

# Development Connections



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Global Community of Practices on HIV and VAW

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## I. Intersections Between Violence Against Women and HIV

Violence and HIV represent serious development and health problems affecting the lives of millions of women in Latin America and the Caribbean (LAC). In 2004, worldwide, half or more of the 40 million people living with HIV/AIDS (PLHIV) were women. The gap of HIV incidence between men and women in LAC has significantly closed in the last few years. At the end of 1999, women accounted for 25% and 30% of adults living with the virus in LA and the Caribbean, respectively, while in 2001 these ratios increased to 30% and 50%, respectively.<sup>1</sup> According to UNAIDS, in Argentina the male/female ratio for new diagnoses has narrowed down to 1.3:1 (as compared to 15:1 in 1988) and in Colombia, from 10:1 in the early 90s to 2-3:1 in 2003-2005; in Nicaragua it went from 7:1 in 1998 to 3:1 in 2003.<sup>2, 3, 4</sup>

This process of HIV feminization is observed in all the countries of the region. This is linked to the susceptibility to the virus generated by gender inequality and, in particular, violence against women (VAW). Available data indicate that 25 and 69 percent of women in LAC report suffering from violence in their intimate relations with their partners.<sup>5</sup> Different forms of sexual violence such as: forced sex in the marriage and while dating, rape by strangers, systematic rape during armed conflicts and in emergency situations due to natural disasters, sexual harassment (including requests for sexual favors in exchange of work or school grades), paid sex, sexual abuse of children, forced prostitution and human trafficking, and marriage at an early age increase women's vulnerability to HIV. Sexual abuse affects between 5 and 46 percent of girls and paid sex is very common among teenaged and young women, drug users, and poor women. This underscores the difficulty to negotiate safe sex and increases their exposure to STI/HIV.<sup>6, 7</sup>

Likewise, two of the world's four countries with the highest number of women victims of human trafficking for sexual exploitation abroad are in LAC: Brazil and the Dominican Republic.<sup>8</sup>

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<sup>1</sup> UNAIDS. 2001. Report on the Global AIDS Epidemic. Geneva.

<sup>2</sup> Programa Nacional del SIDA de la Argentina, 2005; Ministry of Health, 2004. Quoted by UNAIDS in "América Latina: Situación de la epidemia del SIDA." 2006.

<sup>3</sup> UNAIDS and Social Protection Department of Colombia, 2006. Quoted by UNAIDS in "América Latina: Situación de la epidemia del SIDA". 2006.

<sup>4</sup> UNAIDS. 2004. Report on the Global AIDS Epidemic. Geneva.

<sup>5</sup> Luciano, Diny. 2005. Violencia de género y protección social en América Latina – Apuntes para el debate. Gender-based Violence and Social Protection in Latin America – Discussion notes. Virtual Forum on Violence against Women and Social Protection. PAHO/WHO, Washington, DC. (Mimeo)

<sup>6</sup> Ibid, page 5.

<sup>7</sup> Luciano, Diny. 2005. La violencia sexual y la salud en las Américas. Presentation at the Regional Meeting on "Care Alternatives in the Health Sector for Women Survivors of Sexual Violence." PAHO/WHO and IPAS. Washington, D.C.

<sup>8</sup> IOM, 1996. Trafficking in Women from the Dominican Republic for Sexual Exploitation. Geneva, June 1996.

It is important to note that in the Dominican Republic, women between 15-24 years are almost twice as likely of being HIV positive than males of the same age (Alba, Wendy, 2007); and in Trinidad and Tobago, the incidence of HIV is as much as five times higher for girls than for boys 15 to 19 years old (PAHO, 2005).

HIV and VAW are mutually strengthened, and their complex links are associated to social, economic, and biological factors.

### **Link between Sexual Violence and STI**

In a multi-centric study about domestic violence profiles based on demographic and health survey results, a positive link was found between Sexually Transmitted Infections (STI) and domestic violence. The results show that there is a higher incidence of STI in women who have suffered violence in their relationship than in those that have not. Women from the Dominican Republic affected with a STI during the 12 months prior to the survey represented 3.7 percent among those that had suffered violence and 1.0 percent among those that had not faced such situation. In Colombia, these numbers reach 3.1 percent and 1.2 percent, in Haiti 18.4 percent and 10.3 percent, and in Peru 5.4 percent and 3.7 percent, respectively.

