Group on Kaposi Sarcoma and Opportunistic Infections (GHESKIO), Haiti

Description of the programme: GHESKIO is an NGO created in 1982 to provide services for the care and treatment of HIV and related opportunistic infections. The GHESKIO model is designed to provide integrated services at one site. As a response to a growing need, in June 2000, a programme was initiated to provide emergency contraception and post-exposure prophylaxis (PEP) to rape victims. The sexual violence unit is located within the reproductive health department, and offers comprehensive care and support to victims of sexual violence. The majority of clients are referred from the State University Hospital in Port-au-Prince, and all services are provided free to the client. The team includes two obstetrician-gynaecologists, one social worker, one full-time psychologist and one part-time psychologist. Between June 2000 and December 2005, 804 women received care at the sexual violence unit. A majority (73%) of rape victims did not know their aggressors, and 43% of rapes involved more than one aggressor. A small proportion (4.4%) of women were infected with HIV at the time of the initial visit to the clinic. Fifty-seven percent of women received PEP. One of those women receiving PEP and 5 women of the remaining 43% who did not receive HIV prophylaxis became infected with HIV.

Strategies used to address HIV and violence jointly: GHESKIO provides an integrated approach to addressing the medical and psychological care and support needs of clients in its sexual violence unit. This approach offers the opportunity for discussing treatment and prophylaxis adherence, repeat HIV testing, follow-up visits, counselling support, ongoing group support and disclosing the rape and HIV results to partners. When a woman arrives at GHESKIO, a social worker offers testing for HIV and syphilis. The social worker is a trained VCT counsellor. Almost all (98%) women agree to be tested for HIV, STIs and pregnancy. The client is then attended by a medical staff and prescribed appropriate medications and ARVs if needed. The woman is directed to the psychologist who is located within the same facility. The individual psychological consultation lasts between 30 and 60 minutes. It allows the woman to describe her experience, and offers the chance for the psychologist to address issues of treatment and medication side-effects and the need for follow-up tests. Finally, the woman receives the diagnostic test results from the physician, and is directed to the pharmacy for medications.

Women return to the unit for follow-up medical care and psychological support. The protocol for psychological consultation is three individual sessions. At the initial visit, clients are invited for more individual sessions and to a weekly peer support group. The group sessions are designed to encourage the sharing of feelings and emotions in a safe environment, promote support from others going through similar experiences and to help break the feeling of social isolation. Family support and couple testing and counselling are also available through the unit at GHESKIO. The psychologist has set up an informal systematic referral system to organizations for legal assistance, psychiatric care and self-help/support groups for people living with HIV (PLHIV).

For further information see: http://www.haitimedical.com/gheskio/projets.htm#Prévention

EXAMPLE 8

Liverpool VCT Programme (LVCT), Kenya

Description of the programme: LVCT manages 48 VCT sites, and provides technical support to more than 250 additional sites throughout Kenya. It maintains seven post-rape care centres, and from 2004–2005 provided services to 690 rape survivors. LVCT also focuses on promoting policy changes and conducting operational research in relation to HIV testing and counselling.

Strategies used to address HIV and violence jointly: Since 2002, LVCT has offered combined HIV care and post-rape care services. The intervention arose from a lack of guidelines and standards to address the needs of rape survivors and the negative attitudes towards rape survivors among health care providers. The post-rape care programme aims to influence policy and practical responses to gender-based violence and strengthen the linkages between post-rape care and HIV services. LVCT post-rape care programme entails providing support to selected public health facilities by supplying them with PEP and emergency contraception (EC) which are given to survivors of sexual assault. LVCT also trains health care workers in those facilities. HIV counsellors are equipped with the necessary information and skills to provide counselling for crisis and trauma prevention. The ongoing support consists of four additional follow-up counselling sessions with the client. HIV testing is required in order to receive PEP in Kenya. The HIV testing and counselling component is modelled on the Kenyan VCT standard, and takes into account the additional support women may need in disclosing sexual violence and HIV status. The clinical staff is trained on medico-legal issues of post-rape care and the LVCT algorithm for providing care to rape survivors.

Rape trauma counsellors undergo a three-month training on issues of trauma care, HIV testing and counselling, PEP adherence and the Kenyan justice system. The manuals used to train both the rape trauma counsellors and clinicians on post-rape care issues were adopted by the Kenya Ministry of Health in October 2005. Those who undergo training for rape counselling are already practicing VCT counsellors. Police and NGO representatives are also trained on how to be supportive of and advocate for rape survivors. LVCT has expanded this programme from three sites in 2004 to seven in 2005 and is planning to have 15 sites open by the end of 2006.

