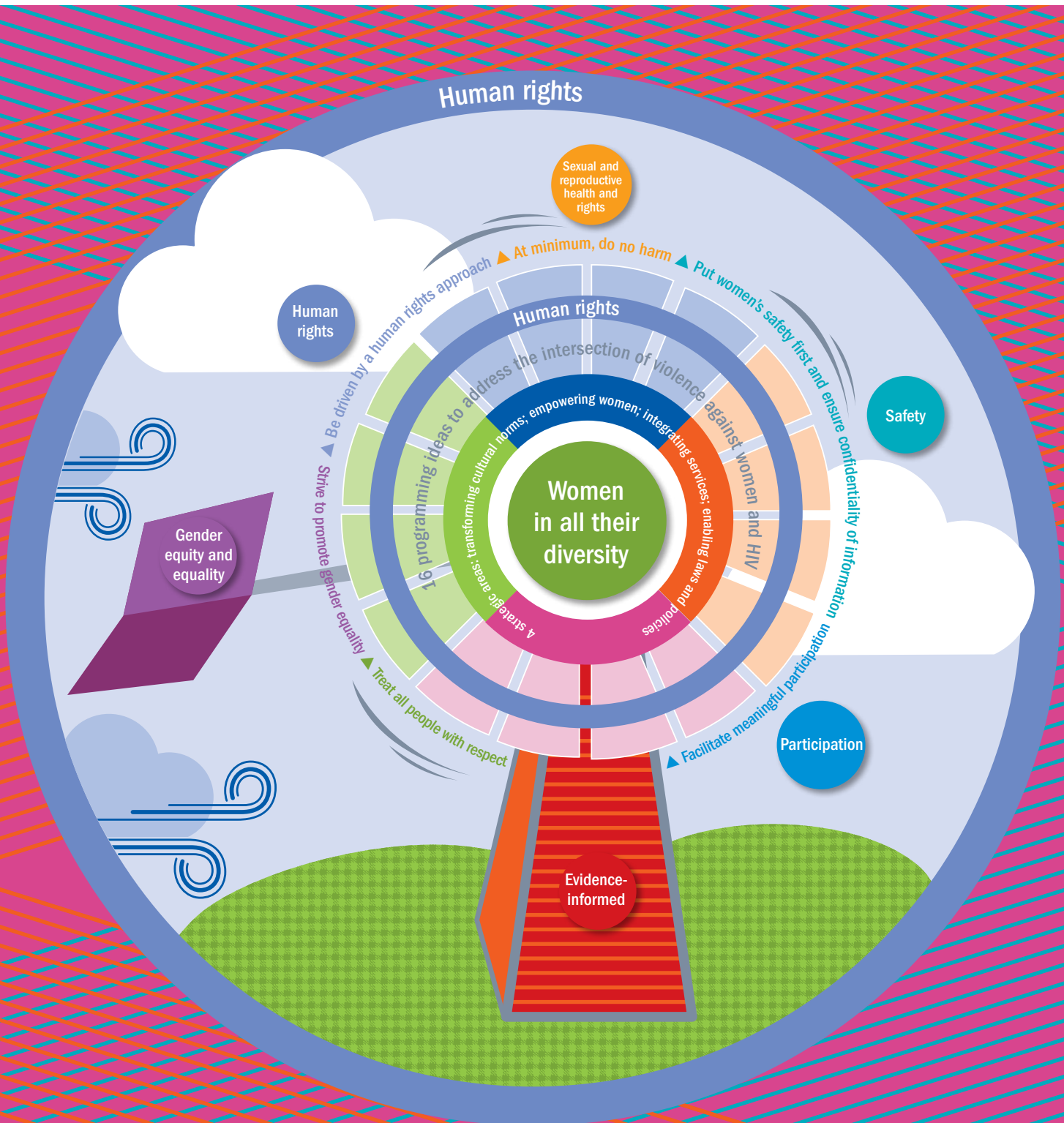


ALIV[H]E

Action Linking Initiatives on Violence Against Women
and HIV Everywhere

framework



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Action Linking Initiatives on Violence Against Women
and HIV Everywhere

framework

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Overview

What: an implementation framework

The Action Linking Initiatives on Violence Against Women and HIV Everywhere (ALIV[H]E) Framework is an applied research implementation framework. It draws on the evidence for 'what works' to prevent HIV and violence against women and adolescent girls (VAW) in all their diversity, in the context of HIV. At the same time, it aims to contribute to expanding the evidence base on what works to reduce VAW.

The ALIV[H]E Framework provides a step-by-step approach to developing an effective programme, including a monitoring and evaluation (M&E) framework, for implementing and evaluating VAW and HIV responses. All the steps and actions are completed through participatory and group-based discussion, practical exercises, and reflection with community members, under the guidance of local non-governmental organizations (NGOs), community based organizations (CBOs) and, ideally, alongside other organizations that support or work with this community.

Why: bridging the gap from *what* to *how*

In 2013, the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) summarized the available evidence on what works to prevent VAW in the context of HIV.ⁱ Based on four pathways linking VAW and HIV, they highlighted 16 programming ideas, clustered under four strategic approaches to address the intersection of VAW and HIV. However, despite the growing body of evidence on the linkages between HIV and VAW, there remains limited practical guidance on how to integrate and operationalize this evidence, either programmatically or within national policies. In addition, there remain significant gaps and weaknesses in the evidence base, including around how VAW affects women, in all their diversity, in the context of HIV. In response, UNAIDS is supporting the development of this implementation framework, which seeks to respond to these gaps. The framework has been piloted by organizations in five countries in sub-Saharan Africa and one in India, and, through an iterative learning process, their experiences have informed the development of this framework.

Who: intended audience

The framework aims to support NGOs and CBOs, working with community members, in leading creative and dynamic programmes to address VAW in the context of HIV. The framework will help NGOs and CBOs to:

- situate their work in the context of the global evidence base on VAW and HIV linkages
- ensure that their work is informed by existing evidence on what works
- monitor, evaluate and document their work in sufficiently systematic ways to enable it to gain the attention it deserves and contribute to and broaden the evidence base on VAW and HIV linkages.

The framework can also be used by donors, researchers, policy-makers and others to expand the evidence base in partnership with NGOs and CBOs.

i. WHO and UNAIDS (2013) *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool*. Available at: www.who.int/reproductivehealth/publications/violence/vaw_hiv_epidemic/en/

Conceptual definitions and language use

Conceptual definitions

Throughout this document we refer to **'women in all their diversity'**. By this phrase we mean transgender women, women with disabilities, women who sell sex, women who use drugs, lesbian and/or bisexual women and all other women, regardless of nationality, country of residence, ethnicity, religion, HIV status, age or other identity.^{ii,1} The principle of 'leave no one behind' as articulated in the Sustainable Development Goals (SDGs),² the UNAIDS *Gap Report*³ and in the UNAIDS 2016-2021 Strategy,⁴ is reflected in the intended inclusivity of this document in relation to all women. Although most of the examples used in this framework refer to heterosexual women, we have also endeavoured to include examples of women with different identities, while acknowledging that there is limited information in relation to effective programming to reduce and mitigate the experiences of violence in the context of HIV of the women listed above.

We use 'we' and 'our' throughout the document to acknowledge the fact that this is a joint struggle we are all engaged in. Recognizing that there are no experts, the use of 'we' and 'our' clarifies that this is a collective effort of learning and doing.

In relation to **'violence against women'** we use the acronym, VAW, which in this document also stands for violence against women and adolescent girls aged 15–19. While we recognize that violence against both boys and girls is widespread, this document focuses only on effective programming to reduce and/or mitigate violence perpetrated against adolescent girls and women and its specific relationship to HIV vulnerability, acquisition and management. This effective programming includes and engages with men and boys, as well as women and girls of all ages, as an essential part of the process.

Gender-based violence and violence against women

The term **'gender-based violence'** (GBV) is often used interchangeably with 'violence against women'. This usage reflects how violence against women is commonly (although not always) rooted in gender inequalities, including unequal gender power relations, which discriminate and drive the particular types of violence experienced by women. Globally, women are subjected to many forms of violence (e.g. intimate partner violence (IPV), sexual violence, trafficking, honour killings, acid attacks, early and forced marriage) because societies often accord women a lower status unequal to men. (See Box 1.)

While some men do experience sexual violence, including male rape, the disproportionate burden of violence experienced by men is of a different nature (e.g. in public spaces, in conflicts, gang-related) and driven by different factors (e.g. poverty, unemployment, community tolerance of violence, availability of weapons). Importantly, the majority of the perpetrators of violence are men, whether it is against women or against other men, and male norms that promote dominance and control are a common factor across many forms of violence.

ii. See UNAIDS (2015) *Terminology Guidelines* for preferred descriptive phrases.

The Action Linking Initiatives on Violence Against Women and HIV Everywhere (ALIV[H]E) Framework focuses predominantly on approaches to overcome violence against women and adolescent girls. It takes into account the intersectional nature of gender and other social and economic inequalities due to sexual orientation, gender identity and gender expression, disability, and HIV status. These inequalities result in stigmatization and marginalization and hence the multiple forms of violence that are perpetrated against women living with HIV, and/or who sell sex, who are lesbian, transgender, or have disabilities.

Lastly, the ALIV[H]E Framework focuses on those forms of violence for which there is strong evidence of a link to HIV (e.g. IPV, sexual violence) and violence against populations that are disproportionately affected by HIV (e.g. women living with HIV, women who sell sex, transgender women).



Box 1: Definitions⁵

Violence against women (VAW): Any public or private act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty with the family or general community. It includes sexual, physical, or emotional abuse by an intimate partner (known as 'intimate partner violence'), family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers); sexual trafficking; forced marriage; dowry-related violence; honour killings; female genital mutilation; and sexual violence in conflict situations.

Gender-based violence (GBV): It describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with 'violence against women'. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they do not conform to or challenge prevailing gender norms and expectations (e.g. may have a feminine appearance) or heterosexual norms.

Intimate partner violence: Behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours.

Sexual violence including rape: Any sexual act, attempt to obtain a sexual act, unwanted sexual comment or advance, or acts or attempt to traffic, or acts otherwise directed against a person's sexuality using force or coercion, by any person regardless of their relationship to the victim, in any setting including, but not limited to, home and work.

Source: WHO and UNAIDS (2013) *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool*

We also use the term 'gender-transformative' to describe programmes that seek to change current attitudes and practices around gender (see Box 2). In contrast to gender-transformative programmes, many programmes are 'gender-sensitive', which while accounting for the differences between women and men, do not seek to transform the relationship. The provision of HIV testing and counselling in supportive antenatal clinics is a good example of gender-sensitive programming – such antenatal clinics are primarily female spaces, providing a safe space for women to get tested for HIV.⁶



Box 2: Definitions⁵

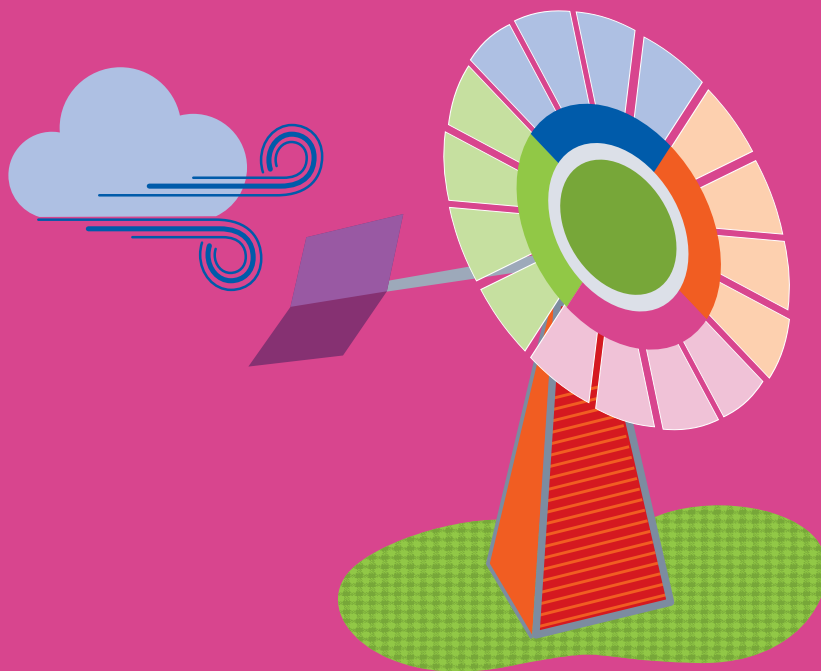
Gender inequality: Refers to gender norms and roles, cultural practices, policies and laws, economic factors, and institutional practices that collectively contribute to and perpetuate unequal power relations between women and men. This inequality disproportionately disadvantages women in most societies. It plays out in women's intimate relationships with men as well as at family, household, community, societal, institutional and political levels. Many women lack access to and control over economic and other resources (e.g. land, property, access to credit, education) and decision-making power (e.g. in sexual relations, healthcare, spending household resources, making decisions about marriage). This lack of power makes it difficult for women to negotiate within, or leave abusive relationships or those where they know they could be at risk for HIV and/or other STIs.