**Source:** Kishor, Sunita and Jonson, Kiersten. 2004. Profiling Domestic Violence: A Multi-Country Study. ORC Macro, Maryland.

HIV and VAW are directly and indirectly linked in several ways:

#### **1.1 Direct Transmission Through Forced Sex (Sexual Violence)**

Forced sex with a PLHIV is one of the ways in which HIV and other Sexually Transmitted Infections (STI) are spread. The biological risk during sexual violence is determined by the type of sexual contact (anal, vaginal, or oral), and women who have been forced to have sex without protection or that have been raped are more likely to be infected with HIV because this type of sex causes more injuries in the anal and vaginal tissue.<sup>9</sup> PAHO/WHO (2002) says that the risk increases for women because physiologically they are two to four times more susceptible to HIV, because their bodies have more mucous areas where microscopic injuries may occur. Young girls and teenagers, whose reproductive systems are not totally developed, are even more susceptible to HIV and other sexually transmitted infections. The risk of

<sup>9</sup> PAHO/WHO. Género y VIH/SIDA. Woman, Health and Development Program. Washington D.C. s/f. Available in: <http://www.paho.org/Spanish/AD/GE/GenderandHIVFactSheetISpanish.pdf>

acquiring HIV increases in women with other non-treated STIs.<sup>10</sup> According to data from population-based surveys carried out in LAC, between 10 and 23 percent of women between 15 and 49 years old in a relationship indicated having suffered sexual violence from their husbands or partners.<sup>11</sup> Likewise, the WHO Health and Violence against Women Study (2005) found that in Brazil 12 percent of all women in São Paulo and 9 percent in Pernambuco were sexually abused before age 15. In Peru, one of every five women said they were sexually abused when they were minors. In both countries, sexual abuse is generally perpetrated by men in the family (other than the father or stepfather), followed by strangers.<sup>12</sup>

The Global Coalition on Women and AIDS and WHO have indicated the methodological difficulties encountered when trying to establish a direct link between rape and HIV and STI transmission. Two studies carried out in the United States suggests that female victims of rape have a higher risk of pre-existent STIs, while the rape itself represents a relatively low additional risk of acquiring a STI.<sup>13</sup>

## **1.2. Indirect Transmission Though Unsafe Sexual Behavior**

Today there is evidence linking high risk sexual behavior in adolescence and adulthood such as sexual activity without protection and/or with multiple partners. In the Dominican Republic, the results of a study on HIV and VAW carried out by the Margaret Sanger Center, UNFPA, and UNICEF (2007) found that women who were victims of psychological and physical violence in their childhood are more likely to have unprotected sex with a steady partner (in this case, boyfriend or fiancé), than those who say they did not suffered these forms of violence in their childhood.<sup>14</sup> This study also revealed that women who suffered physical violence from their partners were more exposed to the following risk factors: a) more sexual encounters with different partners, b) higher alcohol consumption; and c) fear of revealing their serological status.

In a study carried out in the United States of 357 men and women living with HIV, 68% of women and 35% of men said they had experienced some kind of sexual

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<sup>10</sup> PAHO/WHO. Gender and HIV/AIDS. Woman, Health and Development Program. Washington D.C. s/f. Available in: <http://www.paho.org/Spanish/AD/GE/GenderandHIVFactSheetISpanish.pdf>

<sup>11</sup> Luciano, Dinsy. 2007. Empoderamiento de las mujeres, violencia de género y los Objetivos de Desarrollo del Milenio en América Latina y el Caribe. UNIFEM (to be published).

<sup>12</sup> World Health Organization. 2005. Estudio Multicéntrico sobre Salud de la Mujer y Violencia contra la Mujer. Geneva.

<sup>13</sup> The Global Coalition on Women and AIDS and WHO. 2004. Violence Against Women and HIV/AIDS: Critical Intersections. Intimate Partner Violence and HIV/AIDS. Informative Bulletin Series, Number 1.