For further information see: http://www.liverpoolvct.org/VCT_after%20rape/vct_rape.htm

Lessons learned from programmes that focus on sexual assault and HIV:

- Counsellors who work with survivors of sexual assault require specialized skills in understanding the impact of rape on the well-being of women and providing comprehensive rape care services including psycho-social and other counselling.
- Counselling on disclosure for survivors of sexual assault needs to focus both on disclosing the HIV test result and the sexual assault experience.
- Organizations that work with sexual assault survivors need to have a well-functioning network of referral organizations for legal support, medical care (including injuries) and psychiatric care.
- Support groups could be one strategy to provide post-test support for survivors of sexual assault.
- Programmes need to incorporate a focus on social support networks, including families to help survivors of sexual assault cope and obtain ongoing support.
- There is a need to establish additional training for police and NGOs so that they are a part of the referral mechanism and are adequately prepared to handle women who are referred.

Questions remaining related to providing services for victims of sexual assault:

- Should HIV testing and counselling programmes address the needs of victims of sexual assault and if so, how best to do this? In what types of settings should specific services for survivors of sexual assault be integrated?
- What are the challenges and support needed in preparing HIV counsellors to undertake other kinds of counselling, including rape trauma counselling, in addition to HIV testing and counselling and treatment adherence counselling?

2.2.2. Addressing HIV among women experiencing intimate partner violence

Available literature suggests up to three-fold increase in risk of HIV among women who have experienced intimate partner violence compared to those who have not *(23, 24, 25)*. Therefore, violence-related services may serve as a critical entry point to link women abused by partners to appropriate HIV prevention, and AIDS treatment and care services. The current consultation highlighted the experiences of a domestic violence organization in Rhode Island, USA that has integrated a focus on HIV within its programmes.

EXAMPLE 9

WomenCARES project in Rhode Island, USA

Description of the programme: The WomenCARES project was developed under the umbrella of the Sojourner House, a domestic violence agency in Rhode Island. In 1999, the Sojourner House realized that many of their clients were at risk for HIV, and developed the WomenCARES project to educate women of colour on the links between domestic violence and HIV infection. The project serves women of colour aged 15 years and older with current or past involvement in physically, sexually, or emotionally abusive intimate relationships, and/or histories of sexual trauma and subsequent intimate partner violence. Many of these women have elevated risks for acquiring HIV through unprotected sex or injecting drug use. The programme includes individual, group and community/policy level interventions focused on addressing the links between violence and HIV infection.

Strategies to address HIV and violence jointly: At the individual level, WomenCARES has trained 25 peer educators who are survivors of intimate partner violence, some of whom are HIV positive, to work with individual clients providing pre-test counselling, accompanying them to testing sites, and either providing or helping women access post-test support. The peer educators also help women with safety planning, identifying risk factors in their relationships, and developing strategies for sexual protection in abusive relationships. The group-level intervention includes an eight-week, two-hour per week educational series with 4–10 participants per session, and is focused on risk assessment, risk reduction activities, skills- building, safety planning, referrals for HIV and other STI testing, and goal setting. The group-level intervention is geared towards women of colour who are at risk of HIV exposure. At the community level, WomenCARES has partnered with over 50 community-based organizations including AIDS service organizations, churches, social services, hospitals, health centres, hair salons and local businesses. The staff of WomenCARES provides trainings to these partner organizations on domestic violence and HIV. WomenCARES has also been involved in advocating for policy-level changes. The first step was to increase awareness in the Rhode Island State Health Department of the association between violence and HIV and gain support for addressing the problem. Through a campaign called "Are you safe?" the organization has also been advocating for changes so that health care workers routinely ask all women about their risk of both HIV and violence. This question has now been incorporated as an item on the standard intake form used by all Rhode Island public health facilities that provide HIV testing services.

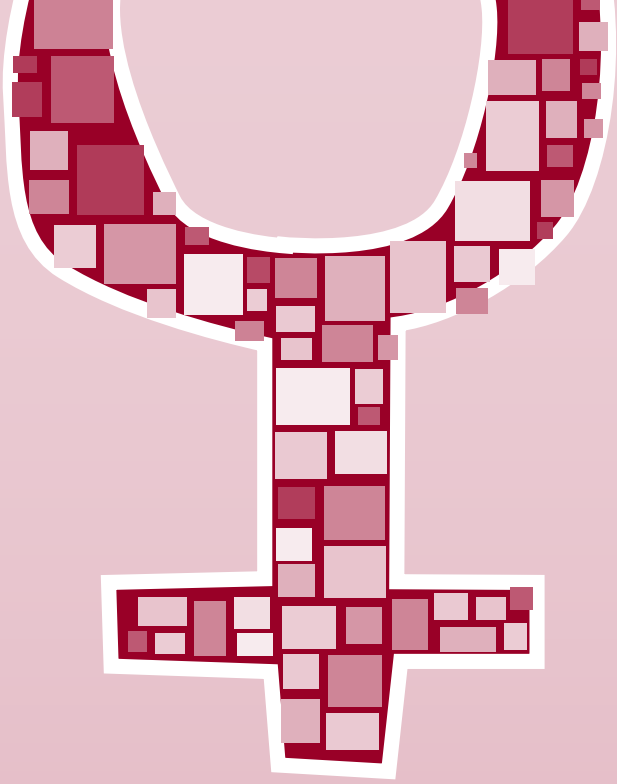
For further information see:
http://www.sojourner-house.org/sojourner/services/Services/WomenCARES.htm

Lessons learned from programmes that focus on HIV within services for intimate partner violence:

- Multi-pronged approaches are important in order to address the individual needs of women, create supportive environments, and advocate for policy-level changes to provide appropriate services to women who are affected by violence and are at risk of HIV infection.
- Involving HIV-infected women who have experience with intimate partner violence as peer educators is an important strategy to reach out to women who need services, and provide them with support networks.
- In settings where there are organizations and services available to support the myriad of needs of women affected by violence and HIV, developing formal linkages with these organizations and partnering with them to develop two-way referral systems is important.