Gender-transformative approaches: these encourage critical awareness of gender roles and norms and include ways to change harmful to more equitable gender norms in order to foster more equitable power relationships between women and men, and between women and others in the community. They promote women's rights and dignity; challenge unfair and unequal distribution of resources and allocation of duties between men and women; and consider specific needs of women and men. Such approaches can be implemented separately with women and girls and with men and boys. However, they are also being increasingly implemented with both women and girls and men and boys together and across generations – either simultaneously, or in a coordinated way in order to challenge harmful masculine and feminine norms and unequal power relations that may be upheld by everyone in the community.

Source: WHO and UNAIDS (2013) *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool*

Part 1

Introduction, core values and policy background



Introduction

What: an implementation framework

The Action Linking Initiatives on Violence Against Women and HIV Everywhere (ALIV[H]E) Framework is an applied research implementation framework. It draws on the evidence for ‘what works’ to prevent HIV and violence against women and adolescent girlsⁱⁱⁱ (VAW) in all their diversity^{iv}. At the same time, it aims to contribute to expanding the evidence base on what works to reduce VAW. We call it the ALIV[H]E Framework to emphasize the key role of the ‘V’ – violence – in many women’s lives. In the context of HIV, and in order to respond effectively, programmes need to address potential and actual violence.

Why: bridging the gap from *what* to *how*

Many United Nations (UN) entities recognize the need to prevent VAW.⁷ In 2013, the World Health Organization (WHO) and UNAIDS summarized the available evidence on what works to prevent VAW in the context of HIV, highlighting 16 programming strategies to address the intersection of VAW and HIV.⁵ Based on available evidence, they outlined four causal pathways describing the links between VAW and HIV, four strategic areas to address these and 16 programming ideas with proven or promising success (see Figure 2).

Despite the growing body of evidence on preventing VAW and HIV, there remains limited practical programmatic guidance on *how* to integrate and operationalize this evidence, either programmatically or within national policies. In addition, there remain significant gaps and weaknesses in the evidence base.

In response, UNAIDS is supporting the development of this implementation framework, which seeks to respond to evidence gaps, specifically in the context of VAW.

Who and where: intended audience

Gaps in research occur around our understanding of how VAW affects women *in all their diversity* in the context of HIV. This document is primarily intended for non-governmental organizations (NGOs) and community-based organizations (CBOs) working in countries and regions where VAW and HIV are strongly linked, including sub-Saharan Africa and India. Many of these NGOs and CBOs are already leading creative and dynamic programmes to address HIV in the context of VAW, but are unable to monitor, evaluate or document their work in sufficiently systematic ways for it to gain the attention it deserves in formally recognized channels such as peer review journals. Moreover, the methods used may not be considered rigorous enough to attract donors. This framework intends to support such NGOs and CBOs to think more strategically about how their work connects with global evidence. It also hopes to enable them to contribute to and broaden the evidence base by evaluating and presenting their work more effectively. In preparing this document, we drew on the impressive work of organizations in five countries in sub-Saharan Africa and one in India (see Annex 1).

We also hope that this framework is useful for donors, researchers, policy-makers and others working in partnership with NGOs and CBOs to expand the evidence base, fill the gaps and address the complex challenges women face globally in relation to VAW and HIV.

The framework should be used by a local NGO or CBO alongside the recipient community and, ideally, other organizations that support, work with or otherwise provide assistance to this community. Community leaders, traditional leaders and other stakeholders (e.g. religious leaders, health service providers) also need to be consulted.

iii. Throughout this framework, we use the acronym VAW to describe violence against women and adolescent girls, see page 4.

iv. For an explanation of what we mean by ‘women in all their diversity’, see page 4.

How and when: framework structure and timings

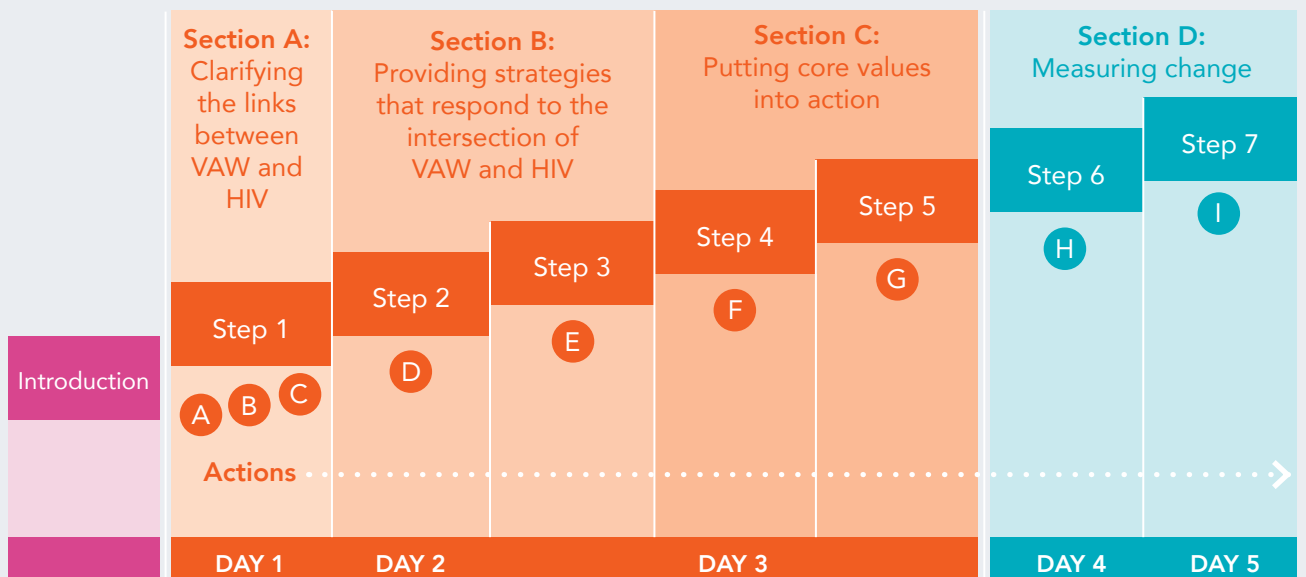
This framework is structured in three parts, containing four sections, seven steps, nine actions and eight annexes. It provides a step-by-step 'staircase' approach to developing a clear programme for implementing more effective VAW and HIV responses, taking you through the planning and monitoring and evaluation (M&E) stages. (See Figure 1.)

It is designed to be completed using a participatory, group-based approach; drawing together community members who are interested in and able to work towards strengthening programming around VAW and HIV. All the steps and actions can be completed through group discussion, practical exercises and reflection with community members.

The actions in this framework could be covered over the course of a week or you could meet weekly for 9 or 10 weeks to cover the same content at a more measured pace. Please choose the timings that work best for you.

Set aside time to cover the steps and actions with different formal and informal groups in the community with whom you want to work. These groups should be organized by age, gender and other diversities.

Figure 1: ALIV[H]E Framework structure and timeline



Part 1:
Introduction,
core values
and policy
background

Part 2: Links, strategies and action

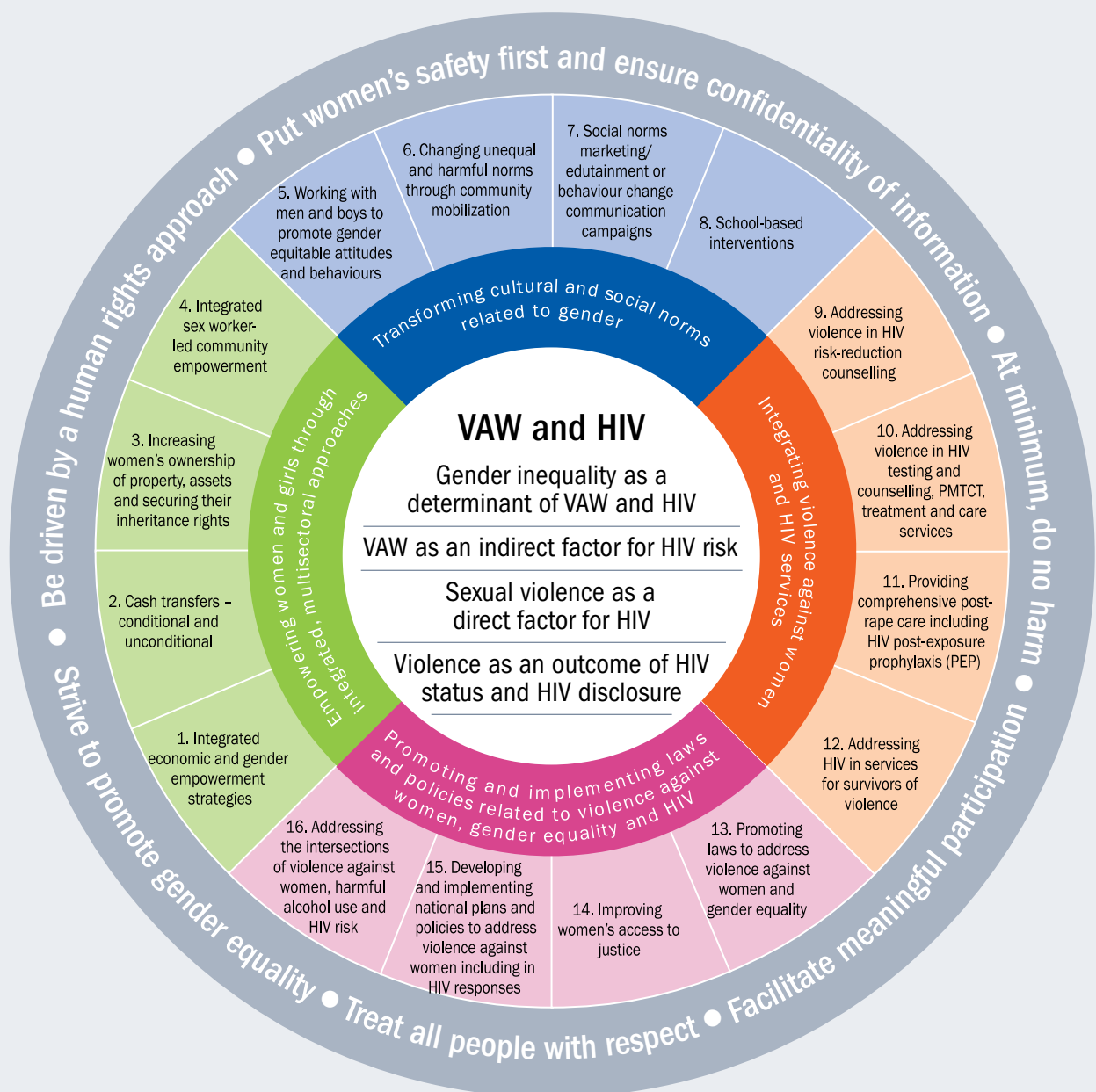
Part 3: Measuring change

Where this framework comes from: the 16 ideas wheel

The ALIV[H]E Framework provides a tool for analyzing VAW and HIV, tracking and measuring progress and contributing to and strengthening the existing evidence for promising and effective practice.

This framework builds on WHO and UNAIDS *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool*⁵ (see Annex 2), which charts the existing evidence base regarding the effectiveness of programmatic interventions in 16 different areas. It is presented as a wheel, divided into four sections. We explain more in Part 2, Section B, (page 31).