<sup>14</sup> Betances, Betania. 2007. Dimensiones del VIH/SIDA y la Violencia contra las Mujeres en la República Dominicana. Lecture in the course “Empoderamiento, VIH y Violencia contra las mujeres en la República Dominicana.” Santo Domingo.

abuse from the age of 15. Victims of sexual abuse had engaged in more unprotected sex than those who were not abused.<sup>15</sup>

### 1.3. Indirect Transmission due to Inability to Negotiate Safe Sex

In some countries, condom use rates are lower among those who suffer violence than among those who do not. In Haiti (2000), among women 15-19 years old who had sex the year prior to the survey, 35% of the women who had suffered violence in their relationships used condoms in their last sexual activity with their husband/partner, while the ratio among those who had not suffered violence was 38.1%. In Peru (2004) and Bolivia (2003), the perception of risk is lower among women that have not suffered violence than among those who have. This could mean that even though women may perceive a higher risk, the conditions imposed by the violent relationship restrict the possibility of negotiating safe sex. The extent of knowledge regarding HIV prevention was low in both countries. No significant differences were found in Peru where 20.6% of the women who had suffered violence and 20.95% of women who had not suffered violence mentioned at least three methods. In Bolivia these figures were 13.7% and 15.3%, respectively.<sup>16</sup>

#### **Violence in Intimate Relationships, Condom Use, and HIV**

*“Sara is 42 years old and lives in a well-known sector of Santiago. Her life, marked by poverty, was worsened last year by HIV. For that reason, she demands that her partner use protection when having sex to avoid getting re-infected because he is also HIV positive. When she asks him to use a condom, her partner physically and verbally abuses her. This past year, besides deprivation, she also suffers physical and verbal abuse from the man who shares her bed.”*

Taken from a newspaper article “Mujeres, más vulnerables al VIH (Women, More Vulnerable to HIV)”. Grisbel Medina. 7/23/2007. Listín Diario. Dominican Republic. Available in: <http://listin.com.do/app/article.aspx?id=21575>

<sup>15</sup> Kalichman, Seth et al. 2002. Emotional Adjustment in Survivors of Sexual Assault Living with HIV/AIDS. *Journal of Traumatic Stress*, Vol. 15, No. 4, August 2002, pp. 289-296, USA.

<sup>16</sup> Data taken from the database of the International Framework of Health and Demographic Surveys of the countries mentioned.

#### 1.4. VAW as a Result of HIV

The likelihood of reporting violence perpetrated by the common law husband is higher among women living with HIV than by those who are not living with the virus.<sup>17</sup> According to the HIV and VAW study carried out by the Margaret Sanger Center, UNFPA and UNICEF (2007) in the Dominican Republic, the violence perpetrated by the partner and reported by women living with HIV is, among others, the following:

- Humiliation and accusations that they were the ones who brought HIV to their homes, even though the evidence shows that most women were infected by their steady partners.
- Violation of the confidentiality of the women's serological status as a way of preventing them from leaving the relationship.
- Physical and sexual violence, sexual rape.<sup>18</sup>

In the United States 4 out of 20 studies report that the women in the study suffered violence due to the HIV test results, on average 8%, from 3.2% to 24%. Some authors indicate that women with a history of physical or sexual violence are more likely to suffer violence when they disclose their serological status.<sup>19</sup>

#### 1.5. Paid Sex, HIV, and VAW

The risk of becoming involved in sex for pay also appears as a behavior associated with violence against women.<sup>20</sup> Analysis of the data from the demographic and health surveys of Peru (2004) and the Dominican Republic (2002), the ratio of women who had suffered some type of violence and had had sex in the previous 12 months and who reported having engaged in sex or sexual activity in exchange of money or benefits was 0.2% and 0.3%, and less than 0.1% among women from both countries who had not suffered violence.<sup>21</sup> In LAC, sex for pay between young women and men ten or more years older than them is common practice. In this type of relationship, generally the man decides about safe sex practices such as the use of condoms and/or contraceptives.

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<sup>17</sup> Luciano, Dinys. 2005. Guide for the development of a national study on violence against women and HIV in Belize, Honduras, and Nicaragua. PAHO/WHO, Washington D.C. (Mimeo).

<sup>18</sup> Betances, Betania. 2007. Dimensiones del VIH/SIDA y la violencia contra las mujeres en la República Dominicana. Ibid.

<sup>19</sup> WHO, 2003. Gender Dimensions of HIV Disclosure to Sexual Partners: Rates Barriers and Outcomes. Geneva.

<sup>20</sup> The Global Coalition on Women and AIDS and WHO. 2004. Ibid.

<sup>21</sup> Data taken from the database of the International Framework of Health and Demographic Surveys, 2002, Santo Domingo.

