



Development Connections

Integrating HIV and Violence Against Women policies and programs – a needs assessment in the Dominican Republic

Dinys Luciano

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Note: This document was part of the follow-up of the course on “Empowerment, HIV and violence against women in the Dominican Republic” that was convened by Development Connections, Presidential Council on AIDS (COPRESIDA), Margaret Sanger Center, Community of Women Living with HIV/AIDS (ICW), Colectiva Mujer y Salud and UNFPA in May 2007.

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Development Connections

Connecting resources for sustainable development
1629 K Street NW Suite 300 – Washington D.C. 20006

www.dvcn.org Email: info@dvcn.org

Tel. (202) 466-0978

Acronyms

The following acronyms may be found in this document:

ARV = antiretroviral

ART = antiretroviral treatment

COPRESIDA = Presidential Council on AIDS

DIGECITSS = National Directorate

DR = Dominican Republic

GBV = Gender-based violence

HR = human resources

IDU = injecting drug user

MSM = men who have sex with men

NGO = non-governmental organization

PLWHA = people living with HIV and AIDS

PMTCT = prevention of mother-to-child transmission

SEM = Secretary of Women (Secretaría de Estado de la Mujer)

UNAIDS = Joint United Nations Programme on HIV/AIDS

USAID = U.S. Agency for International Development

VCT = voluntary counseling and testing

WHO = World Health Organization

I. Background

This needs assessment summarizes the results of the course on “Empowerment, HIV and violence against women in the Dominican Republic” convened by Development Connections, Presidential Council on AIDS (COPRESIDA), Margaret Sanger Center, Community of Women Living with HIV/AIDS (ICW), Colectiva Mujer y Salud and UNFPA in May 2007.

The course aimed to develop competencies of human resources from governmental and non-governmental organizations to integrate HIV and VAW in prevention, treatment and care interception as well as to respond to emerging policy issues regarding both problems. Its specific objectives were:

- a. To analyze the empowerment conceptual framework and its operationalization addressing HIV and VAW.
- b. To examine the strategic and practical implications for integrating policies and programs on HIV and VAW.
- c. To manage tools for carrying out processes within the organizations and intersectoral levels directed toward integration of both issues.

The course had an on-site (face-to-face) session of 16 hours in April and a virtual session of 30 hours during the period May-June, for a total of 46 hours. The on-site session addressed the theoretical basis for integrating policies and programs on both issues and the virtual session focused on assessing strategic and logistical issues regarding the integration process within the participants’ organizations and designing integrated interventions based on the services/activities that were already in place, e.g., voluntary counseling and testing, crisis intervention, referral system, or support groups. Representatives from seven government agencies, twenty-eight civil society organizations and three international agencies participated in the on-site session. The on-line session had participants from 12 organizations.

Along with these two sessions, interviews with key organizations were carried out in order to identify the specific needs for follow-up after the course. This document synthesizes the needs identified in the working groups, plenary sessions, individual assignments and discussions in the on-line sessions; along with a literature review on both issues.

2. HIV and violence against women in the Dominican Republic

2.1. Magnitude of the problem

HIV and violence against women are two of the most pervasive problems in the Dominican Republic (DR). According to UNAIDS and WHO (2006), nearly three quarters of the 250,000 people living with HIV in the Caribbean are in the two countries of Hispaniola Island: the Dominican Republic and Haiti.¹ The national adult HIV prevalence is high in the DR, reaching 1.1% of the population by the end of 2005.² Studies indicate that women younger than 24 years in the DR are almost twice as likely to be HIV-infected compared with their male counterparts.³

In the Dominican Republic, HIV infection levels in pregnant women have been declining since the late 1990s, with overall HIV prevalence in pregnant women roughly stable at 1.4%. The HIV infection levels found among commercial sex workers in Santo Domingo was 3-4%. (UNAIDS and WHO, 2005.)

“HIV/AIDS is currently the leading cause of death in women of reproductive age in the Dominican Republic.”
(Human Rights Watch, 2004)

HIV infection rates are also particularly high in bateyes⁴ which are predominantly populated by Haitian migrants or Dominicans of Haitian descent.⁵ In 2003, only 2% of women 15-49 years old reported having used a condom during her last intercourse.⁶

¹ UNAIDS and WHO. 2006. Caribbean Fact Sheet. December 2006.
http://data.unaids.org/pub/EpiReport/2006/20061121_epi_fs_c_en.pdf

² UNAIDS and WHO. 2006. Ibid...