Figure 2: 16 ideas wheel



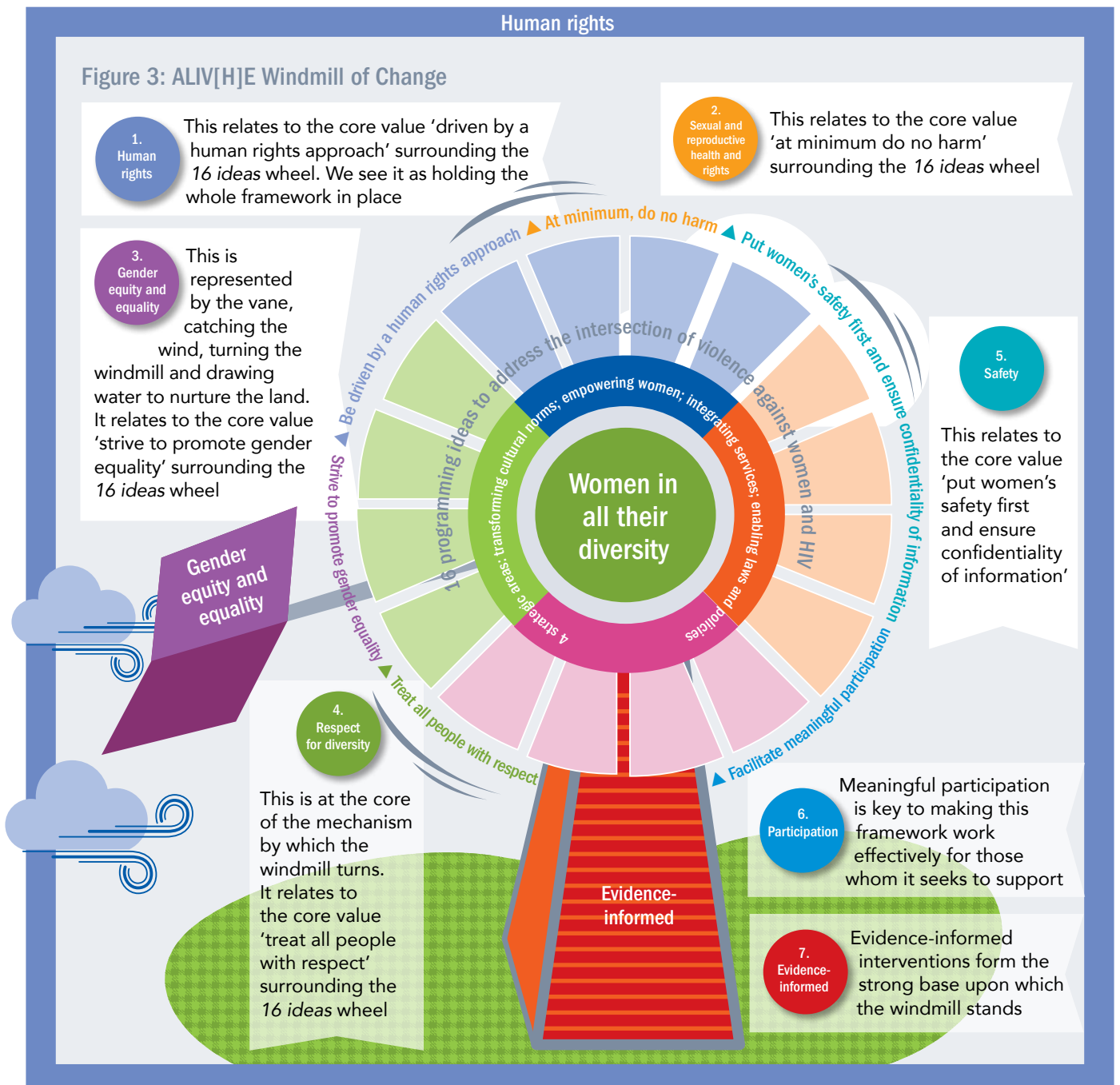
Source: WHO and UNAIDS (2013) *16 Ideas for addressing violence against women in the context of the HIV epidemic: A programming tool*.

Turning the 16 ideas wheel into the ALIV[H]E Windmill of Change

Using the 16 ideas wheel as a starting point, we have developed the ALIV[H]E Windmill of Change, bringing the wheel within a framework of core values (see Part 2, page 45). Michau L. *et al* also created a model based on the same principle as the 16 ideas wheel.⁸ See Annex 3 for more information and examples of other models based on this principle.

The three main aims of the ALIV[H]E Windmill of Change and the ALIV[H]E Framework are centred around building the capacity of NGOs and CBOs to make further practical use of the 16 ideas wheel, in order to:

- deepen understanding of the links between VAW and HIV
- enhance evidence-based programme and policy development
- strengthen M&E skills in assessing their effectiveness.



Core values of the ALIV[H]E Framework

The ALIV[H]E Framework has seven core values in responding to VAW and HIV:



These values form the foundation of the ALIV[H]E Framework. We will look at how the core values can be translated into action in Part 2, Section C (page 40).

1. Human rights

All responses must protect and promote the human rights of all people. The following global conventions support the upholding of the human rights of women and adolescent girls in all their diversity:

- *The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW)*.⁹ While all the human rights treaties protect and promote the rights of all people, CEDAW specifically addresses the rights of women and girls.
- *The Convention on the Rights of Persons with Disabilities (CRPD)*.¹⁰ CRPD outlines the need for full and effective participation and inclusion in society as a right for all individuals living with disabilities. CRPD places people and their right to dignity, inclusion, non-discrimination and participation at the heart of its intention. Article 16 enshrines the right to “freedom from exploitation, violence and abuse”.

“State Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.”
CRPD, ARTICLE 6

- *The Convention on the Rights of the Child (CRC)*.¹¹ CRC ensures that the best path to safeguarding the rights of the child is through the holistic well-being of the family unit.
- *UN Security Council Resolution 1983*, adopted in 2011, enshrining the importance of integrating GBV and HIV in peacekeeping operations undertaken by the UN.¹²
- *UN Security Council Resolution 2242*, passed in 2015, specifically addresses sexual violence and exploitation in peacekeeping operations.¹³

2. Sexual and reproductive health and rights

VAW and HIV cannot be separated from a wider sexual and reproductive and rights (SRHR) agenda, and one that recognizes that people’s health and well-being can only be achieved through comprehensive approaches. VAW and HIV, and the pathways between them, are a central component of a comprehensive SRHR response. Since the International Conference on Population and Development (ICPD) in 1994, SRHR have been increasingly recognized and addressed through global and regional frameworks and commitments.¹⁴ Sexual rights remain an area of emerging consensus.

3. Gender equity and equality

Effective responses to VAW and HIV need to focus on transforming gender norms^v (structural change) and promoting gender equity (changes through practical strategies to redress disadvantage or exclusion) in order to achieve gender equality^{vi, 15, 16, 17}. Sometimes, these two terms are used interchangeably.¹⁸ However, in this document, when we say equity, we refer to the qualities of justness, fairness, impartiality and evenhandedness. When we talk about equality, we mean equal sharing and exact division. Equity leads to equality. Gender equality is at the very heart of human rights and is a basic human rights principle.^{vii, 19} VAW and HIV acquisition among women and girls are driven by gender *inequalities*. There is gender *inequality* when there is an unequal distribution of power over the decision-making, activities and resources between people of different genders. This is reproduced over generations. Given the connections between gender inequalities and VAW and HIV, effective responses need to focus on structural interventions to promote gender equality, including through efforts to promote egalitarian gender norms, women's empowerment, and legal changes to redress women and girls' systemic discrimination, disadvantage or exclusion.²⁰

4. Respect for diversity

Communities and the people in them are diverse. Recognizing and respecting this diversity is critical when programming for women and girls. In addition, ensuring the meaningful involvement of women most affected by VAW and HIV, including transgender women, adolescent girls and women from key populations, in any response is crucial. In the context of HIV, we see GIPA (greater involvement of people living with HIV) and MIWA (meaningful involvement of women living with HIV)^{viii, 21} as basic human rights principles that must be central to any response. (See also Part 2, Section A.)

5. Safety

Programmes need to ensure that at minimum they do no harm to women and girls and, ideally, they should actively promote their safety and autonomy. Our vision is for greater safety, security and well-being in our communities. We work to foster peaceful, just and inclusive societies that are free from fear and violence. There can be no sustainable development without peace and no peace without sustainable development. (See Box 3.)

6. Participation

Meaningful participation of those most affected by VAW and HIV in the development of effective responses lies at the heart of this document. It is both a human right and of strategic importance; only through personal experience can people gain insight into the challenges they face, including potential opportunities for improving them. Meaningful participation of community members in formal research has conventionally been considered to bias the process. However, recent studies have challenged this view and recognize the limitations of not including those most affected.^{ix, 26, 27}

v. "Gender-transformative approaches actively attempt to examine, question and change harmful gender norms and the imbalance of power between women and men as a means of reaching development and gender equality objectives." FHI360 (2012) *Gender Integration Framework*. See also the Interagency Gender Working Group (IGWG) training module, *Gender Integration Continuum Categories*.

vi. See www.unfpa.org/resources/frequently-asked-questions-about-gender-equality

vii. United Nations (1995) Beijing Platform for Action. The inclusion of a stand-alone goal in the 2015 SDGs on gender equality is also key.

viii. GIPA is based on The Denver Principles (UNAIDS, 2007), which built on the work of the women's rights organization, Boston Women's Health Book Collective (authors of the ground-breaking manual *Our Bodies Ourselves*). The International Community of Women Living with HIV (ICW) supplemented the GIPA principle with MIWA, which specifically calls for the meaningful involvement of women living with HIV.

ix. See the BetterEvaluation website.



Box 3: Why do we use the term ‘safety’ instead of ‘stigma and discrimination’?

If we look at the other headings in this section we will see that they are framed as either positive or neutral. Stigma and discrimination, by contrast, are negative issues. We seek not just an end to stigma and discrimination, but also to replace them with something positive – described in this document as ‘safety’.

Conventional research methods traditionally start with a problem statement, but recent neuropsychological research^{x,22} suggests that we are more creative and productive thinkers when we focus on solutions – not on ‘what is our problem?’ but rather, ‘what is already working well in our lives? How can we build on our strengths to take this further? Where would we like to be and how can we reach this future place?’¹²³

This positive approach to thinking and working is called appreciative inquiry. It is gaining traction as a positive working methodology for action-oriented research and solution-oriented community development.^{24,25} This is why, throughout, we have focused on the positive concept of **safety** – how to achieve a safe environment for us all, *beyond* problems, *beyond* stigma and discrimination, and *beyond* violence. This is a new and different way of thinking and it does not always come easily. But, with practice, this approach will open up ideas and offer possibilities and rewards.

7. Evidence-informed

As far as possible, this document focuses on evidence-based initiatives where a formal evaluation process has taken place. Figure 4 illustrates the conventional approach to the hierarchy of evidence, with systematic reviews at the top.²⁸ However, UNAIDS and others recognize that evidence for the effectiveness of some initiatives is still incomplete and hard to measure by conventional means.^{2,29} We also recognize the importance of evidence-informed initiatives. An example is the use of by-laws to limit excessive alcohol consumption at local social or sports events to reduce VAW. As of yet, there is no formal evidence for this, but there is a convergence of evidence from around the world that indicates this is an effective means of reducing VAW in communities. Therefore, this framework takes a more inclusive approach to evidence and how it can be collated and from whom.^{30,31,32}

Figure 4: Conventional hierarchy of evidence



x. See, for example, Siegel D. *Mindsight*.

Policy background: ending violence against women and adolescent girls within the current context of HIV

The new 2030 Agenda for Sustainable Development, anchored around the 17 Sustainable Development Goals (SDGs) – such as SDG 3: Good Health and Well-being and SDG 5: Gender Equality – puts gender equality and the empowerment of women and girls at the centre and promotes peace, justice and inclusive societies.² It is against this broader backdrop that we see high-level attention to, and action around VAW, including the May 2016 adoption by the World Health Assembly of a global plan of action on violence against women, girls and children'.⁴³

As part of the Global Partnership to End Violence Against Children, consolidated guidance on seven strategies for ending violence against children is gathered in the INSPIRE package.³³ The strategies are: implementation and enforcement of laws; norms and values; safe environments; parent and caregiver support; income and economic strengthening; response and support services; and education and life skills.

Further, there is increased global recognition of, and action to end, VAW as an essential part of halting HIV acquisition and improving the lives of women and girls living with HIV. Women, girls and gender equality are at the core of the 2016 Political Declaration on HIV and AIDS³⁴ and the below strategy and initiative, and guidelines:

UNAIDS 2016-2021 Strategy

Achieving gender equality and empowering women and girls is one of the targets within the UNAIDS 2016-2021 Strategy. The Strategy focuses on the unfinished agenda of the Millennium Development Goals (MDGs) and is fully aligned with the SDGs. While gender considerations are mainstreamed throughout the Strategy, gender equality also constitutes one of the eight result areas built on SDG 5 – where women and girls are empowered, and men and boys are engaged – to prevent GBV, including sexual violence and IPV, and promote healthy gender norms and behaviours.

Using the Fast-Track approach, the UNAIDS Strategy seeks to achieve a focused set of ambitious and people-centred goals and targets by 2020 in order to end the AIDS epidemic as a public health threat in all places and among all populations by 2030. The Fast-Track approach has a number of central components, each of which recognizes VAW as a central aspect:

- **Prevention:** The combination prevention package includes creating synergies to programmes addressing VAW in high prevalence settings.³⁵ The target is 90% of women and men, especially young people and those in high prevalence settings, have access to HIV combination prevention and SRH services. The 2016 UNAIDS guidance on HIV prevention among adolescent girls and young women, highlights the importance of comprehensive approaches to HIV prevention, including addressing harmful gender norms and VAW.³⁶ It is important to recognize that IPV, which often starts early in the lives of adolescent girls and young women, is a key barrier to achieving the prevention target. Studies suggest that up to 11.9% of new HIV acquisitions among young women are due to IPV, particularly in eastern and southern Africa.³⁷ A longitudinal study in Uganda showed that approximately 22.2% of all HIV acquisitions in their study were attributable to women's experience of IPV. Increased HIV acquisition was associated with longer and more severe forms of IPV.³⁸
- **Treatment:** The 90-90-90 component seeks to ensure 90% of people living with HIV know their HIV status; 90% of those who know their HIV status are receiving treatment; and 90% of those on treatment are virally suppressed. VAW prevention is central to achieving this; women who experience VAW (including IPV and other forms) are less likely to test for HIV, access or adhere to treatment and to be virally suppressed.^{39,40,41,42}

- **Discrimination and gender equality:** Protecting and promoting human rights is central to the HIV response. Target 7 of the UNAIDS Strategy calls for 90% of women and girls to live free from gender inequality and GBV, to mitigate the risk and impact of HIV. The 2016 Political Declaration and 2016 'Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls and against children'⁴³ (adopted at the 69th World Health Assembly in May 2016) also speak to this.

DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe)

The DREAMS initiative (supported by the US President's Emergency Plan for AIDS Relief (PEPFAR), Bill & Melinda Gates Foundation and Nike Foundation) focuses on young women aged 15–24 years, in ten priority countries in sub-Saharan Africa (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe). DREAMS aims to reduce HIV incidence in young women by 40% by the end of 2017. The DREAMS initiative seeks to “provide a core package of evidence-based interventions that have successfully addressed HIV risk behaviours, HIV transmission and gender-based violence”.⁴⁴ The initiative includes two standardized indicators that recognize the importance of VAW in shaping the HIV epidemic: the number of people completing an intervention pertaining to gender norms; and the number of people receiving post-GBV care.⁴⁵

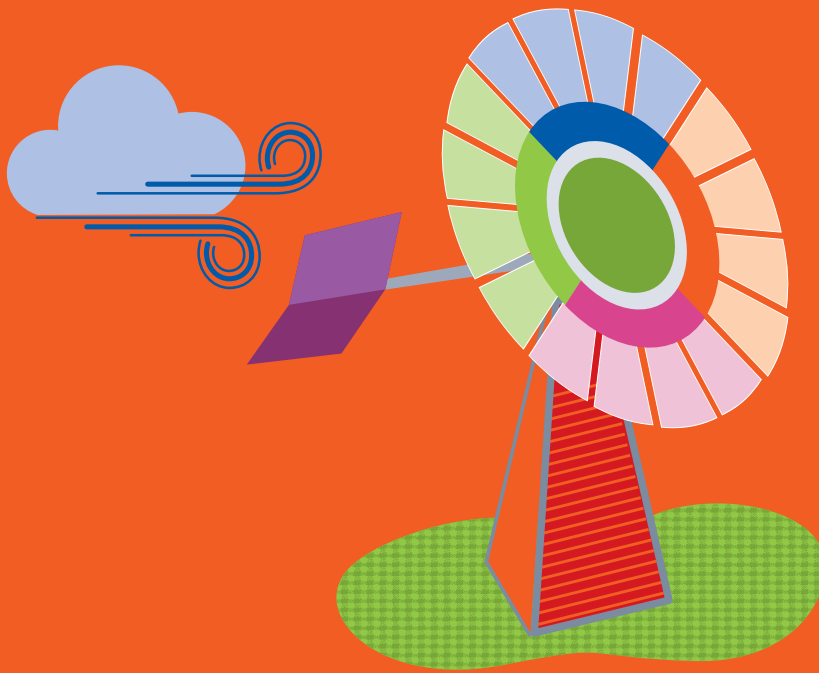
World Health Organization Guidelines

In 2014, WHO published *Healthcare for women subjected to intimate partner violence or sexual violence: A clinical handbook*. The handbook gives clinical and policy guidelines for healthcare workers to support them to explore and respond to female clients' experiences of intimate partner violence and sexual violence.⁸⁸

In 2017, WHO launched the new *Consolidated guideline on sexual and reproductive health and rights of women living with HIV*. Available at: <http://apps.who.int/iris/bitstream/10665/254885/1/9789241549998-eng.pdf?ua=1>

Part 2

Links, strategies and action



Section A: Clarifying the links between VAW and HIV

This section includes **Step 1** and **Actions A, B** and **C**. It aims to:

- provide evidence on the relationship between VAW and HIV
- suggest tools and strategies to understand how VAW and HIV are interconnected in certain contexts or groups.



Key messages

- In some settings, women who experience IPV are more likely to acquire HIV.
- Lesbian, bisexual and transgender women, women who sell sex, women who use drugs and women with disabilities experience high levels of violence.
- HIV increases women's vulnerability to violence.
- VAW is caused by unequal gender power relationships and specifically male power over women.
- Unequal gender power relationships are supported at multiple levels: structurally, through the lack of supportive and protective laws and policies and high levels of economic inequality; institutionally, through girls' exclusion from education, non-accommodating health services and work environments; and at the community and household levels, through social norms.

Evidence linking violence against women and HIV

Evidence shows that VAW, and IPV in particular, is a key risk factor for women acquiring HIV and that acquiring HIV can be a key cause of VAW.

“Violence is a key risk factor for HIV among women, including sex workers, transgender women and other women from key populations. Global and regional estimates of violence against women and the related health consequences show that it is a significant public health concern as well as a violation of women's rights.”

UNAIDS 2014⁴⁶

UNAIDS advocacy brief, *Unite with women: Unite against violence and HIV*, outlines five key messages for why effective responses to HIV must include effective responses to VAW:³⁷

- Violence is a human rights issue.
- Women who experience violence are more likely to contract HIV, in some settings.
- Women living with HIV report high levels of violence.
- Women most vulnerable to HIV are also most vulnerable to violence.
- Violence undermines the HIV response by creating barriers to accessing services.

Results from a 2014 global WHO-commissioned values and preferences study of women living with HIV showed marked increases in GBV experienced by women after an HIV diagnosis.^{40,47}

Four pathways linking VAW and HIV

In *16 Ideas for addressing violence against women and girls in the context of the HIV epidemic*, WHO and UNAIDS describe four pathways linking VAW and HIV.⁵ The pathways highlight unequal power relationships between men and women as the key factor shaping high levels of VAW and HIV.

1. Gender inequality as a common determinant of VAW and HIV

Laws, policies, institutions and harmful gender norms, as well as men's behaviour, perpetuate unequal power relationships. Large studies of men globally, including in Asia-Pacific, sub-Saharan Africa and Latin America, all highlight that men who hold gender inequitable attitudes are:

- more likely to perpetrate IPV
- more likely to perpetrate non-partner rape
- more likely to engage in transactional sex
- less likely to use condoms.^{48,49,50}

Global research has established that when VAW is considered acceptable within a community, women are much more likely to experience IPV.⁵¹ Community acceptability of VAW also makes programming far more challenging.

The criminalization of women who sell sex increases their vulnerability to VAW and HIV. This includes state violence in the form of police harassment and arrest, including for carrying condoms.⁵² One study estimates that if sex work was decriminalized, between 33% and 46% of all new HIV acquisitions in sex workers could be averted in the following ten years.⁵³

2. VAW as an indirect factor for increased HIV risk and a barrier to uptake of HIV services, poor treatment adherence and response

Women who experience IPV have higher levels of mental health issues, including depression and anxiety, higher use of alcohol and less control over sexual decision-making.⁵⁴ One study found that women who experienced IPV were 55% more likely to acquire HIV, with the population attributable fraction being 22.2%.⁵⁵

A systematic review showed women who experienced IPV were less likely to adhere to antiretroviral therapy (ART), and that the impact of IPV on adherence was greater than that caused by other factors, including depression, substance use, stigma and financial constraints.³⁰ More widely, research has shown that women struggle to access and benefit from services – including ART – because of violence or the fear of violence.³¹

3. Sexual violence as a direct risk factor for HIV transmission

Sexual violence can be experienced by all women and girls, but certain groups are particularly vulnerable.

Studies show that disabled children and adults are at greater risk of experiencing physical and sexual violence than their peers.⁵⁶ When combined with their limited access to health services, including post-violence care, people with disabilities can be at a high risk of acquiring HIV.

During and after humanitarian crises there are often higher levels of sexual violence, with inadequate access to legal forms of protection and restitution, and limited access to post-rape health services. The Inter-Agency Standing Committee has issued guidelines on strengthening the response to VAW and sexual violence in humanitarian settings.⁵⁷

Transgender women often face high levels of sexual violence. In Papua New Guinea, a 2010 study showed 57% of transgender women had experienced sexual violence in the past six months. In Bangladesh, 48% of transgender women reported being raped in the past year.⁵⁸

4. Violence against women as an outcome of HIV status and disclosure

When women learn of and subsequently disclose their HIV status, they risk experiencing a range of forms of violence. A study in Nigeria of 289 women living with HIV, found that those who had disclosed their HIV status to their partner were three times more likely to have experienced physical and emotional violence following diagnosis than those who had not.⁵⁹

The forced and coerced sterilization of women living with HIV (a form of state institutional violence) has been documented globally. The African Commission on Human and People's Rights, Resolution 260, clearly spells out the obligations of states to promote and protect the rights of women living with HIV, specifically to eliminate forced and coerced sterilization.⁶⁰

The criminalization of HIV exposure and transmission puts women living with HIV at particular risk of blame, violence and legal sanction, because, in many settings, women learn of their HIV status before men do.⁶¹

Snapshot: Violence against women and adolescent girls who use drugs

“Usually, it is girls and women who use drugs who are blamed for the situation [rape]. Women and girls face many challenges. Their children are taken away from them, and they can be beaten, raped and sent to do so-called work on the side of the road; their money and condoms are taken away, they are thrown out of their homes, they are treated for drug use without rehabilitation, and they are refused medical care, especially if they are HIV-positive.

This year, we opened a centre for women who use drugs who have children, many of whom have experienced domestic violence. Recently, a former assailant of these women broke our windows because his former partner had decided to stay with us. The police drew up a report and said that it would be considered disorderly conduct only if the attack to the centre happened during the daytime on a business day and directly interfered with the organization's operations.”

SVETLANA MOROZ⁶²

Step 1

Step 1: Understanding your context and the links between VAW and HIV for programmatic planning

- The relationship between VAW and HIV varies depending on the context in which we are working and who we are working with.
- Developing an understanding of *who* in our context is the most vulnerable to VAW and HIV and the *causes* of their vulnerability is a critical first step for effective programming.
- The information collected during this step will be used in Step 2 as we think through how best to respond to the intersection of VAW and HIV. To do this we need to first complete Actions A, B and C.
- In Step 2, we will draw on the current knowledge base, using reports, data and other sources of information, to strengthen our understanding and inform our work.

All the actions in this framework are best completed as group-based exercises with everyone who will be involved in the programming. It is essential to include the women whom we see as most central to the programme in this process, to ensure their voices shape the discussion (see Box 4).



Box 4: Ensuring the participation of those most excluded when analyzing contexts

Wherever possible, ask the people we work with, or want to work with, about their understandings and experiences of VAW and HIV. Ensuring the meaningful participation of those who are most vulnerable not only builds a better understanding of how and why they are vulnerable to VAW and HIV, but can also build more effective and sustainable responses.

Good practice: Ensuring women living with HIV are heard, supported and their needs acted upon

The Bolivian Network of People Living with HIV/AIDS (REDBOL) undertook a body mapping project with diverse groups of women, including **women who sell sex**, women living with HIV and **transgender women**, to understand their experiences of violence. They found 98% of women had experienced some form of violence, with 70% experiencing physical violence and 50% sexual violence. This work enabled collaboration between divergent groups and fed into advocacy around the Country Coordinating Mechanism of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund).⁶³

Good practice: Engaging young women who live in urban informal settlements

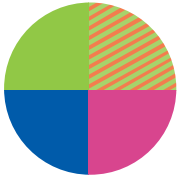
In South Africa, **young women** living in urban informal settlements suffer high HIV incidence and levels of violence. Research conducted in Durban, South Africa, found that 60% of young women (average age 22.5 years) living in urban informal settlements had experienced IPV in the past year. Recognizing this, Project Empower, a Durban-based NGO, worked directly with young women who were out of school, aged 17 and older, and living in shack settlements, rather than with community forums where young women were excluded from participation. They asked the young women to describe their lives and identify problems, and then worked with them to create their own solutions. The women said they were often blamed for IPV or ignored, with community members preoccupied with other problems such as crime or lack of access to services. The young women successfully campaigned for greater involvement in community structures and VAW became a central issue for community responses.⁶⁴



Action A: Who are the most vulnerable to VAW and HIV in our community?

Think of the different people who live in your community – those who have more power and those who have less.

In your group work you can start the discussion with some of these questions: Who in our community has the best education, the best healthcare, the highest salary and the most influence over how things are done? Who has the least safe housing, the poorest diet and the least chance of seeing a doctor? How old are the people in the different groups? What other characteristics define them? How might they experience different forms of violence?