### Paid Sex, Violence, and HIV

"I'm really afraid that my results turn out positive, because I live with a man a lot older than me and he is very violent. The problem is that my parents made me go out with him because he has a lot of money, but I don't love him, and it's been two months since I've been going out with the guy who was my first boyfriend, who is the love of my life, but what worries me the most is that he is married and he hangs around with other women, and I know he doesn't use protection."

Testimony of a 19 year old woman involved in a relationship with a 52-year-old high-ranking military man. Presented by Ana Gloria García of Profamilia - Dominican Republic in the course "Empowerment, HIV and Violence against Women in the Dominican Republic". April 2007, Santo Domingo.

A study on young population (15 to 25 years old) was carried out in Cuernavaca, Morelos, Mexico (2004). It was found that *"in order to hide the use of sex as means of achieving social or economic goods, young women engage in sexual activity within a 'relationship' and play by rules that limit them regarding the use of condoms and exposes them to sexually transmitted infections."* The authors conclude that even though sex for pay per se is not necessarily a risky practice, the context in which the young women engage in sex leads to behaviors that exposes them to a higher risk of contracting STI.<sup>22</sup>

Other modalities of sex for pay that are not related to sexual favors in exchange for money, food or essential goods to support the family or to buy drugs, are those that take place as part of the activities of the members of a group. These relate to sex transactions that occur within the framework of reaffirmation rituals of the group's identity. Among male adolescents, it is common to have sex with one or more teenagers in their social activities in order to prove that they are not virgins. In adolescent girls it is part of a ritual to demonstrate that she is friend/peer of the group of males. The benefit is acceptance as a member of a certain group.<sup>23</sup>

### 1.6. VAW and use of HIV Prevention and Care Services

Violence may be an access barrier to HIV prevention and care services. In Uganda, studies show that women are afraid to ask their husbands for money or permission to visit a HIV health center or seek information. In other cases, partners have explicitly prohibited women from

<sup>22</sup> Théodore, Florence et al. 2004. *El sexo recompensado: Una práctica en el centro de las vulnerabilidades (STI/HIV/AIDS) de las jóvenes mexicanas*. *Salud Pública de México* /Vol.46, No.2, March-April 2004. Mexico, D.F.

<sup>23</sup> Krauss, Beatrice. Who Wins in the Status Games? Violence, Sexual Violence, and an Emerging Single Standard among Adolescent Women. *The Hunter College Center for Community and Urban Health, New York, New York, USA*. *Ann. N.Y. Acad. Sci.* 1087: 56–73 (2006). C\_ 2006 New York Academy of Sciences. doi: 10.1196/annals.1385.001.

getting a HIV test.<sup>24</sup> WHO has indicated that in several countries pregnant women refuse to submit to the HIV test and use the counseling services because they fear abuse from their partners. There is limited and inconclusive information available in LAC about access barriers to HIV services. For example, in Haiti (2000) and Colombia (2004), the ratio of women who have suffered violence and knows where to get a HIV test is 23.7% and 49.9% respectively; while the ratio of women who have not suffered violence is 21.8% and 54.6%. However, the ratio of women who has suffered violence for both countries is 3.6% and 20.4%; while the ratio of women who have not for both countries is 3.7% and 17.1%, respectively.

On the other hand, WHO (2003) states that communicating the results of the HIV test to sexual partners may result in an increase in preventive behaviors, including condom use. Information from several countries indicates that violence not only becomes an access barrier but also limits women from disclosing the HIV test results to their partners. WHO (2003) indicates that the reporting rate of HIV test results to sexual partners by women in developed countries averages 71%; while in developing countries it averages 52%. Among the barriers to disclosing the serological status are fear of abandonment, rejection and/or discrimination, fear of violence, fear of angering family members, and fear of being accused of infidelity.<sup>25</sup>

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<sup>24</sup> Human Rights Watch, 2003. *Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda*. Vol. 15, No. 15 (A). New York: Human Rights Watch.

<sup>25</sup> WHO. 2003. *Gender Dimensions of HIV Disclosure to Sexual Partners: Rates Barriers and Outcomes*. Geneva.

## 2. Empowerment, HIV, and VAW

### 2.1. Social Exclusion, HIV, and VAW

Intersections between HIV and VAW are the result of inequality between men and women based on age, ethnicity, place of residence, place of work, income level, and immigration status, among others.