³ UNAIDS AIDS Epidemic Update 2005, p.54.

⁴ Bateyes: sugar cane fields.

⁵ Amnesty International. 2007. HIV and human rights in the Dominican Republic and Guyana. Available at: <http://thereport.amnesty.org/eng/Regions/Americas/Guyana>

⁶ CESDEM et al. 2003. Encuesta Demográfica y de Salud 2002. Santo Domingo, República Dominicana.

HIV/AIDS in the Dominican Republic

Population of the Dominican Republic (July 2005 est.): **9,049,595**

Estimated number of people living with HIV/AIDS by the end of 2005: **66,000**

Estimated percentage of adults (ages 15-49) living with HIV/AIDS by the end of 2005: **1.1 %**

Estimated number of women (ages 15-49) living with HIV/AIDS by the end of 2005: **31,000**

Estimated number of children (ages 0-15) living with HIV/AIDS by the end of 2003: **3,600**

Estimated number of deaths due to AIDS during 2003: **6,700**

Sources: [UNAIDS 2006 Report on the Global AIDS Epidemic](http://www.unaids.org/pressroom/2006/20060501_01.htm). May 2006. Available at: <http://www.globalhealthreporting.org/countries/dominicanrepublic.asp?collID=16&id=1188&mallID=1190&tbID=1189&hivIC=1197&mallC=1198&tblC=1199&map=1201&con=Dominicanrepublic&p=1>

On the other hand, according to the Demographic and Health Survey (2003), 28% of women between 15-49 years old reported experiencing some type of violence by an intimate partner.⁷ Profamilia (2002) screened 179 new clients in two clinics in Santo Domingo and found that 65.3% reported emotional violence, 32.4% physical violence, 31.3% sexual violence, and one out of five women reported childhood sexual abuse (22.3%). The majority of cases of emotional (67%), physical (78%), and sexual violence (77%) were perpetrated by the woman's partner and nearly all (95%) cases of childhood sexual abuse were perpetrated by a family member or someone known to the child.⁸

Sexual violence, like other forms of violence against women in the DR, is underreported, yet during 2002, 3,300 complaints of sexual assaults were filed at the SEM.⁹ Ten percent of femicide cases in 2001 included sexual violence.¹⁰ In terms of trafficking in women

⁷ CESDEM et al. 2003. Ibid...

⁸ IPPF. Violence Against Women in the Dominican Republic: A Silent Epidemic. *Basta!*, No. March 2002 (Published: 2002.03), p. 3. Available at: http://www.ippfwhr.org/publications/serial_article_e.asp?SerialIssuesID=5&ArticleID=27

⁹ Informe referente a la práctica de derechos humanos en la República Dominicana. 2004. Informe sometido a la Comisión de Asuntos Exteriores de la Cámara de Representantes y la Comisión de Relaciones Exteriores del Senado de los Estados Unidos por el Departamento de Estado de conformidad con las secciones 116(d) y 502(b) de la ley de 1961 de Asistencia Exterior y sus enmiendas. Available at: http://www.usemb.gov.do/HR_report_2004.pdf

¹⁰ Pola, María Jesús. 2002. Femicidio en la República Dominicana. Profamilia. Santo Domingo.

and girls, it is estimated that there are 50,000 women from the DR overseas in the sex industry—the fourth highest number in the world, after Thailand, Brazil and the Philippines.¹¹ Another estimate puts the total number of Dominican women working abroad in the sex industry as high as 100,000.¹² The prevalence of HIV in women who have experienced violence in the DR is not available, but in 2002, the prevalence of STIs among women who had ever experienced violence was 3.7, and among women who had experienced violence in the last year was 4.6. In contrast only 1.0% of women who reported they had never experienced violence had an STI in the 12 months preceding the survey.¹³

2.2. Legislation and other policies

2.2.1. The AIDS Law 55-93: it was passed in 1993 and includes measures regarding diagnosis, prevention care of PLWHA and sanctions for those violating them. But its implementation faces significant gaps regarding the access to services, confidentiality, consent for testing, and discrimination in the employment sector. A report published by Human Rights Watch in 2004 documented cases where people had been tested during a job application process and not been given the job, and also Amnesty International's research revealed that women and men are sometimes tested for HIV/AIDS as part of their job application process, often without their consent and knowledge.¹⁴ In terms of access to treatment, the number of PLWHA accessing treatment increased to 1,500 in July 2005; 3,457 in June 2006; and 4,332 as of September 30, 2006. Even so, more than half of those needing ART remain without it.¹⁵ HIV/AIDS-related stigma and discrimination pose a challenge in the Dominican Republic.