Questions remaining related to incorporating a focus on HIV within violence against women services:

- What elements of violence against women and HIV could be incorporated minimally in each type of programme to address the overlapping epidemics of HIV and violence against women? For example, can programmes addressing violence against women undertake community education and support women in accessing and negotiating HIV testing and services, while HIV programmes conduct risk assessment, cross-refer and assist women in safety and disclosure planning?
- Where there are services in place to support victims of intimate partner violence, what is the minimum package of training for HIV testing and counselling staff that would be needed to address the violence faced by some of their clients?
- What are the best mechanisms to build networks between organizations that provide HIV testing and counselling services and those that provide services for violence against women?



SECTION 3:

Conclusion and recommendations

With the goal of universal access to HIV prevention, care and treatment programmes by 2010, considerable efforts are currently under way to increase the numbers of people who are aware of their HIV status. Women will be among the main beneficiaries of the expanded access to HIV testing and counselling services. Evidence indicates that fear of and actual violence has an impact on women's uptake of HIV testing and counselling services, HIV status disclosure and access to post-test services. This consultation aimed to identify strategies that could be implemented to address these issues through HIV testing and counselling programmes, and by integrating HIV testing and counselling into programmes serving women who are survivors of sexual assault or intimate partner violence. Such strategies include HIV testing and counselling programmes addressing issues of violence against women, while acknowledging that addressing violence against women requires a broader effort beyond the health sector, including efforts at the policy level and with communities to change social norms. However, recognizing that the expansion of HIV testing and counselling services provides an opportunity to address women's needs, the meeting participants focused on identifying concrete strategies for HIV testing and counselling programmes and services to address fear of or experience with violence.

The current consultation made recommendations for integrating issues of particular concern for women, such as intimate partner violence, within existing HIV testing models and protocols. The group identified four specific opportunities to integrate a focus on violence within HIV testing and counselling programmes, including: 1) violence as a barrier to women accessing HIV testing and counselling services; 2) violence as a barrier to women disclosing HIV test results to their sexual partners; 3) violence as a barrier for women to negotiate HIV risk reduction with partners and 4) the post-test support needs of women living in violent relationships. The proposed strategies described below are based on the programme examples that were presented and on discussions that took place during the consultation.

3.1. Addressing violence as a barrier to women accessing HIV testing services

Concerns about male partners' attitudes and reactions to HIV testing are major barriers to women's uptake of HIV testing services. The advent of provider-initiated models of HIV testing may help bypass some of these barriers by reaching women and offering them the opportunity to test when they come into contact with the health care system for other health conditions, including pregnancy and childbirth. This may help overcome women's concerns about accessing testing services without the explicit knowledge and consent of partners. However, even within these models women are still faced with the decision about whether to test, and to inform their partners of their testing decision, as well as of the test results. To address violence – and fear of violence – as a barrier to accessing HIV testing services, awareness of the associations between HIV and violence needs to be raised at various levels. In many settings, health care providers, particularly those who are managing HIV testing and counselling services – and HIV counsellors themselves – are not aware of the associations between HIV and violence against women. Meeting participants highlighted the need to raise awareness among providers, so that services can be designed to respond to the specific needs of women, particularly those living in violent relationships and/or with the threat of violence.

In this light, participants recommended that information, education and communication (IEC) materials geared towards programme managers should be developed. For example, greater awareness could be achieved through distribution of relevant WHO-published fact sheets on the association between HIV and violence to all national HIV testing programme offices within the Ministry of Health. The distribution of printed material should be supplemented by seminars and similar orientation opportunities. National HIV testing and counselling managers could be supported

to organize seminars for all HIV testing and counselling programme managers on the intersections between violence and HIV, including how violence affects uptake and acceptance of HIV testing and counselling.

To build capacity of HIV counsellors to respond to issues of violence against women, participants recommended that existing training should make efforts to address violence against women. For example, core training modules could include practice case studies highlighting the barriers that women living in violent relationships face in accessing HIV testing services, disclosing their HIV test results to their partners, negotiating HIV risk reduction, and accessing post-test support and care. Most core HIV testing and counselling training workshops use case studies and role plays as part of the training, and adapting at least one role play to focus on the situation of women should be feasible. Vignettes have been developed by FHI for use in training HIV counsellors in the Asia-Pacific region, and are described in the text box on the next page.