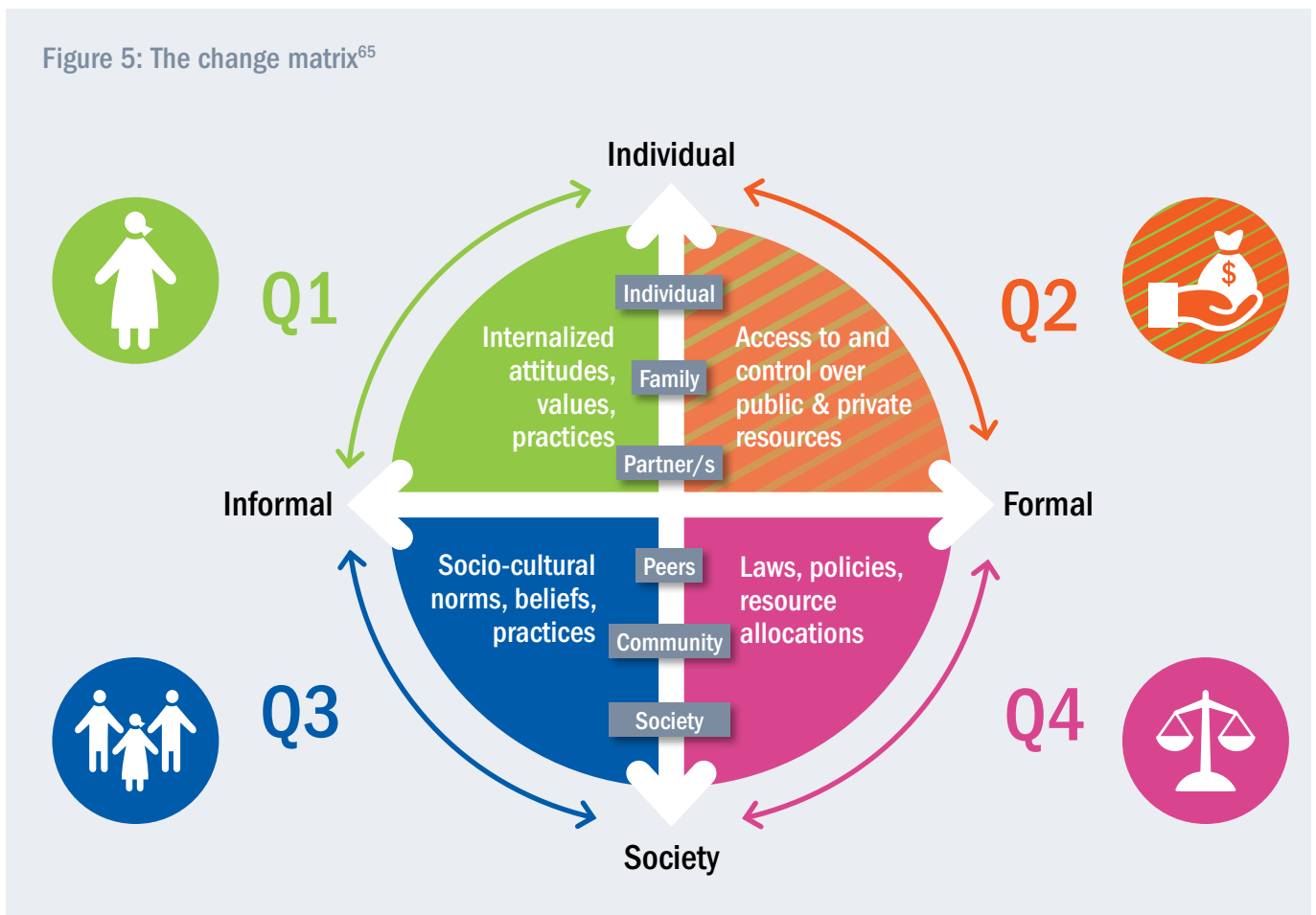


Where change happens: the change matrix

The change matrix in Figure 5 is adapted from a matrix used by Gender at Work^{xi, 65} and is also similar to matrices used by the Global Fund for Women,⁶⁶ Association for Women in Development (AWID)⁶⁷ and AmplifyChange⁶⁸. It shows how two intersecting fields create four areas for potential change. The vertical line refers to people; moving from the individual at the top, to the whole society at the bottom. The horizontal line refers to spaces; moving from those governed by thoughts, beliefs, customs and practices (more unwritten or ‘informal’ areas), to those governed by rules, regulations and policies (more written or ‘formal’ areas). In each quadrant we can see examples of how gender inequality and other forms of marginalization occur. Ultimately, all the quadrants are interconnected and influence each other. As we work through this section, the steps and actions will help to unpack this matrix in the different contexts and communities in which we work.

It is important to remember that all four areas are interconnected and influence each other both ‘positively’ and ‘negatively’. There is a constant tension between the quadrants and it is this tension that creates the space for change.

Figure 5: The change matrix⁶⁵



xi. Gender at Work. <http://genderatwork.org/Home.aspx>



Q1: Individual/informal: internalized attitudes, values and practices

This area refers to personal beliefs and values and how these are expressed through the attitudes, practices and behaviours of individuals, between couples and within families. For example, people accept that women should do the housework and look after children while men go out to work and are 'breadwinners'. These are not written rules, but for many women and men it is unthinkable that men should wash dishes or change a nappy because this is considered 'women's work' and demeaning for men. These beliefs place different values on different roles and give more power to some people and less to others. But, these tasks, roles and values are not permanent – they can and do change over time.

Importantly, in the context of VAW and HIV, there are many attitudes and beliefs that support VAW. For example, in some contexts it is seen as acceptable for husbands to physically beat their wives, particularly if a woman is thought to have broken a social norm. There is clear evidence that perceiving wife beating as acceptable is often a factor associated with IPV in some settings.^{38,39}

Example: Investing in young women

Zaituni in Uganda wanted to go to college and on to university, but her father would not sell his coffee beans to fund her education as he felt women should not receive higher education. After a Stepping Stones workshop, the other men persuaded her father to do this and she went to college and later became a teacher. Now, she teaches in the local school. Her father's internalized values about girls' education changed through the influence of his peers and his daughter was able to achieve her goals.⁶⁹



Q2: Individual/formal: access to and control over public and private resources

This area is about an individual's or family's ability to access and use resources. Resources can be food, land, money or services, such as healthcare, education or legal. It is important to look at both the availability of services and resources as well as the accessibility.

Sometimes, services tailored to the needs of specific groups simply do not exist or are few and far between. For example, women with disabilities may experience additional barriers to accessing reproductive health services. These services may not be physically accessible (e.g. steps with no ramps, small doors) or they are not user-friendly (e.g. no sign language or Braille). Similarly, women from ethnic minorities who do not speak or understand the dominant language and/or live in isolated rural locations may be excluded from accessing information and services.

Also, for many reasons, it is easier for some people to access public and private goods and resources than others. For example, when men are the breadwinners they may also make decisions about how the money is spent, which can limit women's ability to access resources even when they are available. This is an example of how Quadrant 1 influences Quadrant 2. In some settings, people do not always use available services – for example, fear of violence (including stigma and discrimination) when using police or healthcare services.

Example: Challenges to accessing healthcare services

During the 2017 *Global Treatment Access Review*, focus group discussions were held by and with women living with HIV. In Cameroon, one woman reported that, "Some husbands do not want their wife to go to the hospital. In this case the woman goes secretly. If not, she will miss the appointment – if she can't justify the reason to go out the day that she is supposed to collect medicine."

In both Cameroon and Nepal, women spoke about having to visit their health facility monthly for treatment refills. This put a strain on limited resources – where transport costs, long distances, long waiting times, stock-outs, taking time off work and/or paying for childcare all come into play.⁷²

This example highlights the links between the issues described in Quadrants 1 and 2 of the change matrix.⁷¹

Example: Negotiating condom use

Anthony Madeya lives in the Zomba district in Malawi. He is openly living with HIV, married and has six children. He said, "My wife always insisted on using condoms, but I always refused, which became a centre of our quarrels as a couple. I never saw the point of using a condom considering that we are both HIV positive. I therefore used to force my wife to have sex without condoms". After they had both attended *Stepping Stones* sessions, they discussed the issue and he apologized for the sexual violence he was perpetrating. He went on to say that they had agreed to be open about their sex life and communicate better on issues to do with sex to avoid similar occurrences.⁷⁰



Q3: Society/informal: socio-cultural norms, beliefs and practices

This area is about societal values and how these are expressed through attitudes, norms and practices, including customary or traditional, religious and cultural. For example, if a husband questions the norm of his wife preparing the family meal or the woman questions the man being the sole family breadwinner, peer pressure from family and neighbours is likely to make it hard for either of them to change what they do.

Peer pressure can also offer support (e.g. women helping each other when one of them is ill) but it is often challenging to change established norms, such as acceptance of GBV, spending household income or condom use. It can also make it difficult for women to claim property and inheritance rights if the husband dies without having written a will.

Example: Claiming property rights

In Namibia there are clear laws about widows inheriting property and goods from the marriage, but traditional practices can obstruct this process. The Namibian Women's Health Network produced a film showing VAW being used to obtain property and goods from a widow (widowers do not get treated in this way). In the film, siblings of the deceased visit his widow and demand that she hand over his house and belongings. The women chase the in-laws away.⁷³ Examples like this show how violence against women can be perpetrated by in-laws as well as by others.



Q4: Society/formal: laws, policies, resource allocations

This area of the matrix is about societal values that are more formal because they are in writing and embodied in law, policy, research and resource allocation.

Laws and policies both govern and underpin societal behaviour and are influenced by public statements. For example, when certain populations or behaviours are criminalized, this can support the societal marginalization of and violence against these groups. More progressive and inclusive public statements, research and practice can apply political and policy pressure to change laws or to change their implementation. So, there is a two-way relationship between the informal and formal sectors, as already described above.

Example: Analyzing national HIV programmes

In 2011, ATHENA Network, HEARD and partners developed a tool for analyzing how the prevention of and response to GBV was integrated into HIV national strategic plans, policies and programmes. The tool has been used in over 40 countries to strengthen analysis and accountability.⁷⁴ In eastern and southern Africa, the review found that only four countries (Mozambique, Rwanda, South Africa and Tanzania) provided an adequate response to VAW and even these countries failed to include women, in all their diversity.⁷⁵

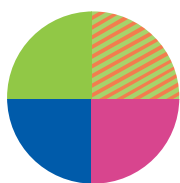


Action B: Can we identify gender norms in our communities?

Think of two examples of gender norms in our community:

- one that upholds inequitable gender roles; and
- one that reduces or challenges them.

For example, do people in our community believe that teenage girls should not know about sex or how to look after their sexual health? What beliefs are held about girls who do know about these things? And what happens to these girls? Sometimes it helps to compare the lives of our grandmothers to that of young women today. What can young women do today that their grandmothers could not or did not when they were young? Or, what is less safe for young women to do today that their grandmothers could do in safety when they were young?



Using the change matrix to show what change looks like

Our vision is for greater safety, security and well-being in our communities. The boxes below show what this look like when we use the change matrix. Our theory of change (see Part 3, Introduction) and results framework (see Part 3, Step 6) explain more about how we achieve these results using the ALIV[H]E approach.



Q1: Internalized *gender-equitable attitudes, values and practices*

- More women and girls, in all their diversity, know about their rights and have the skills and knowledge to claim them.
- More women and girls can recognize, name and reject different forms of violence and know where to seek redress if they experience any of these.
- More men and boys individually recognize and uphold women's and girls' rights, and encourage, support and facilitate women and girls to claim their rights.
- More women can make and enact decisions about their healthcare, including avoiding unwanted pregnancies and sexually transmitted infections (STIs), and access harm reduction and HIV services.
- More women living with HIV can choose when and whether to have relationships and start a family or have more children.
- More women feel they can start a conversation about sex with their partners and children.
- More women and men make joint decisions about and share domestic responsibilities such as chores and childcare.



Q2: *Increased access to and control over public and private resources*

- More adolescent girls and women have access to and use a full range of quality healthcare services and information, including for sexual and reproductive health (SRH) and comprehensive post-rape care.
- More women access and use legal services, financial services, credit schemes and social justice mechanisms.
- More women can access all services without the permission of their husband or male family member, and adolescent girls can receive confidential information and advice on SRH (including family planning) without parental consent.

- More service providers are sensitized to the needs of women living with HIV, adolescent girls and young women, women who sell sex, transgender women and women with disabilities, among others.
- There are more tailored, integrated SRH and HIV services, including VAW services.
- Girls are able to complete primary and secondary education in safety.
- Girls and boys have access to comprehensive sexuality education.



Q3: *Gender-equitable socio-cultural norms, beliefs and practices*

- More people collectively adopt gender-equitable attitudes and practices, including rejection of GBV in all its forms.
- There is less HIV- or sexuality-related stigma and discrimination.
- More shared decision-making and more men undertaking traditionally female roles, such as in child and community care.
- More women are involved in community decision-making processes.
- There is less violence against women and children, and less alcohol consumption.



Q4: *Laws, policies and resource allocations that respect, protect and fulfil women's human rights*

- Legal obstacles preventing access to information and services for women and adolescent girls, in all their diversity, are removed.
- More women, in all their diversity, are supported to meaningfully engage in decision-making processes.
- More laws (including by-laws), policies, guidelines and strategies protect and uphold women's rights, including through gender-sensitive budgeting, funding and other resource allocations.



Box 5: *The knowledge-attitude-practice gap (KAP-gap)*

There is an assumption that once people have knowledge this will change their attitude and then change their practice (behaviour). This linear cause and effect understanding of behaviour change is also known as KAP (knowledge-attitude-practice). Many behaviour change initiatives have used (and still use) this implicit theory of change. However, it is clear that this model is over simplistic.^{76,77} If we think about condom use; many people know that condoms help prevent unwanted pregnancy, HIV and other STIs. Yet, people who know about condoms still do not necessarily use them. There are many reasons for this, including limited access and cultural norms. Sometimes practices change before attitudes do. For instance, men may feel pressure from other men to send their daughters to school and then realise that this has positive results, which can feel good, as in Zaituni's story on page 23.