The Strategic Plan on Prevention and Control of STI and HIV/AIDS 2007-2015 was adopted by COPRESIDA in May 2007 and its target populations are: PLWHA, youth, women, MSM, bateyes residents, sex workers, children and adolescents, people with disabilities, IDU, and prisoners. Gender equality and human rights are included within its core values and principles. The response to HIV/AIDS in the Dominican Republic is led by COPRESIDA – an umbrella body chaired by the Minister of Health and the Director of which is directly appointed by the President. COPRESIDA's membership includes various relevant government bodies, civil society organizations and HIV/AIDS service providers. DIGECITSS, which is located within the Ministry of Health, is responsible for overseeing the implementation of the National HIV/AIDS Strategic Plan. It is the technical agency responsible for the government HIV/AIDS services, including the national treatment

¹¹ "Trafficking in Women from the Dominican Republic for Sexual Exploitation," *IOM*, June 1996.

¹² "Dominican Republic Investigates Alleged Prostitution Ring Linking Caribbean and Europe," *Associated Press*, 7 July 2003.

¹³ Kishor, Sunita and Jonson, Kiersten. 2004. Profiling domestic violence: a multi-country study. ORC Macro. Maryland. June, 2004.

¹⁴ Amnesty International. 2007. *Ibid...*

¹⁵ International Treatment Preparedness Coalition. November 2006. Missing the target # 3: Stagnation in AIDS treatment scale up puts millions of lives at risk. Available at: <http://www.aidstreatmentaccess.org/>

program. Several NGOs, including organizations of PLWHA, develop initiatives at national and local levels.

2.2.2. The Law 24-97: The Dominican Republic ratified several international conventions requiring member states to institute measures combating violence against women. In 1982, the Dominican Republic ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), and in 1996 it ratified the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women ("Convention of Belem do Para"). In 1997, the Law 24-97 introduced important changes to the country's Criminal Code, criminalizing violent and discriminatory conduct in an effort to guarantee women equal protection and equal benefit of the law. It includes measures on prevention, care and sanctions for perpetrators. But even though the Law does not establish conciliation between the victim and the perpetrator, this became the most common method for dealing with the complaints of domestic violence filed in selected police stations specializing in VAW cases called "Police Stations friendly to women" (Destacamentos Amigos de la Mujer).¹⁶ In general, the implementation of the Law 24-97 faces significant gaps regarding safety and security of survivors of violence.¹⁷ The national response to VAW is coordinated by the SEM through: a) national program on care and prevention, b) training to HR of the justice administration and health systems, c) community outreach programs, d) local networks. Other government agencies have specific programs on VAW such as the Attorney General's Office, Justice Administration, SESPAS and Secretary of Education.¹⁸ The NGOs created the first services and empirical evidence on VAW since the Eighties. Currently organizations such as NAM, CEAPA, Profamilia, Colectiva Mujer y Salud offer services, community programs, prevention, research and advocacy for intersectoral policies.

¹⁶ Luciano, Dinys and Santana, Rosa. 2005. La conciliación de los casos de violencia doméstica en la República Dominicana. CEAPA. Santo Domingo.

¹⁷ Perez, Mercedes. 2005. Legislative Reform and the Struggle to Eradicate Violence against Women in the Dominican Republic. Columbia Journal of Gender and Law, Vol. 14, 2005. Available at: <http://www.questia.com/googleScholar.qst;jsessionid=G9pLBpsjNHtGkfjV1v5Jv64VcvpgGLP0GPQGkLN3wQT05PJNGI21!1110889658?docId=5009587062>

¹⁸ Office of the United Nations High Commissioner for Human Rights. 2006. Special Rapporteur to the Commission on Human Rights. Available at: <http://www.ohchr.org/english/issues/women/rapporteur/thematic.htm>

3. Objectives and methods

3.1. Objectives

The needs assessment was a process that sought to:

- a. Identify the alternatives for integrating HIV and VAW policies and programs.
- b. Determine priorities on capacity building of the organizations interested in integrating HIV and VAW interventions.
- c. Identify potential barriers and gaps to be filled in a process of integrating services and programs on both issues.