Even though HIV and VAW affect all social groups, their impact is concentrated in groups with less economic and social power. Social, political, and institutional structures, in addition to individual and collective abilities and assets, make certain groups more vulnerable to HIV and expose them to more severe consequences of the epidemic. Social distribution of risks and their effects, based in the unequal power distribution among different social groups and the links between HIV and VAW, help widen these inequalities and weaken the exercise of women's human rights. Some data illustrates these HIV and VAW political dimensions:

- **Socio-economic level:** UNAIDS (2006) showed that in Brazil the poorest sectors of the population seem to be the most vulnerable. Increasing levels of HIV infection are being detected among undereducated people in the lowest socio-economic strata (Cardoso et al., 2005; Fonseca et al., 2003).<sup>26</sup>
- **Female workers in low-paying jobs:** In surveys of women working in the Peruvian canned fish industry, 68% stated that they had been victims of sexual harassment.<sup>27</sup> In a qualitative study on sexual violence among domestic workers in Peru (2007) it was found that “live-in domestic workers are most vulnerable –especially if they are underage– making it easier for male employers to abuse them sexually through harassment and sexual abuse.”<sup>28</sup>
- **Ethnic minority:** In Honduras, the epidemic seems especially severe among ethnic minorities. In this case, the garifunas, Afro-Honduran descendants of slaves from West Africa. Studies carried out in garifuna communities found an 8-14% incidence of HIV (Ministry of Health of Honduras, 1998).<sup>29</sup>

On the other hand, indigenous (Miskito) women face forms of violence that include sexual harassment and violence from state agents at the Nicaragua-Honduras borders

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<sup>26</sup> UNAIDS in “América Latina: Situación de la epidemia del SIDA, 2006.”

<sup>27</sup> . Moncayo, Maripaz. 2003. Sobre el acoso sexual. Available in [www.emprendedorasenred.com.ar/articulos/articulo27.htm](http://www.emprendedorasenred.com.ar/articulos/articulo27.htm)

<sup>28</sup> Ojeda Parra, Teresa. 2007. La violencia sexual en trabajadoras domésticas en Lima, Peru. Development Connections. Washington DC. <http://www.dvcn.org/Documents/VStrabDom1.pdf> pp. 3.

<sup>29</sup> UNAIDS in “América Latina: Situación de la epidemia del SIDA”, 2006.

when these women cross over to work the land and/or harvest medicinal plants.<sup>30</sup> African-American and Hispanic women, for example, represent less than one fourth of all women in the United States, however, in 2000 they represented 80% of reported AIDS cases in women (US Centers for Disease Control and Prevention, 2002).<sup>31</sup>

- **Pregnant women:** In Honduras, nationwide, the incidence of HIV among women served at prenatal health centers was 1.4% in 2004, but in the Sula valley it reached 3-4% (Ministry of Health of Honduras, 2006).<sup>32</sup>
- **Imprisoned populations:** In Argentina, up to one fourth (28%) of prisoners in some urban prisons are HIV positive (Ministry of Health of Argentina 2004).<sup>33</sup> This population's vulnerability is transferred to those women whose partners are in prison, and the risk of transmission from conjugal visits or subsequently. Female political prisoners and underage girls living in state institutions also face specific HIV and VAW risks.
- **Mobile populations:** In Colombia, 36% of displaced women report they have been forced to have sex with strangers.<sup>34</sup> In a study on drugs and violence against Dominican women victims of human trafficking (2003), it was found that 96.2% of them said they were abused at work abroad and 61.0% while working in the Dominican Republic.<sup>35</sup> Mobile populations in general have less power and protection alternatives than resident populations, because authorities neither in their place of origin nor in the host country recognize their civil rights.<sup>36</sup>

Given that the links between HIV and VAW are mainly based in the inequality of power, policies and programs that address these issues should implement an empowerment approach, based on the promotion of human rights and gender equality, to allow to address both epidemics with actions to increase *“expansion of goods and skills so that women may participate, negotiate, influence, control, and make institutional processes that affect their lives accountable.”*<sup>37</sup> From a gender perspective it implies generating changes in power relations between men and women, power translating into access to, use, and control of physical and ideological resources

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<sup>30</sup> FIMI. 2006. Mairin Iwanka Raya - Indigenous Women Stand against Violence, A Companion Report to the United Nations Secretary-General's Study on Violence Against Women.