It is clear that we need to move beyond the 'KAP-gap' to a much more holistic and fluid approach as to how attitudes and behaviours change over time.^{78,79,80,81} The ALIV[H]E Framework adopts this approach.



Action C: What are the underlying causes of VAW and HIV in our communities?

- Action C builds on and extends Actions A and B. Again, it is best done through a group-based process, whereby we draw on everyone's expertise and knowledge.
- Here, we look at each quadrant in relation to the community where we work and ask questions to identify the underlying causes of VAW and HIV vulnerability. Through this process we start to identify the major challenges and what we might want to change through strengthened programming.
- The key resources in Annex 4 provide additional sources of information to supplement what was discussed and identified in Actions A and B.
- Some groups may be more aware of these issues than others. We are all at different stages on the same learning journey. These questions are to help you to understand where you and your community are on this journey. For each quadrant, think of any other questions we want to add that are relevant to the women and/or adolescent girls with whom we want to work.



Using the change matrix to identify the causes of VAW and HIV



Q1: Internalized gender-equitable attitudes, values and practices

- Do women and adolescent girls recognize various acts, such as harsh words, physical harm, lack of access to a partner's income or forced sex when married, as violence? If not, what do they think about each of these issues? Do men and boys see these as acts of violence or as normal behaviour?
- What do women and girls think about violence against them? Do they consider safety as a basic right? What do men and boys think?
- What do women and girls understand as sexual and reproductive health? What do women and girls understand as sexual and reproductive rights? What do men and boys understand about SRHR?
- Do women and adolescent girls feel they are 'allowed' to talk about and enjoy sex? Do they think it is okay for boys and men to?
- Are women able to use condoms with their male partners? (Think about women's confidence in accessing condoms, in negotiating their use and in using them with their partner.)
- Do women and adolescent girls place a high value on their own health, education and political participation?
- Do people in your community feel that they have control over their health and well-being or that these are beyond their control? Or somewhere in-between? Which areas do they feel they have control over? What suggestions do they have that might help them have more control over other areas?
- Do parents talk to their children about gender equality, healthy sex and sexuality, and sexual violence? Do parents demonstrate gender equality in family life? If not, where do children learn about these things?
- Do women and girls feel that they can make choices about what happens to them? Can they give examples of choices they can make and choices they cannot?
- If they can exercise choice, do they feel safe to carry out these choices?
- Are there any women who are excluded from any of these activities in the community or at home? Think about age, disability, class and sexual orientation.

- *What is the situation you first thought of that puts some women or girls at greater or lesser risk?*
- *Who are the women or adolescent girls you are thinking of?*
- *Where do these women or girls live? Who do they live with? What different realities (e.g. age, relationship status, sell sex, disabled) do they have? Do they also have other identities, sexualities and experiences?*
- *What sort of relationships do they have with the people in their lives, such as peers, family, neighbours and community?*
- *How do personal beliefs, values, attitudes and actions that reinforce gender roles, place these women or girls at greater risk of HIV?*
- *Have women experienced any forms of violence because of personal beliefs, values, attitudes and actions that reinforce gender roles?*
- *If so, from whom and in what form?*
- *Do women and girls know where to get help if they experience violence?*



Q2: Access to and control over public and private resources

- Do women have access to the information and services they need to look after their health and that of their children? Do they use the services that are available?
- Are services widely available, integrated and free at point of delivery?
- Are service providers friendly, supportive and non-judgemental?
- Are women able to access health, financial and other services without the consent of their husband or another male family member?
- Are all girls, as well as boys, going to school in this community? If not why not?
- Are schools safe for all children in this community? If not, why not?
- Can girls in your community access sanitary wear from schools?
- Do girls in your community continue to go to school during their menstruation?
- Do women have the same opportunities to seek paid employment as men?
- Are women able to make decisions about how household resources are used?
- Do services meet the diverse needs of women with disabilities?
- Are condoms freely available to all women?
- What access do women – irrespective of their age, HIV status, sexual orientation, disability, whether they sell sex, use drugs, etc. – have to food, land, money, housing and safety? Can they make and enact decisions about their lives? Can a woman own property or land, either now or in the future?
- What access do women have to SRH, HIV and family planning services? Do people treat them with care and respect when they access these services?
- What tailored services and approaches are in place that could help women, in all their diversity, to achieve their health and life objectives?
- What kind of employment opportunities do women have?
- Do women receive peer support from others in the community, irrespective of their background and context?
- How many – and which – women finish school or go on to university? Think about ethnicity, sexual orientation, HIV status, class, disability, etc.
- Can women, in all their diversity, easily go to the police if they experience physical or sexual violence? How will a woman be treated if she is transgender, lesbian, old or very young, disabled, sells sex, or is living with HIV?



Q3: Socio-cultural norms, beliefs and practices

- Do most people in your community believe that violence against women and children is ever acceptable? Please explain more.
- Are harmful traditional practices, such as child marriage, female genital cutting and widow inheritance, outlawed in your community?
- Is education for girls valued as highly as for boys?
- Are girls supported to go to school by the leaders in your community?
- How are different groups of people involved in decision-making and civic life? For example, are women equally represented on political bodies?
- Are there any groups that experience barriers to fulfilling their potential because of other people's attitudes?
- What informal structures exist at the community level to protect and support women in all their diversity? What networks and support systems do women have? How are women regarded by society – what are society's attitudes and beliefs about different women?
- What informal factors undermine women's safety and/or increase their vulnerability to HIV at different times of the day or night?
- Are there any accepted cultural practices that place women at risk for acquiring HIV or experiencing violence?
- What other factors affect women and girls that result in them being perceived as 'different' (e.g. disability, LGBTI, women who sell sex)?
- Thinking of all the questions above, which women do you think are the most marginalized and vulnerable in your community through poverty and/or social isolation?
- What are people in your community already doing to support vulnerable women? What activities are they doing to support themselves? How can we meet with them to discuss all these questions?



Q4: Laws, policies and resource allocations

- Does your country have laws against marital rape?
- Does your country have laws against rape?
- Is VAW addressed in your country's HIV national strategic plan? If so, are VAW programmes for women and girls costed, budgeted and included in the accountability framework?
- Does your country have a national strategy on gender equality and women's empowerment?
- Are any or certain sexual orientations and/or gender identities criminalized in your country? If so, are there efforts to decriminalize them?
- Is sex work and/or drug use criminalized in your country? If so, are there efforts to decriminalize them?
- Is HIV transmission and/or HIV exposure criminalized in your country? If so, are there efforts to decriminalize them?
- What formal structures exist to protect and support women and adolescent girls in all their diversity? What laws, policies and programmes protect and uphold their rights? (e.g. a disability equalities act).

- What formal structures (e.g. laws, policies, guidelines, resource allocations) exist that increase a woman's vulnerability to HIV and/or VAW?
- What laws and policies reduce her vulnerability to HIV and/or VAW?
- Where does she live in relation to most available services?
- Does your HIV or VAW national strategic plan address how to condone the negative attitudes and gender inequality that reinforce GBV in society? If it does, please explain how.
- Are activities that promote the rights of women and girls, advance gender equality and address VAW, fully costed and budgeted in national strategies and operational plans on HIV and VAW?
- Are there community by-laws that protect or increase women's and girls' vulnerability to HIV?
- Is women's civil society adequately resourced?
- Are members of civil society aware of what funds have been allocated to programmes that affect their lives?
- Are women engaged in monitoring these programmes? And demanding accountability?

Key results from Section A

By the end of this section, we should have completed Actions A, B and C in Step 1 with the community where we work:

Action A: identified who are the most vulnerable to VAW and HIV in our community.

Action B: identified some of the gender norms in our community.

Action C: identified some of the underlying causes of HIV and VAW in our community.

When you have completed these three actions, you are ready to move on to Section B.

Section B: Providing strategies that respond to the intersections between VAW and HIV

This section includes **Steps 2** and **3** and **Actions D** and **E**. It aims to:

- outline the evidence on integrating VAW and HIV
- identify strategies already being used
- identify additional strategies to be implemented to prevent VAW and HIV.



Key messages

- Violence against women and HIV are both preventable.
- There are evidence-informed initiatives that work to prevent VAW and HIV.
- Community-based organizations are already doing much of this work.
- Understanding ‘what works’ and adapting it to our contexts can strengthen responses.

Step 2

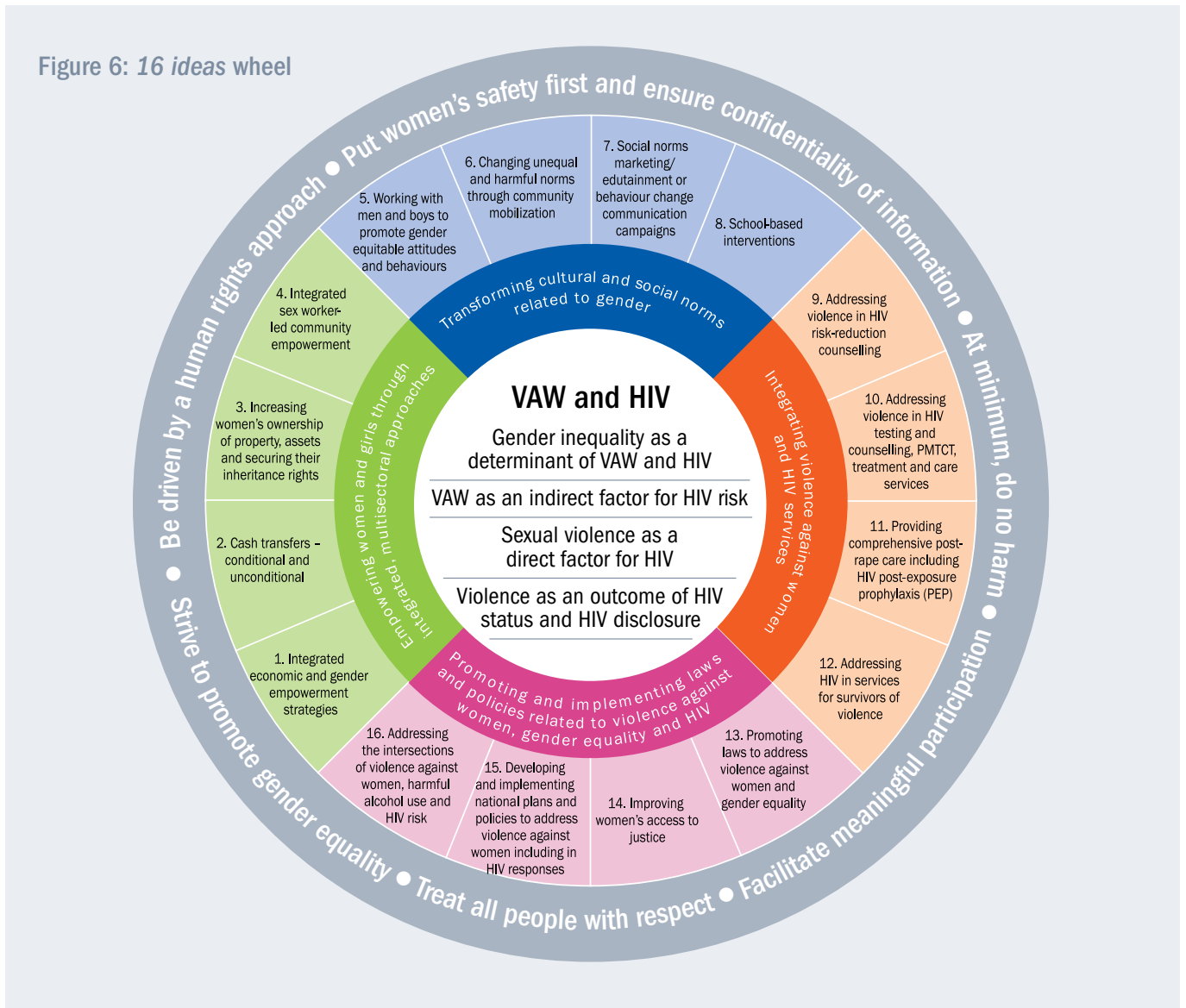
Step 2: Violence against women and girls is preventable: the evidence on integrating the response to VAW and HIV

There is growing evidence that VAW is preventable. The programming tool, *16 Ideas for addressing violence against women in the context of the HIV epidemic*, provides guidance on this.⁵ There is additional guidance on preventing GBV for communities who may experience intersecting forms of violence, stigmatization and marginalization:

- WHO (2013) *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* provides comprehensive guidance more widely, but includes specific chapters on addressing violence against sex workers.⁸²
- WHO (2016) *Implementing comprehensive HIV and STI programmes with transgender people: practical guidance for collaborative interventions*.⁸³

The *16 ideas* programming tool outlines four main strategies for what works to prevent and respond to VAW at the intersection of HIV. All four areas are interdependent and interrelated. Go to <http://apps.who.int/reproductivehealth/topics/violence/16ideas/> for an interactive online version of the tool.