3.2. Methods

Several strategies were employed to get input in the needs assessment process:

- Results of the working groups carried out during the on-site session of the course on “Empowerment, HIV and VAW in the Dominican Republic”
- Results of the individual/organizational assessments carried out during the virtual session of the course
- Key informant interviews with selected government and NGOs (SEM, DIGECITSS, SESPAS, Profamilia, ODEMIHF, and Asolsida)
- Literature review on both issues: legislation, surveys, and documents from international organizations.

4. Results

4.1. On-going initiatives linking HIV and VAW

Various initiatives are undertaken by government agencies, civil society organizations and international agencies, described below.

On-going initiatives linking HIV and VAW

1. **Legal framework:** Draft of the National norms and protocols on intrafamily violence and against women include HIV PEP.
2. **Advocacy for public policies:** National Committee on VAW and HIV (SEM, COPRESIDA, SESPAS, MSCJ, ONUSIDA, UNFPA, OPS, CMS, MSCJ, Alianza de Género and others). It is expected to carry out a process for designing a “National Strategy linking HIV and GBV”.
3. **Projects at community level:** Colectiva Mujer y Salud, ASOLSIDA, CEPROSH and Bra Dominicana
4. **Services –Reproductive health:** Profamilia
5. **Knowledge management:** a) study on HIV and GBV carried out by MSCJ, UNFPA, UNAIDS and UNICEF, and b) study by PROFAMILIA
6. **Training:** course on “Empowerment, HIV and VAW” carried out by DVCN, COPRESIDA, ICW, MSI, Colectiva Mujer y Salud and UNFPA.

Source: Betania Betances. 2007. The country’s response to linkages between HIV and VAW in the Dominican Republic. Presented at Course on Empowerment, HIV and VAW in the DR” April, 2007

4.2. Strategic issues

HIV and VAW programs and services are a logical context in which to introduce integrated interventions in both issues. VAW services are often in contact with interventions addressing an ample range of health risks. Incorporating considerations regarding STIs/HIV can provide opportunities to discuss, assess their risk, evaluate STI prevention, methods for STI protection, get information about VCT, and services available. Also, services for victims of sexual assault must include HIV post exposure prophylaxis programs. Since VAW increases the risk of HIV infection and vice versa, STIs/HIV programs should include VAW strategies in VCT, PMCTC, care and treatment, support groups, and prevention.

Rationale for integrating HIV and VAW services

Equity and fairness

HIV and VAW are two pandemics endangering women's health, wellbeing, and lives. VAW is a major driver and consequence of HIV and their linkage increases the stigma and discrimination that women and girls face in their families and communities, in peace and in conflict settings, by state and non-state actors.

- Access to HIV prevention, treatment and care of vulnerable populations, specifically women victims of violence is an urgent public health and development priority, but also an ethical and human rights imperative

Utility

- Maximize the benefits for women of the current HIV and VAW services and resources available.

Efficiency and efficacy

- VAW and HIV mutually reinforce each other, undermining the initiatives to prevent them. Uncoordinated efforts make strategies in both issues dysfunctional and ineffective.
- Women's health needs may be better met by providing an integral pack of services of HIV and VAW. VAW and HIV services can be used as mutual entry points in order to overcome barriers to their accessing prevention, treatment and care on both problems.
- Separate funding and programming streams – to combat HIV&AIDS on one hand and, on the other, to eradicate violence against women and girls – translates into less resources allocated to efforts to address violence as a cause and consequence of HIV infection. (Campaign Women Won't Wait, 2007. <http://www.womenwontwait.org/>)

The strategic issues identified for integrating HIV and VAW policies and programs are: a) policy design, b) intersectoral coordination, c) evidence production, priority programs/services, and d) specific populations and geographic areas.



a. Public policies

Changes within the current policy framework are necessary in order to carry out the process of integrating HIV and VAW programs and interventions. Issues such as PEP, VAW interventions in VCT, PMTCT, ART and prevention programs are lagging behind. The priorities identified are:

- Integration of links between HIV and VAW into the process of reforming the Penal Code and revision of the Law 55-93 in order to incorporate specific measures regarding both issues.
- Foster an intersectoral dialogue in order to design the National Strategy on HIV and VAW that will include: interventions, HR, budget, planning and monitoring and evaluation.
- Integrating VAW and HIV into planning, programming and funding in a reliable and on-going fashion within the government organizations responsible for the national response of both issues.
- Gender equality and VAW as integral components of COPRESIDA and DIGECITSS' monitoring and evaluation system.
- The SEM should incorporate specific actions in order to promote policies and programs linking HIV and VAW.

b. Intersectoral coordination and strategic alliances

The integration process requires intersectoral coordination based on strategic, long-term alliances at national, subregional and local levels within the decentralization process of the government agencies. Key issues regarding intersectoral coordination were raised:

- Government agencies and civil society organizations have to evaluate systematically why and how they integrate services. The ethical, political and managerial implications of integration of both issues, has to be examined. The availability and accessibility of services has to be established as well as the consequences of integrating HIV and VAW in the current services settings.
- Strengthen the collaborative work with national AIDS responses to better understand the linkages between VAW and the dynamics of the epidemic at national level.
- Develop a programmatic response addressing HIV as both cause and consequences of VAW, linking to other efforts against violence against women.
- Community outreach programs including peers, small and large-group discussions on issues relevant to the links between HIV and VAW.
- Mechanisms for systematic interchange of information, resources and experiences are needed.

c. Evidence-based policies and programs

The current state of the empirical evidence available is not suitable for developing evidence-based policies and programs.

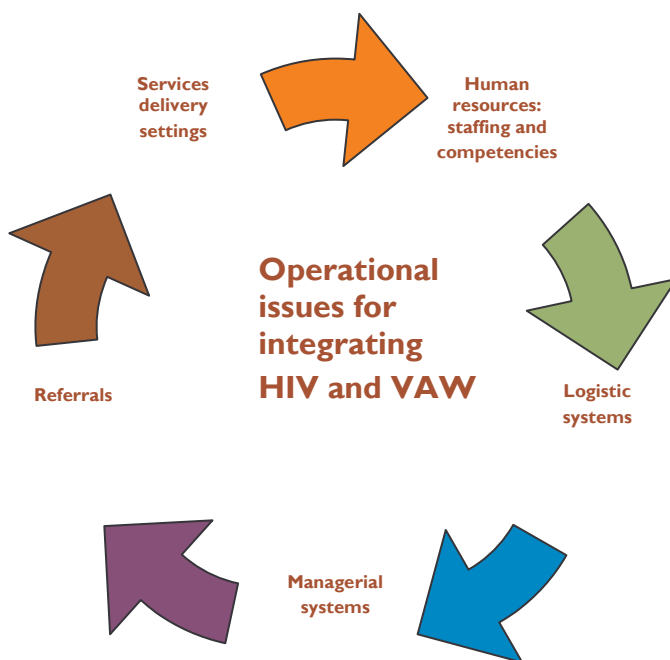
- Information on the prevalence of STI/HIV and VAW is needed in order to get a better knowledge of the magnitude of both problems and their linkages. Information on the size of the problem, to what extent women are at risk of facing the two problems, barriers to access to both VAW and HIV services, among others, is necessary for integrating services in an ethical and sustainable manner.
- Sex-disaggregated data on VAW prevalence in PLWHA, as well as on access to HIV treatment with emphasis on clinical outcomes and its relation with VAW is needed. This information can be used as a basis for prioritizing patient follow-up.
- Documenting the current efforts on linking HIV and VAW should be established as a priority in order to identify lessons learned and scaling-up good practices.

d. Choosing specific population groups and geographic areas for priority delivery of integrated services of HIV and VAW

Due to the lack of HIV and VAW services in some geographic areas the criteria for integration should take in consideration the implications of creating a demand for services that can greatly exceed the availability of HR, supplies and the overall infrastructure. The selection should be based on the ethical principles, the practical feasibility and the realities of the VAW and HIV epidemics. Since the target population established in the Strategic Plan on Prevention and Control of STI and HIV/AIDS (2007-2015) are PLWHA, youth, women, MSM, bateyes residents, sex workers, children and adolescents, people with disabilities, IDU, and prisoners, the selection should be based on those.