While core HIV training modules can be adapted to address violence against women, meeting participants also highlighted that not all issues related to violence can be adequately covered in standard HIV counselling training programmes. As standard HIV counselling training modules already cover many topics and issues, it may be challenging to include additional topics. It was also recommended therefore, to develop a one or two day supplemental training for counsellors – with a specific focus on gender equality and violence against women. This supplemental training should enable a more in-depth focus on how violence serves as a barrier to women accessing HIV-related services, implementing risk reduction plans, and disclosing HIV status. Issues that could be covered in a supplemental training are proposed in the textbox at right.

Participants also highlighted the need to raise awareness of violence against women among those who access HIV testing services. For example, the WomenCARES project was instrumental in implementing a campaign in Rhode Island to raise awareness about domestic violence among clients of public health services. The "Are you safe?" campaign involved adding this question to all clinic intake forms at public health facilities that provide HIV testing services. Standardizing the process and asking all women the question about their safety at intake provided an opportunity for women and health care providers to talk about how the sexual and physical risk in their relationships may influence their risk for HIV, and potentially jeopardize their physical safety if they share information about their health status with their partner. Participants suggested adapting this approach in other settings and developing IEC materials for women waiting in HIV testing and counselling facilities, as a way to raise awareness and encourage discussion between women and HIV counsellors about their exposure to violence.

Topics for counsellor training on violence and HIV

- Review associations between HIV and violence, including ways in which violence affects women's risk for HIV.
- Review women's experiences with disclosure of HIV status.
- Learn counselling strategies to address violence and fear of violence during counselling and disclosure.
- Review experiences of women who negotiate risk reduction in violent relationships.
- Learn risk reduction counselling strategies for women living in violent relationships.
- Practice skills for providing ongoing support to women living in violent relationships.
- Identify how to address the post-test support needs of women living in violent relationships.

Examples of training vignettes for HIV counsellors

Vignette 1: A 22 year-old married woman. Five years ago she worked in karaoke bar of a five star hotel and had sex with some men. She does not know how she got infected with HIV, her husband has never mentioned he has HIV, maybe he has it but maybe he does not. Her husband does not know about her previous life. She indicates to the counsellor that her husband and family would be very angry if they knew what she had done in the past. She discloses that her husband sometimes gets very angry after he has been to the bar. He threatens her many times, and has hit her severely twice. She is worried that he will hit her and the family will reject her. She is not using contraception at present as her husband wants to have a baby. She is not yet pregnant. How would you counsel this woman regarding disclosure of her HIV status?

Vignette 2: A 17 year old woman has presented at the clinic; she requests an HIV test. She reported sexual contact over a period of two years, whilst she was working as a maid, with a boyfriend and a co-worker. She has returned to her family home. She requires parental consent for an HIV test. She has provided a full sexual history. She expresses fears of family violence if the clinic contacts her family. She indicates that she has had significant risks with a known HIV positive partner. She is fearful that a neighbour saw her coming to the clinic and she fears her father and brothers will present at the clinic and demand to see the medical records. She has disclosed fears of her family killing her for bringing dishonour on the family. She is frightened that she will 'disappear'. She comes from a family with strict religious beliefs. There are no women's shelters or groups to refer her to. Child welfare and police authorities have a poor reputation for willingness and effectiveness to protect women and children. How would you counsel this woman regarding disclosure of her HIV status?

Vignette 3: A couple in their thirties present at the clinic for HIV testing. The male partner does all the talking despite the counsellor's best efforts to elicit responses from the wife. The male refuses to allow the wife to spend any time with the staff alone. Her result has come back positive, he has declined to test. He says he is in the army and has been tested and is ok. The wife seems to be threatened by the husband and the mother-in-law. She has four children. The counsellor observes bruising on the wife's upper arm when blood is taken. The husband offers an unlikely explanation. How would you work with this couple? Assuming you could manage to speak with the woman alone, how would you counsel her regarding disclosure?

Vignette 4: The client is a young transsexual male involved in a domestic relationship with an abusive male partner. The partner frequently drinks and abuses the client sexually and physically. The client is an outcast from his family. He is solely dependent on the partner for accommodation and basic life necessities. His test came back positive on a test done in an STI clinic. A public health officer has told the client that he must inform the partner within three weeks and bring the partner to the clinic, or the public health officer will visit the partner. He had to show the public health officer his ID card with his address. Therefore, the client came to the VCT clinic for assistance. There are no NGOs or religious organizations in this prefecture to assist. How would you counsel this client regarding disclosure?

For further information contact: kcasey@fhibkk.org

3.2. Addressing violence within HIV testing and counselling protocols

The second opportunity to ensure a focus on violence is through HIV testing and counselling protocols. The focus on expanding access to HIV testing necessitates modification of existing HIV testing and counseling guidelines and the development of new operational guidelines and protocols. There are efforts under way to re-examine the models of HIV counseling and adapt them to the diversity of settings and target them to specific populations. For example, the WHO Integrated Management of Adult and Adolescent Illness (IMAI) approach has two standard training packages: one for management of acute illness and one for chronic illness. A protocol for provider-initiated testing and counselling (PITC) has been incorporated into IMAI and is currently being updated. Additionally, the IMAI protocol includes a quick-check guide for management of emergencies and this has a section on management of rape and sexual abuse. These two protocols provide an opportunity to identify women who might be vulnerable to violence and assist them through the testing and counselling protocol *(26)*.