<sup>31</sup> Status of AIDS Epidemic, December 2004. Available in:  
[http://whqlibdoc.who.int/unaid/2004/929173392X\\_chap1.pdf](http://whqlibdoc.who.int/unaid/2004/929173392X_chap1.pdf)

<sup>32</sup> UNAIDS. 2006. “América Latina: Situación de la epidemia del SIDA.”

<sup>33</sup> UNAIDS. 2006. “América Latina: Situación de la epidemia del SIDA.”

<sup>34</sup> Lara, Silvia. 2006. Las Metas del Milenio y la Igualdad de Género. El caso de Colombia. CEPAL. Serie Mujer y Desarrollo # 81. Santiago de Chile.

<sup>35</sup> Luciano, Dinys and Tapia, Margot. 2003. Drogas y experiencias de violencia en mujeres dominicanas víctimas de la trata de personas. CEAPA and DVCN. Santo Domingo.

<sup>36</sup> Organización Internacional par alas Migraciones. 2003. Salud sexual y reproductiva, enfermedades de transmisión sexual y VIH/SIDA en jóvenes de 10-24 años de una ciudad receptora de población desplazada. Monteria, Colombia.

<sup>37</sup> Narayan, Deepa. 2004. Conceptual Framework and Methodological Challenges. In “Measuring Empowerment: Cross-Disciplinary Perspectives. Edited by Deepa Narayan. The World Bank. Washington, DC.

in a social relationship. Margaret Schuler (1997) defines empowerment as “a process through which women increase their capacity to control their own lives and their environment, an evolution in women’s awareness of themselves, their status and their effectiveness in social interactions.”<sup>38</sup> The inclusion of HIV and VAW in policies and programs requires phased changes in the structure of opportunities to facilitate the empowerment of women through public policies in family and community structures that promote participation and autonomy. It also implies helping women, particularly those living with HIV/AIDS, as well as victims/survivors of different typologies of PLHIV through the development of skills and assets at the individual and collective levels. This translates into:

- Change in power relations to increase the well-being and individual and collective benefits of women.
- Addressing the dimensions of psycho-social, organizational, and collective actions as well as those related to HIV and VAW.<sup>39</sup>
- Processes to facilitate that women, groups and communities acquire control or influence over their own issues or subjects of interest.<sup>40</sup>
- Interventions focused on increasing personal and group power based on women’s skills, capabilities, needs and interests.

The following figure describes the components of the theoretical framework for empowerment in HIV and VAW.