4.3. Operational Issues

The strategic issues are intertwined with the operational issues and must be assessed together, in order to make critical decisions about the appropriate and feasible integrated intervention/activities. Changing policy, new intersectoral coordination, creating evidence, and defining a package of integrated services, have implications for planning, budgeting, staff management, and monitoring and evaluation. The key operational issues identified were: a) services delivery settings, b) human resources, c) logistic systems, d) managerial systems; and referrals.



- a. **Services delivery settings:** the settings used by the current VAW and HIV services determine the types of activities the organizations will be able to introduce. Some organizations could face some difficulties if their services/activities are delivered in geographic areas lacking the basic infrastructure for clinical services, counseling or even crisis intervention for VAW cases. The lack of conditions to guarantee privacy and confidentiality, also can

constrain the opportunities for some services. For instance, in some bateyes, there is no emotional or medico-legal support for victims of rape or domestic violence, and some HIV programs are part of a mobile outreach service. This situation poses a potential barrier for screening VAW within the HIV services.

- b. **Human resources/staffing requirements and competencies:** having the required personnel for integrating HIV and VAW services is crucial. For instance, because of the overload of responsibilities that some VAW services providers are facing, integrating HIV interventions can be seen with some resistance. Also in the public sector the turnover rate of personnel is very high due to the political changes every four years with the arrival of the new authorities after elections. Those changes within the government agencies also can imply for some services a reduction in staff available.

At the same time, the staff will need to acquire new competencies (attitudes, skills and knowledge) in order to implement the new activities. A general understanding of the links between HIV and VAW is necessary in order to receive specific training in selected interventions. The choices for training the staff could include continuing education in coordination with universities or on-the-job training depending on the results of the assessment of the staff's competences. For instance, PLWHA groups identified the need for training of the volunteers on primary care on VAW such as: screening, counseling, referral and support groups' techniques. Also they need to incorporate a mental health professional as part of the team.

The training needs identified were:

- HIV priority interventions: VCT, PMCTC, care and treatment, and prevention, directed toward HR working on VAW
- VAW priority interventions: screening, counseling, clinical evaluation, risk assessment, safety measures, referral support groups directed to HR working on HIV
- Management of operational issues on integration of HIV and VAW services and activities, for both groups of HR
- Intersectoral networks integrating HIV and VAW, with emphasis in rural communities and bateyes
- Legal framework and other public policies regarding HIV and VAW
- Youth and adolescents: specific needs for integration
- Support groups integrating HIV and VAW
- Monitoring and evaluation of public policies and programs.

- c. **Logistic systems:** integrating HIV and VAW will require a reliable drug logistic system with the leadership of DIGECITSS. HIV interventions linked to VAW involve STI/HIV testing, laboratory, diagnosis, and drug treatment that in some communities are not available. Managerial skills for dealing with the logistic

system are also required in settings and geographical areas where supplies and infrastructure is adequate. Groups working in rural areas are particularly concerned about the complexity of logistic systems required for integrating HIV and VAW since if the supplies will not be in place continuously, for instance, the integration of VCT and VAW counseling can be jeopardized. Organizations working specifically in prevention also pointed out that the educational materials for distribution in general population and specific groups, have to be available in the settings.

- d. **Managerial systems:** the management of the organizations integrating HIV and VAW interventions should be strengthened in order to handle the new challenges. The integration may involve changes in planning, budgeting, infrastructure, resource mobilization, intersectoral coordination, including relations with the community, HR management, monitoring and evaluation, and referrals. For small organizations or organizations with management skills in the early stage, managerial issues pose a big challenge.
- e. **Referrals:** due to the lack of resources for providing “one stop” integrated services in the organizations, it is necessary to identify relevant services to which women can be referred, within a health facility and between facilities and/or services. Organizations located in the Northern Region of the country are already carrying out a process of creating awareness on the linkages of both issues, creating a resource directory and identifying access issues such as transportation, and cost of services, among others. Creating referral forms and carrying out orientation sessions to all the staff about the inter-institutional links will help to improve the referral systems. Also, it is recommended to establish measures for encouraging referrals and follow-up through some rules such as no-wait appointments, and discounts for clients referred from the other organizations within the same network.

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