There are two specific opportunities in HIV testing and counselling protocols to address violence. The first is the counselling that women are provided about disclosing their HIV status. It is recognized that violence and fear of violence play a role in women's decision to disclose or not their HIV status to their partner. The consultation did *not* advocate screening all women in HIV testing and counselling programmes for violence because the effectiveness of violence screening protocols in health care settings has not yet been established. There is also a lack of adequate support services to serve female victims of violence in many settings. However, there was a concurrence that counsellors should engage in a discussion with women during the HIV counselling process about the role of violence in their decision to disclose to their partner (for example, probe women about potential consequences of HIV disclosure). Examples of counselling protocols that are used in different settings to assess women's risk for violence are provided in the box on the next page. The first example is from an HIV testing and counselling clinic in Dar es Salaam, United Republic of Tanzania and the second example is drawn from Family Health International's (FHI) work in the Asia-Pacific region. There is a need for more research to evaluate these different counselling protocols in a variety of settings (e.g., ante-natal care clinics, VCT services, and other health care settings) and a variety of regional contexts (sub-Saharan Africa, Latin America, Eastern Europe and the Asia-Pacific region).

Support for HIV disclosure can also be provided through mediated disclosure, where women are given the option to bring their partners back to the clinic to disclose in the presence of the counsellor, or to identify a trusted family member or friend at home who could be present with them when they disclose to their partner. Research is also needed on strategies to address the special needs of women who undergo HIV testing after sexual violence and how best to support them in disclosing both the experience of sexual violence and their HIV status. This is especially problematic where both sexual violence and HIV are highly stigmatized.

Protocols incorporating a focus on violence within counselling on HIV status disclosure

Example 1: Counselling protocol from Dar es Salaam, United Republic of Tanzania

In a voluntary HIV counselling and testing clinic in Dar es Salaam researchers piloted the following protocol to raise the issue of violence during counselling on HIV disclosure. Counsellors asked women the following questions:

1 Is your partner aware that you will be tested for HIV?

2 If you told your partner you tested positive for HIV, do you think he would react supportively?

3 Are you afraid of how your partner will react if you share your HIV test results with him?

4 Has your partner ever physically hurt you?

5 Do you think that your partner may physically hurt you if you tell him that you have tested for HIV and your HIV test results are positive?

Counsellors supported women's decision to disclose if they answer positively or negatively to question 1, positively to question 2 and negatively to questions 3–5. If women answer negatively to question 2, and positively to any of questions 3–5, then counsellors proceeded with caution and explored in more depth each woman's risk of disclosure-related violence. If the counsellors determined that the risk was high, they explored alternative options including opting not to disclose, deferring disclosure to a time when a woman's safety was ensured, or developing a plan for mediated disclosure in which women either brought the partners to the clinic to disclose or identified a trusted family member or friend to be present when they shared their HIV test results with their partner. If women answered negatively to question 2 and positively to questions 3–5, regardless of how they answered question 1, then counsellors explored these alternative options for disclosure.

Example 2: Family Health International: Asia-Pacific region

In the Asia-Pacific region, FHI developed the following protocol for counsellors to use when counselling clients regarding disclosure.

1 Counsellor asks: "There are some routine questions that I ask all of my clients because some are in relationships where they are afraid that their partner may hurt them. What response would you anticipate from your partner if your results come back positive?"

2 If client indicates that they are fearful or concerned then the counsellor asks, "Have you ever felt afraid of your partner? Has your partner ever pushed, grabbed, slapped, choked or kicked you? Threatened to hurt you, your children, or someone close to you? Stalked, followed, or monitored your movements?"

3 If they respond affirmatively to any of these points counsellors then add, "Based on what you have told me, do you think telling your partner will result in a risk to you or your partner?" The client is then encouraged to make a decision to disclose based on a realistic appraisal of the threat.

3.3. Addressing violence within risk reduction counselling protocols

Another opportunity to address violence within the HIV testing and counselling context is during risk-reduction counselling. There is ample evidence to indicate that women who live in violent relationships are less likely to be able to negotiate condom use with their partners, and when they do raise the use of condoms with their partner, they are more likely to suffer negative consequences. In the risk-reduction planning that counsellors do with clients during the post-test counselling session, there must be an assessment of the extent to which women feel empowered to negotiate safer sex in their relationships. The box below provides an example of a role-play that FHI has developed for HIV counselling with youth. Additional questions have been proposed to help female clients think about strategies to promote condom use with partners who may become physically violent.