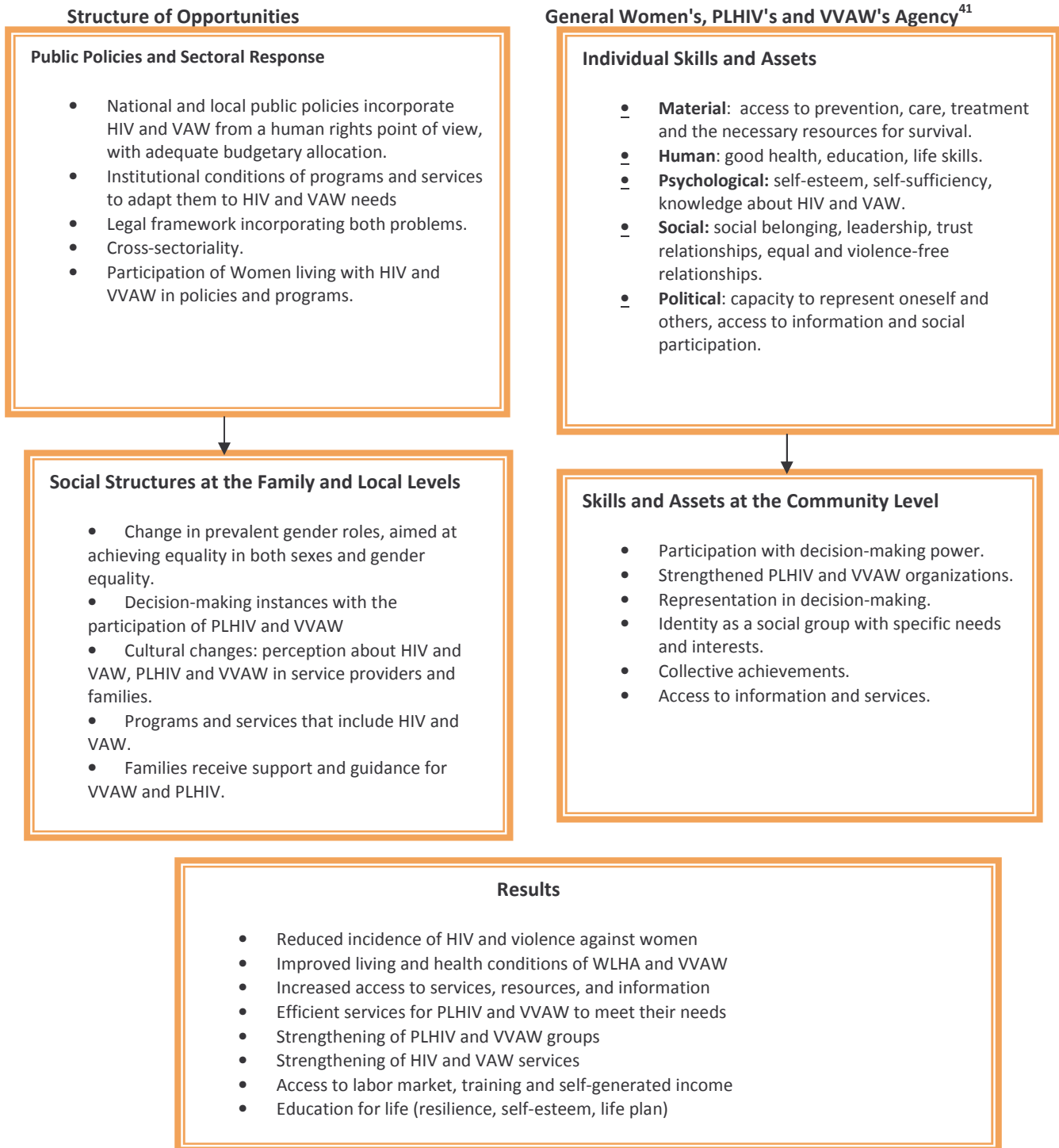
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<sup>38</sup> De León, Magdalena. 1997. Poder y empoderamiento de las mujeres. Bogota. Región y Sociedad, Vol. XI No. 18. 1999. [http://lanic.utexas.edu/project/etext/colson/18/18\\_8.pdf](http://lanic.utexas.edu/project/etext/colson/18/18_8.pdf)

<sup>39</sup> Based on the Empowerment Continuum proposed by Ronald Labonté and quoted in "Taller de capacitación en Género, Salud y Desarrollo". PAHO/WHO, Washington, DC, 1995.

<sup>40</sup> Rappaport, J. 1987. Community Psychology: Values, Research, and Action. New York: American Journal of Community Psychology.

## Conceptual Framework on Empowerment, HIV, and VAW



<sup>41</sup> VVAW = Victims of Violence Against Women

## 2.2. Development, Empowerment, HIV, and VAW

Human rights and promotion of empowerment in HIV and VAW integrated policies and programs should be part of the development program for the following reasons:

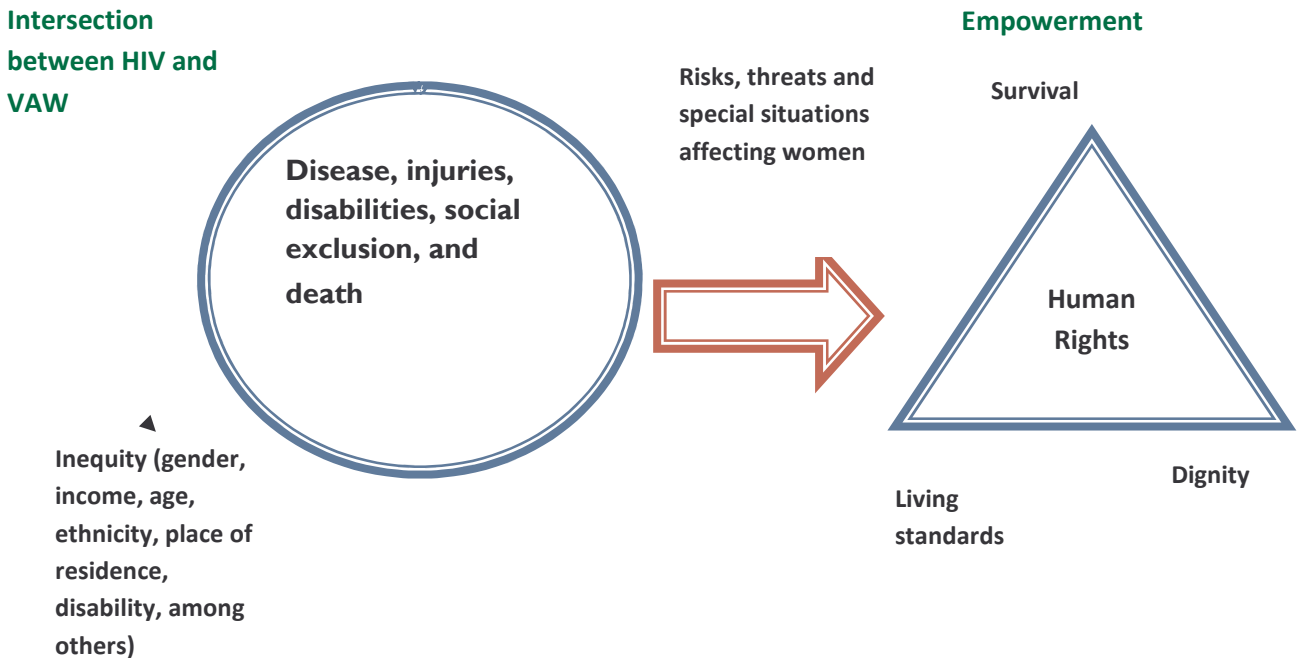
- HIV and VAW are serious threats to human development because they endanger women's health and survival and human dignity, which are the main objectives of development policies.
- VAW and HIV are inequality markers that help map the magnitude, distribution and trends of social inequalities and human rights over time.<sup>42</sup> They are also forecasters of future risks.
- HIV and VAW must be a priority for current and future development: exposure to certain situations and risks associated to HIV and VAW contribute significantly to increased social exclusion, poverty, and the presence of disease, injuries, disabilities, and even death in certain stages of life.
- Integration of HIV and VAW policies and programs favors empowerment as it increases access to services, thus improving social equity. It facilitates the incorporation of women in the labor market, increasing household income levels, and thereby contributing to overcome poverty.<sup>43</sup>
- Investing in VAW and HIV reduces the cost of protection, rehabilitation, and repair the damage caused and to be caused by both problems.

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<sup>42</sup> Chen, Lincoln and Narasimhan Vasant. 2002. Health and Human Security – Pointing the Way Forward. [http://www.fas.harvard.edu/~acgei/Publications/Chen/LCC\\_Health\\_and\\_HS\\_way\\_forward.pdf](http://www.fas.harvard.edu/~acgei/Publications/Chen/LCC_Health_and_HS_way_forward.pdf)

<sup>43</sup> Camarena, Isabel. 2006. Estructura general de los Centros Ternura. Programa Ternura. Office of the Fist Lady, El Salvador.

The following figure shows the links between empowerment, HIV, and VAW.<sup>44</sup>



### 2.3. How is Empowerment Translated into HIV Prevention and Care Programs?

Jill Gay (2007) has identified some initiatives that exemplify the use of the empowerment approach in HIV programs:<sup>45</sup>

- Training for PLHIV about their sexual and reproductive rights.
- Public campaigns to eliminate cultural regulations that restrict access to condoms and demand by young women that their partners use them.

<sup>44</sup> Adapted from Lincoln Chen. 2004. Human Security and Human Health. <http://www.humansecurity-chs.org/finalreport/English/chapter6.pdf>

<sup>45</sup> Gay, Jill. 2007. Principios del enfoque de empoderamiento aplicados al VIH y la VCM. Lecture in the workshop “Empoderamiento, VIH y violencia contra las mujeres en la República Dominicana,” Santo Domingo.

- Sexual education for adolescents and preteens based on the promotion of gender equality, self-esteem, and sexuality.
- Public policies to ensure access to care from a human rights perspective, emphasizing the right to health.
- Advocacy of the rights of sexual workers, elimination of violence against them, and demand of more intensive work for HIV prevention within this population group, focusing on the reasons leading to sexual work.

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