Figure 6: 16 ideas wheel



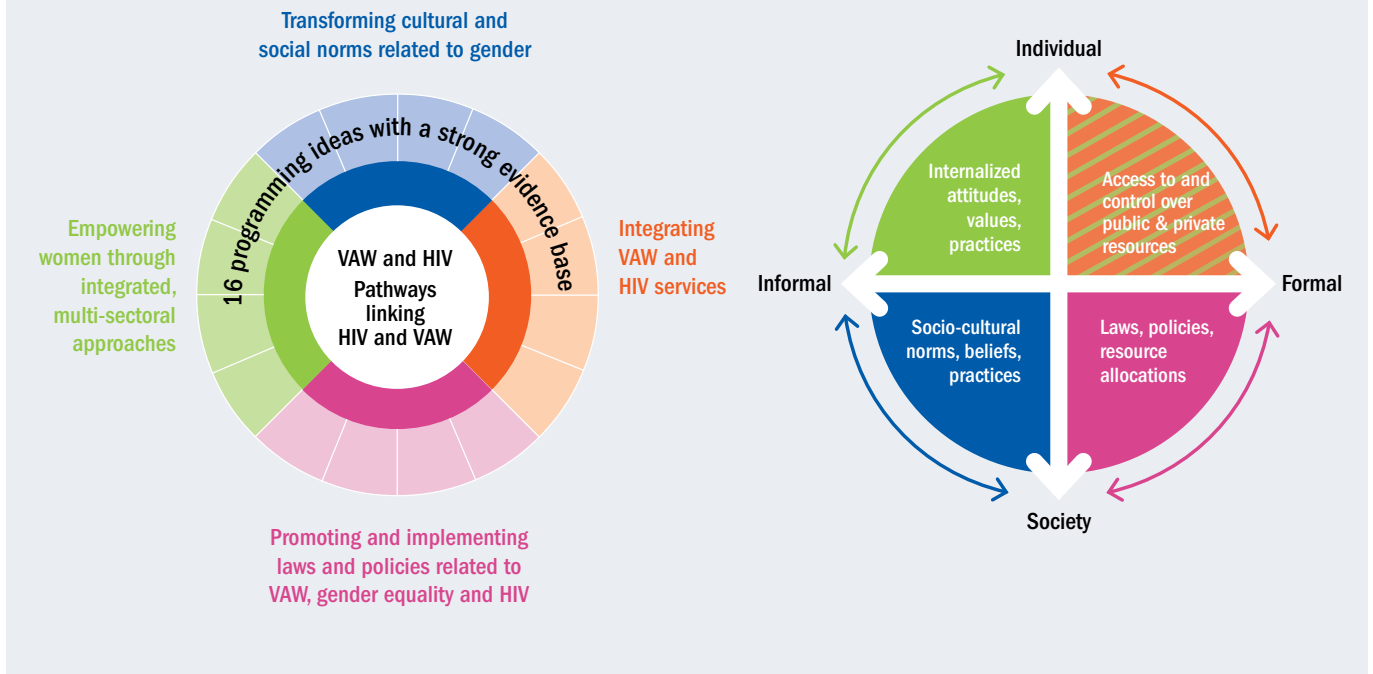
Connecting the 16 ideas wheel to the change matrix

The four sections also relate to the quadrants discussed in the change matrix (see page 22).

1. **Empowering women through integrated, multi-sectoral approaches** – this relates to both quadrants 1 and 2 of the change matrix.
2. **Integrating VAW and HIV services** – this relates mainly to quadrant 2.
3. **Transforming cultural and social norms related to gender** – this relates mainly to quadrant 3.
4. **Promoting and implementing laws and policies related to VAW, gender equality and HIV** – this relates to quadrant 4.

Each strategy area of the *16 ideas* wheel contains four programming ideas for working on VAW and HIV, making 16 in total. (See Figure 6.) Each programmatic idea has a strong

Figure 7: 16 ideas wheel and change matrix: how they relate



evidence base for effectiveness. The 16 ideas wheel presents the strategies as 16 distinct programmes. However, we need to recognize the importance of all the different levels and understand the response to VAW and HIV as a jigsaw, whereby different organizations and agencies with specific skills and experience can work on each component. Only by working collectively can change happen.

Gaps in the evidence base

The 16 programming ideas are not comprehensive and gaps exist where current practice has not been evaluated rigorously. For example, reducing harmful alcohol use comes under the strategic area 'Promoting and implementing laws and policies' because laws on alcohol use have been formally evaluated and are known to help reduce VAW. However, reducing harmful alcohol use is not under 'Transforming cultural and social norms' even though a lot of work on reducing alcohol use at the community level takes place and is widely reported to have a valuable effect in reducing violence. Because this work has not been *formally* evaluated, as of yet, there is no *formal* evidence base for its effectiveness at this level. This emphasizes the importance of implementing programmes with strong M&E and research components so that they can contribute to the formal evidence base on 'what works' to integrate VAW and HIV and, in turn, inform programmes, policies and strategies.

Adapting existing evidence for women in all their diversity

The 16 ideas can be adapted for the women that we identified as most vulnerable to VAW in our community, even if the evidence for what works for these women does not yet exist. For example, there is strong evidence that working with women around gender norms and economic empowerment (programming idea 1 in the strategic area 'Empowering women through integrated, multi-sectoral approaches') is an effective way of reducing IPV, yet, there is little to no evidence specific to women living with disabilities. The ALIV[H]E Framework will help you to adapt an initiative to use with women who are the most vulnerable.



Remember!

No-one can do everything, and no-one is asking us to. But, by thinking through what we are already doing, we will start to think about what we may be able to do more of and do more effectively.

Action D: What are we already doing? Where is our current response to the VAW and HIV intersection focused?

We have already identified in Actions A and B who are the most vulnerable in our community and in Action C we strengthened our understanding of the multiple underlying causes of this vulnerability and in which quadrants these issues reside. In this action we will look at our work to date and identify which of the four quadrants of the change matrix and the *16 ideas* wheel, our work corresponds with.

It is important to reflect on what we are already doing to respond to VAW in our community. The following questions will help us think through what we are doing and what is working well:

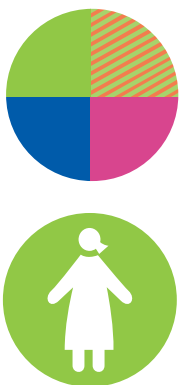
- Which of the 16 ideas are we already using?
- Which populations are involved?
- Which populations are being excluded and why?
- What are we already doing that is *not* included in the *16 ideas* wheel?

This action is best done in a group, involving not only organizational staff but also people you work with on a daily basis.

Step 3

Step 3: What can we do differently to strengthen our response to the VAW and HIV intersection?

- In Action D, we identified what we are already doing. We can also think about expanding our work to other areas and reaching women we have identified as most vulnerable to VAW but may not be working with currently. Throughout, it is important to refer back to the questions in Step 1, Action A, about which women and girls are most vulnerable.
- The following boxes give examples of the types of initiatives that could be used to address intersections within each of the four quadrants. These are discussed in more detail in the *16 ideas* programming tool. We have also included examples of good practice.



Using the change matrix to identify relevant strategies

Q1: Internalized gender-equitable attitudes, values and practices

This area is about politicizing individual experiences – recognizing that the ‘personal is political’ – and investing in the agency of women and girls throughout their life cycle, through building self-esteem, assertiveness skills and confidence. Approaches include:

- Capacity-building to support the meaningful involvement, consultation and leadership development of women living with and affected by HIV. Increasing the understanding of processes and opportunities for engagement.
- Young women’s leadership development.
- ‘Know your body, know your rights’ workshops. Understanding how our lives are gendered and shaped by diverse factors.
- Strengthening women’s agency through participatory initiatives.
- Peer counselling and support.



Good practice: Meaningfully involving women living with HIV in research

In Kenya, LVCT Health and the Better Poverty Eradication Organisation purposefully engaged women living with HIV to identify the specific vulnerabilities to VAW that women living with HIV faced at the individual, family and community levels. Women living with HIV were involved as trainers and champions to address gender attitudes, highlight risks to VAW, identify areas for capacity-building and conduct awareness-creation activities.⁸⁴



Good practice: Engaging women in all their diversity

In South Africa, Refugee Social Services in partnership with Project Empower, celebrated South Africa's National Women's Day by holding a workshop that brought together refugee women, women living in shack settlements and women who sell sex. These different groups had previously had little contact with one another and viewed each other with hostility. During the workshop, women shared their experiences and discovered commonalities in their lives that cut across their perceived differences. They were able to identify the root causes of the challenges they faced – located in the wider social structures of patriarchy and capitalism.⁸⁵



Good practice: Addressing power, autonomy and violence for LGBTI women in Africa

The Coalition of African Lesbians (CAL) frames the issue of violence against women who are lesbian, bisexual or transgender around sexuality and gender, and analyses the issue in terms of power and autonomy. This enables a reflective and agenda-setting approach that emphasizes agency and choice over victimhood. This framing situates violence against lesbian, bisexual and transgender women within a broader structural issue of power imbalance and the regulation of women's bodies, lives and sexuality by gendered social norms and expectations. In this understanding, violence is a mechanism of such regulation. The 'I am/More than' campaign led by CAL has engendered collective advocacy that recognizes commonalities between diverse women on the basis of gendered power relations. The campaign acknowledges lesbian, bisexual and transgender identities while underscoring that women are more than these identities.⁸⁶



Good practice: Young Women's Leadership Initiative

ATHENA Network's Young Women's Leadership Initiative (YWLI) was launched with UNAIDS in 2011 and has seen catalytic impacts in bringing young women's voice, visions and priorities to the centre of global policy and strategy on HIV. Young women from all regions of the world, living with and most affected by HIV, are 'graduates' of and peer mentors within YWLI. The programme has developed spaces and strategies to create and support the meaningful engagement of adolescent girls and young women in the HIV response: Participants of the programme have:

- engaged in policy fora and informed entities such as the Global Fund and PEPFAR
- shaped, informed and implemented in-country project work
- conducted and participated in community dialogues and led participatory action research
- sat on global reference groups alongside more experienced women living with HIV activists and taken part in informal dialogue with key global leaders
- participated at the Commission on the Status of Women, regional and international conferences, HIV Research for Prevention (HIV R4P) meetings and other ATHENA-convened spaces, including the Women's Networking Zone.⁸⁷



Q2: Increased access to and control over public and private resources

This quadrant is about ensuring all people can equitably access the resources and services they need to live healthy and safe lives. Strategies include:

- SRHR service provision, tailored for women and girls in all their diversity (age, sexuality, HIV status, disability, gender identity, substance use, profession, etc.).
- Sensitization of healthcare staff on linkages between HIV and VAW, including how services can be places of vulnerability for women living with HIV and/or women and girls with diverse identities (as above).
- Male partner engagement initiatives (e.g. couples counselling and testing, prevention of vertical transmission [also known as mother-to-child or perinatal transmission]) – as long as it is optional and checks are in place to ensure women's safety.
- Peer-led service provision and peer mentoring within a facility.
- Unconditional cash transfer interventions for women and children.
- Provision of a comprehensive post-rape care package (free of charge at point of delivery).
- Integration of HIV counselling and testing in post-rape care settings.
- Provision of pre-exposure prophylaxis (PrEP) – as long as it is optional and checks are in place to ensure women's safety.
- Integration of violence screening processes and linkage to care in HIV counselling and testing services and in antenatal care.⁸⁸
- Access to economic initiatives for women, including access to land rights.



Good practice: HIV counselling and testing by and for deaf people

People living with disabilities often have limited access to HIV counselling and testing. In Kenya, LVCT Health worked with deaf people to develop specific HIV counselling and testing services run by deaf people. Over a two-year period (2004-2005), 1,709 deaf and 1,649 hearing clients were seen. Not only did deaf clients receive high quality HIV counselling and testing, the team was also able to show that deaf clients were at risk of HIV and required additional services.⁸⁹



Good practice: Women living with HIV claim their rights and access to services

Between 2012 and 2014, the Coalition of Women Living With HIV and AIDS (COLWHA) in Malawi, ran a programme to strengthen the rights of women living with HIV. This included translating laws into the local language and providing women with a clear understanding of their rights, thereby enabling them to demand their rights from service providers.⁵³



Good practice: Women in the driving seat

Women in a rural area of Kenya developed an income-generating project – making earrings. However, each woman was anxious not to make too much for herself in case her husband got angry with her for earning more than he did, undermining his traditional male role as breadwinner. Instead, they decided to pool their earnings and support the development of the local primary school. That way, instead of any one woman getting blamed for earning more than her husband, all the women could work together for the benefit of them all and ensure a better education and future for their children.⁹⁰ (This example shows how quadrants 1 and 2 are closely connected to each other.)