Role play for risk reduction counselling with young people *(27)*

If your clients are sexually active and wish to remain so, emphasize that condoms provide dual protection against STI and HIV transmission, as well as unintended pregnancy. Young people, especially women may need strong negotiation skills for using condoms. You can help your clients practice what to say if one partner is pressuring the other not to use a condom. Role-play talking about condoms:

If their partner says:	**They can say:**
"I don't like using condoms, it does not feel good."	"I feel more relaxed and if I am more relaxed, I can make it feel better for you."
"We have never used a condom before."	"I don't want to take any more risks."
"Using condoms is no fun."	"Unplanned pregnancy or getting an STI is much less fun."
"Don't you trust me?"	"I trust you are telling the truth. But with some STIs there are no symptoms. Let's be safe and use condoms."
"Why should we use a condom? Do you think I have AIDS?"	"No, but I could have an STI. We need to protect both of us."
"I will pull out in time."	"I can still get pregnant or get an STI."
"I thought you said condoms were for casual partners."	"I decided to face facts. I want us to stay healthy and happy."
"I guess you really don't love me."	"I do, but I don't want to risk my health to prove it."
"We're not using condoms and that's it."	"Okay. Let's do something else, then."
"Just this once without."	"It only takes once to get pregnant, or get an STI, or get HIV."
Additional scenarios to address the risk of violence:	
"If you don't have sex with me without a condom, I will force you."	"Forcing me to have sex is not the answer. Let's talk about this calmly."
"I have a right to have sex with you without a condom. "	"You do not own me or have a right to my body. If you love and respect me, you will understand that."
"Stop asking me to use a condom. It makes me angry."	"I am sorry that you are getting angry. Maybe we should wait to have sex until you feel less angry."

3.4. Addressing violence with regard to women's post-test support needs

The fourth opportunity to address violence in the context of HIV testing and counselling is related to the post-test support needs of women who live in violent relationships. If violence emerges as an issue for women in the HIV testing and counselling process, then counsellors need to be prepared to offer women some ongoing support options. In settings where there are services to support female victims of violence, referrals can be made directly to these services. Alternatively, where support services do not exist, or are inadequate to meet the needs of women, there is a need to build post-test support systems. A strategy used in some settings to meet women's post-test care and treatment needs is the development of peer support groups.

The meeting highlighted two examples of peer support programmes. In Mwanza, United Republic of Tanzania, community-based counsellors provide post-test support to women who test positive for HIV. These lay counsellors are individuals who are selected because they are perceived to be trustworthy, and are available at times that clinic staff are not. They receive basic training in HIV testing and counselling, and support women with disclosure and accessing post-test support services. The WomenCARES project in Rhode Island, United States uses peer support groups to help women through the HIV testing process and to help them access essential post-test services. The programme has trained 25 peer support/advocates that help women through the HIV testing process. These women are survivors of intimate partner violence, and several are also living with HIV. The advocates accompany clients to the counselling and testing sites, help them navigate referral services, accompany them to receive test results, and assist them in accessing health services. The advocates also discuss risk reduction strategies with women in abusive relationships, referred to as 'sexual safety plans.'

3.5. Research recommendations

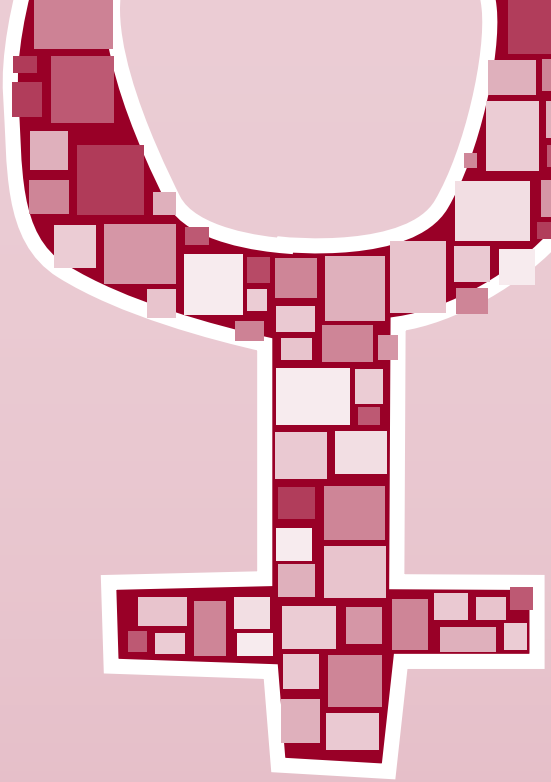
The consultation identified two broad gaps that require operational research. Participants recognized that there is a gap in knowledge about women's experiences of being counselled and tested in general, and even more so in relation to provider-initiated models. The implications for women of various models, including the provider-initiated model of HIV testing and counselling, need to be better understood. For example, research is needed to document whether women are able to make informed and voluntary choices with respect to testing. Do they understand the implications of accepting the HIV test? Are they adequately prepared to learn and/or disclose their HIV status and access post-test services? What considerations should be taken into account during the testing and counselling process for women who fear negative outcomes?

There is also a need for operational research to assess tools (e.g. counselling, communication and referral tools) to support women through the disclosure and risk-reduction planning processes. For example, as provider-initiated testing and counselling is scaled up, how best can this approach ensure the safety of women affected by negative outcomes, support them in mitigating any adverse outcomes of HIV status disclosure and reduce barriers in accessing appropriate post-test services? These tools need to be adapted and piloted in different regional/cultural contexts and in different HIV testing contexts (e.g., antenatal care settings versus free-standing HIV testing and counselling services).

Another research gap is to identify and work with men who could be violent towards their partners upon HIV diagnosis. While there was not adequate representation of and reflection on experiences of working with men in HIV testing and counselling settings, some meeting participants expressed the need for strategies that would identify when men undergoing testing and counselling might get violent, and work with them to minimize partner violence through counselling and referrals.

Key recommendations made by the meeting participants to address violence against women in HIV testing and counselling programmes

1. **Address violence as a barrier to women accessing HIV testing and counselling services by**
   - Raising awareness of the links between HIV and violence among programme managers, counsellors and clients.
2. **Address violence as a barrier to HIV disclosure, and as an outcome of disclosure for some women by**
   - Implementing tools that counsellors can use to identify and counsel women who fear violence and other negative outcomes following HIV status disclosure.
   - Offering alternative models for HIV disclosure, including mediated disclosure with the help of counsellors.
3. **Address violence as a barrier to women implementing risk-reduction strategies by**
   - Assisting women to develop strategies to protect themselves when negotiating safer sexual relationships.
4. **Address post-test support needs of women in violent relationships**
   - Referring women to peer groups to provide ongoing psychosocial support.
   - Developing referral networks to organizations that offer services for female victims of violence.
   - Where these services do not exist, building support systems for women, including peer support models.



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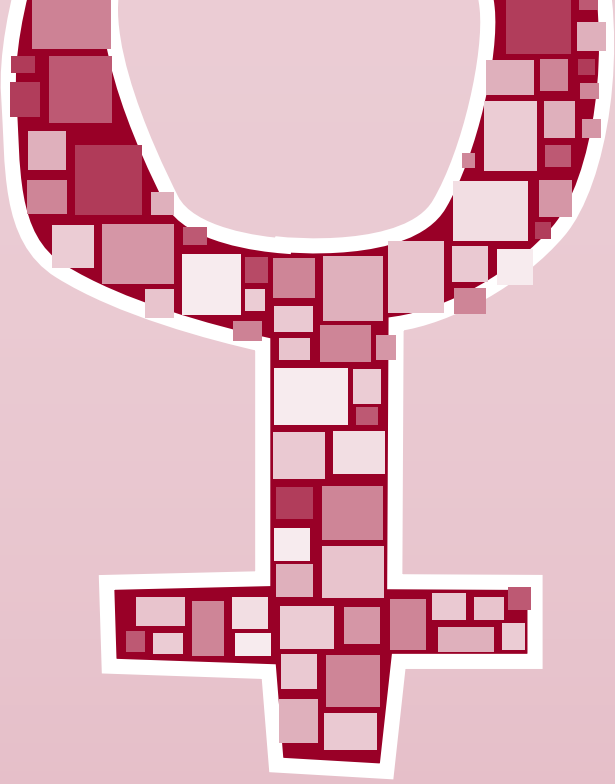

ANNEXES:

A. Objectives

B. Agenda

C. List of participants

Annex A: Meeting objectives

Background:

Violence against women has been identified as one of the most urgent public health problems affecting women, and is increasingly recognized as a manifestation of gender inequality that increases women and girls' risk and vulnerability to HIV infection.

As increasing numbers of women and girls become infected with HIV and as HIV programmes including HIV testing and counselling, PMTCT, treatment, care and support efforts are being scaled up in many countries, there is an opportunity and a need to address violence against women in the context of HIV and AIDS programmes.

HIV testing and counselling is one such situation where it is important to identify women at risk of violence in order to provide appropriate advice about disclosure, referrals and services. A review of gender dimensions of HIV status disclosure focusing on rates, barriers and outcomes that was conducted in 2004 identified violence and fear of violence as one of the main barriers to HIV status disclosure among women.

Purpose and objectives:

This consultation seeks to build on this previous work and will focus on identifying programmatic strategies that address violence in the context of HIV testing and counselling. The consultation will also consider the implications of the increasing access to ARVs and a push to make testing and counselling more widely available through strategies such as routine offer of testing to women affected by violence.

Specifically, the consultation will:

a) review and identify promising, innovative, and feasible strategies to support women through the counselling, testing and disclosure process and;

b) develop recommendations to guide programmes and policies related to testing and counselling, taking into consideration the new strategies being considered to expand access to these services.

The consultation will consider in more detail the role that violence and fear of violence plays:

1) **As a barrier to the uptake of HIV testing and counselling.** We want to consider the implications of efforts to expand testing and counselling through new provider-initiated methods such as routine offer and diagnostic testing and counselling on women's uptake of testing. We want to examine what needs to be done to promote HIV testing and counselling among women, while ensuring their safety in the process. We also want to develop guidance on how programme implementers can assess violence and fear of violence as a barrier to counselling and testing in their settings.

2) **As a barrier to women disclosing their HIV status to their sexual partners.** To examine what can be done within the context of HIV testing and counselling to minimize this barrier for women. We want to examine the implications of efforts to expand testing through new provider-initiated methods on women's experiences with HIV-status disclosure to sexual partners. We also want to develop guidance for programme implementers on how violence and fear of violence as a barrier to disclosure can be assessed during testing and counselling.

3) **As a barrier to women accessing post-test support services, including their uptake of PMTCT services in antenatal care (ANC) settings.** We want to identify effective strategies to provide women with ongoing support to access post-test support for themselves and their family members. In settings where there is little or no post-test support available, we want to consider what is feasible to do in the context of HIV testing and counselling to provide ongoing support for women.

Annex B: Agenda

Day One: Monday, January 16th

Time	Topic	Presenters
9:00–9.30	Welcome and Opening	Dr Claudia Garcia-Moreno, GWH Dr Kevin O'Reilly, HIV
9:30–10.00	Review agenda and meeting objectives	Dr Avni Amin, GWH
Session 1: Overview: HIV and VAW links and testing and counselling (T&C) programmes and policies. ***Moderator – Claudia Garcia-Moreno***		
10.00–10.30	Overview of HIV TC and violence	Dr Suzanne Maman
10:30–10.45	Tea break	
10.45–11.15	Overview of HIV VCT: Challenges from the field	Dr Gloria Sangiwa
11:15–11.45	Expanding access to HIV TC	Dr Donna Higgins
11:45–12.30	Discussion related to HIV TC and expanding access to HIV TC	
12:30–13.30	Lunch	
Session 2: Programme Examples: Training and capacity building to respond to VAW in HIV testing and counselling. ***Moderator – Avni Amin***		
13.30–14.00	Case study 1: Center for violence and reconciliation, South Africa	Ms Lisa Vetten
14.00–14.30	Case study 2: Center for AIDS Research and Training, India	Ms Brinelle D'Souza
14.30–15.00	Case study 3: Training counsellors in the Asia-Pacific Region	Ms Kathleen Casey
15.00–15.30	Case study 4: Training counsellors in Uganda	Ms Jennifer Wagman
15:30–15.45	Tea break	
15.45–17.00	Discussion: Cross-training HIV service providers to address violence in the context of HIV TC	

Day Two: Tuesday, January 17th

Time	Topic	Presenters
9:00–9.30	Synthesis and review from Day 1 Review agenda for Day 2	Dr Suzanne Maman
9.30–10.00	Framework for assessing best practices and developing recommendations to respond to VAW in the context of T&C	Dr Avni Amin
Small group session: To develop recommendations related to capacity building for responding to VAW in T&C programmes		
10.00–10.30	Small group discussions to develop recommendations related to capacity building on VAW for HIV service providers	Moderators to be appointed from among the participants for each group
10.30–10.45	Tea break	
10.45–12.30	Continued…Small group discussion to develop recommendations related to capacity building on VAW for HIV service providers	As above
12:30–13.30	Lunch	
13.30–14.30	Presentation of recommendations from small group sessions to the entire group	As above
Session 3: Providing T&C and post-test services to women who experience sexual violence. ***Moderator – Claudia Garcia-Moreno***		
14.30–15.00	Case study 5: Liverpool VCT, Kenya	Ms Carol Njema
15.00–15.30	Case study 6: GHESKIO, Haiti	Ms Nathalie Coicou
15:30–15.45	Tea break	
15.45–16.15	Case study 7: RWISA, Rwanda	Ms Henriette Byabgamba
16:15–17.30	Discussion: Providing testing and counselling and post-test services to victims of sexual violence	

Day Three: Wednesday, January 18th

Time	Topic	Presenters
9:00–9.15	Synthesis from Day 2 Review agenda for Day 3	Dr Avni Amin
Session 4: Providing T&C and post-test services to women who experience domestic violence. ***Moderator – Suzanne Maman***		
9:15–9.45	Case study 8: AIDS Information Center, Uganda	Ms Florence Mahoro
9.45–10.15	Case study 9: WomenCares Project, USA	Dr Donna Williams
10.15–10.45	Case study 10: Mwanza counselling association	Ms Verdiana Kamanya
10:45–11.00	Tea Break	
11.00–11.30	Discussion: Providing T&C and post-test services to women who experience domestic violence	
Small group session: To develop recommendations related to responding to violence in different models of T&C		
11:30–12.30	Small group discussions to develop recommendations	Moderators to be appointed from among the participants for each group
12:30–13.30	Lunch	
13.30–14.30	Continued…Small group discussions to develop recommendations for providing T&C and post-test services to women who experience violence	As Above
14.30–15.30	Presentation of recommendations from small group sessions to the entire group	As above
15.30–15.45	Tea Break	
15.45–17.00	Wrap up discussion on identifying best practices, recommendations and next steps for addressing violence against women in context of T&C	Dr Claudia Garcia-Moreno, Dr Suzanne Maman, Dr Avni Amin
17:00	End of Meeting	

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