Q3: Gender-equitable socio-cultural norms, beliefs and practices

This quadrant is about ensuring that community structures and processes enable and uphold the safety, human rights and participation of all people, especially those who are the most vulnerable. Strategies include:

- Community mobilization to transform gender norms.⁹¹
- Comprehensive sexuality and gender transformative education in school settings.
- Breaking down taboos.
- Media campaigns, community radio and 'edutainment'.
- Working with traditional leaders, faith leaders and community decision-makers.



Good practice: Working with community leadership to give women a voice that is heard

In rural South Africa, older women used participatory exercises and group discussion to identify a conservative land ownership practice, preventing women from accessing land in their own right, as a factor for increasing HIV risk. Supported by Project Empower, more than 250 women in the village approached the traditional leadership body and successfully demanded that women sit on the traditional council and that women be allocated land in their own name rather than through a male family member.⁷²



Good practice: Working with faith and community leaders to promote condom acceptance

In the Gambia, Mohamed Conteh, a trainer and film-maker, filmed a group of imams holding a discussion about condoms in the context of the Quran. The discussion eventually led to an agreement among them that condoms, in the context of HIV and STI prevention, were to be welcomed and encouraged. The trainer then invited individual imams to go with him to show the film to village elders and then discuss together the issues raised in the film. This process led the community elders to accept and promote condom use in their communities.⁹²



Good practice: Supporting 10-year-old girls to 'speak truth to power'

In Entebbe, Uganda, a training workshop run by Rose Mbowa, Professor of Dance and Drama at Makerere University, was approached by a group of 10-year-old girls, asking if they could take part. Initially, they were told that they were too young, but they insisted and the organizers agreed they could have their own peer group. During the workshop, it emerged that the girls, many of whom were orphaned, were being harassed by older men when sent to do shopping in the market for their aunts. In the final community meeting, the girls role-played this situation in front of the Mayor and other community leaders, and requested that this practice stopped. The councillors were shocked to discover this and resolved to pass a by-law sanctioning men who harassed girls.⁹³



Good practice: Amplifying the voices of young women who sell sex

In Addis Ababa, Ethiopia, the Nikat Charitable Association developed a radio programme, run by and for young women who sell sex, as part of the Link Up project. The radio diary programme 'Betengna' gave young women who sell sex, a platform on which to share their experiences and needs to a wider audience, helping to break down widespread stigma and discrimination. The radio programme received an overwhelmingly positive response, improved relations between women who sell sex and the police in Addis Ababa, and fostered broader understanding and acceptance of the rights and needs of women who sell sex.⁹⁴



Good practice: Engaging community members to inform the development of information, education and communication (IEC) materials on gender norms transformation

In Kenya, LVCT Health and the Better Poverty Eradication Organisation conducted focus group discussions with diverse groups in a rural community, in order to identify prevalent negative gender norms. The information obtained was validated through workshops with 55 community champions and informed the development of positive gender and context-specific IEC messages. Participants identified the key messages to be used for a campaign to create awareness of positive gender norms. These materials were packaged to have a wide appeal and be easy to disseminate by the champions, and also contributed to the mobilization of participants into the initiative.



Q4: Laws, policies and resource allocations that respect, protect and fulfil women's human rights

This quadrant is about ensuring that national and local governments protect, respect and uphold the human rights and safety of all citizens – especially the most vulnerable – through the creation and implementation of laws, policies and programmes, and adequate resource allocation. Strategies include:

- Advocacy for comprehensive sexuality education.
- Documentation of human rights violations.
- Legal reform to recognize and criminalize marital and date rape.
- Advocating for the decriminalization of sex work, sexual orientation or gender identity issues, drug use, and HIV transmission and/or exposure.
- Advocate for gender-transformative community by-laws.
- Sensitization of policy-makers, donors and parliamentarians.
- Meaningful participation of people most affected by HIV and VAW.
- Shadow reporting on CEDAW and other relevant international human rights conventions.
- 'Know your rights' approaches among women, other community members and professionals employed to protect rights (e.g. police, service providers, magistrates, customary courts), in accordance with relevant national and international laws, policies, frameworks and conventions. Awareness of the mechanisms of redress.
- Mainstreaming the principles of inclusion, participation, non-discrimination and equality from the CRPD.



Good practice: Ending forced and coerced sterilization of women living with HIV in Namibia

During a workshop organized with ICW in 2009, young women living with HIV who were members of the Namibia Women's Health Network (NWHN) realized that a number of them had experienced coerced sterilization after giving birth. From this workshop there followed a process of documentation of human rights abuse, litigation and sustained advocacy and movement-building around this issue. The process then developed into a long and challenging legal campaign led by NWHN to hold the Namibian Ministry of Health to account for this practice. This was eventually achieved in November 2014.^{95,96,97}



Good practice: Ensuring disability is integrated into national policies

In Rwanda, local disability rights organizations were supported to establish a national technical working group on the integration of disability into national HIV and GBV policies. Specifically, this has resulted in the Ministry of Health and the Rwanda Biomedical Centre integrating training on the elimination of GBV against people with disabilities into core HIV modules for healthcare professionals.⁹⁸



Good practice: Decriminalizing sex work through sex worker-led advocacy

WHO guidelines, released in 2012, explicitly urge states to decriminalize sex work and establish rights-based laws to protect sex workers against violence and discrimination.⁹⁹ The guidelines took into consideration a qualitative survey¹⁰⁰ conducted with sex workers on the values and preferences relating to the interventions being considered, alongside a wealth of other recent evidence and studies. These WHO recommendations are now promoted as a minimum global standard. Following these guidelines, a sex worker implementation tool (known as the SWIT) was produced in consultation with sex workers. Crucially, the SWIT recognizes the importance of implementation at a grassroots level and being sex worker-led. It also highlights the importance of sex workers influencing HIV policy at national, regional and international levels through sex worker-led networks. The SWIT also reaffirms that the health of sex workers does not happen in a vacuum and that countries should work towards the decriminalization of sex work and the empowerment and self-determination of sex workers as a fundamental part of the HIV response.



Action E: How can we strengthen our response?

Remember to work collectively in a group to identify areas that could enhance and strengthen your current programmes. This group work should include everyone who works with you – in your organization, your community and any informal or formal groups you identified as vulnerable. Consider:

- Which of the four quadrants of the change matrix are you working in?
- What additional strategies could we adopt to strengthen our work within the existing quadrants (e.g. expand and work with another community that our programmes are currently not reaching)?
- Are there additional strategies we could adopt to link across to another quadrant (e.g. add an advocacy programme to our existing programme, build partnerships with other organizations working in other quadrants)?

Key results from Section B

By the end of this section, you should have completed Steps 2 and 3 and Actions D and E with the community where you work:

Action D: identified what you are all already doing and where your current response to the VAW and HIV intersection is focused.

Action E: identified how you can strengthen your response.

When we have completed these two actions, we are ready to move on to Section C.

Section C: Putting core values into action

This section includes **Steps 4** and **5** and **Actions F** and **G**. It aims to:

- identify our strengths and weaknesses around the core values of human rights, SRHR, gender equality, respect for diversity, safety, participation and evidence-based approaches
- look at how programmes can be strengthened by using the evidence base, and how the evidence base can be strengthened by the implementation of new programmes.



Key messages

- All responses to VAW must be grounded in a set of core values that support human rights.
- It is important to reflect on what these core values mean for women from different groups and most impacted by HIV and VAW, in order to apply the core values as inclusively as possible.

People who are vulnerable to VAW and HIV have tended to be excluded from shared power and decision-making processes around issues that affect their lives. It is important to develop a sense of trust with people in communities we are working with and meaningfully engage with them. The core values provide a checklist for all our work and ensure our work is grounded in human rights. These core values are not a fixed list and more can be added.



Step 4

Step 4: Enacting ALIV[H]E values in our work

- In Steps 2 and 3 we identified what we are already doing to respond to HIV and VAW in our communities. We have also identified the women who are most vulnerable (Actions A and B) and have considered what we could do differently to strengthen what we already do (Actions D and E).
- This step seeks to ensure that these core values are central to all our responses to VAW. Without this, we risk losing the trust of the people we work with and fail to meaningfully and safely respond to VAW in our communities.



Action F: Values checklist

Work through the checklist on the following pages to identify priority gaps in the implementation of our values and strategies for addressing them. We can add additional questions as necessary.

Values checklist

1. Human rights

- Do our programme activities protect participants' privacy and confidentiality?
- Does our language affirm human rights? In some countries this language is seen as inflammatory or challenging to political structures. Does our language need to be adapted to be appropriate locally and to assure political buy-in at all levels? For example, is it more politically acceptable to use the words 'social justice' rather than 'human rights' or 'participation' rather than 'inclusion'?

2. Sexual and reproductive health and rights

- Do our programme activities increase participants' awareness of their own SRHR, especially for young and unmarried women?
- Do our programme activities increase the access of women, in all their diversity, to their SRHR?
- Are the SRHR of our staff and volunteers promoted and upheld at all times?
- Are SRH commodities available? Is there a risk of stock-outs if demand for a product or service goes up?
- If the programme involves strengthening, expanding or integrating services, are staff, clinic buildings, supply mechanisms and other existing structures equipped to take on these changes?

3. Gender equity and equality

- Do our programme activities take into account traditional male and female roles and responsibilities and the implications of these on participants' time?
- Do our programme activities address the different factors that shape the vulnerability to HIV for men and women? For instance, women's vulnerability is related to their experiences of limited power and autonomy in male-dominated societies, while men's vulnerability is influenced by the availability of a limited range of male norms and stereotypes that emphasize toughness and control.
- Do our programme activities seek to change or challenge gender norms or ascribed gender roles? Do they use gender-transformative and gender-equitable processes?
- What capacity and resources do we have within our organizations? To what extent has gender been 'mainstreamed'?
- Do all our colleagues understand what a programme that 'seeks to transform gender norms and promote gender equity' means? And, do they all agree that gender equality is desirable? This includes everyone from the executive director to administrative staff and volunteers – and everyone in between. And, don't forget the board of trustees!



Good practice: Taking into account women's unpaid care responsibilities

In the pilot of *Stepping Stones and Creating Futures* in South Africa – a participatory initiative with young women and men to transform gender relationships and strengthen livelihoods – two-thirds of the women had to look after children. To enable young women to participate meaningfully, childcare was provided during the programme sessions.¹⁰¹

- Do we meet resistance in the community when we talk about gender equity and equality? Will men feel threatened? Will women feel exposed?
- Some gender programmes experience a backlash – for example, microfinance programmes that result in women having control of money, have sometimes resulted in men becoming resentful, with higher levels of IPV as a consequence.¹⁰² Similarly, HIV ‘disclosure’, often seen by policy-makers, healthcare workers and researchers as an empowering experience, can result in increased IPV and community- and health centre-based violence.⁴⁰ What can be done to guard against a backlash?
- Do our programme activities consider equity, particularly with regard to women with disabilities who may experience additional barriers to accessibility (e.g. transport) and costs (e.g. care and support)?



Good practice: Ensuring the safety of volunteers

Through a participatory initiative, community health workers in rural South Africa identified that they faced significant safety issues as they walked from house to house, around being attacked by men. Once this had been identified, strategies to ensure the safety of the health workers were put in place.¹⁰³

4. Respect for diversity

- Are all women – especially young women – fully involved in decision-making processes regarding our planned activities?
- What systems and processes do we use internally to maximize the meaningful participation of all staff and volunteers in decision-making processes?
- What systems and processes do we use internally to promote diversity within our organization?
- Do people see the benefit of being involved in our project? Do they have time? Is participation effectively a form of volunteerism? How can people feel that their participation is valued and valuable?
- Are women and adolescent girls living with HIV and/or from key populations participating, accessing and/or leading programme activities, and involved in planning and decision-making?
- Are women and girls with disabilities participating, accessing and/or leading programme activities, and involved in planning and decision-making?



Good practice: Using evidence to change practice

The project, Shaping Adolescents in Zimbabwe (SHAZ!), focuses on the prevention of HIV and exposure to IPV among young adolescent girls. Recognizing the importance of economic empowerment for young women, the project initially used a microfinance intervention. Through quantitative and qualitative evaluation, they discovered that the young women struggled with repayments and the approach. SHAZ! took this onboard and developed a vocational training programme that, when evaluated, showed significant impacts on reducing HIV risk and experiences of violence for adolescent girls.^{104,105}

5. Safety

- Do our organizations have child and young adult safeguarding mechanisms in place?
- Do our organizations have other protection mechanisms in place to ensure that there is no exploitation of girls and women in marginalized communities, such as women who sell sex?
- Could our programme activities increase or exacerbate potential GBV in the community? If so, how can we work to stop this happening?
- What systems and processes do we have in place to ensure staff and volunteers' safety at all times?
- Do the programme activities compromise the safety of any of the participants or expose them to new sites of violence or vulnerability?
- Do our programme activities ensure 'first do no harm'? What can we put in place to ensure their safety?
- Do our organizations provide safe spaces and accommodation for those experiencing disability?

6. Participation

- Do we ensure meaningful involvement of women, in all their diversity, at all the stages of planning, implementation, M&E, project management and governance (decision-making)?
- Do we use participatory tools that do not demand high levels of literacy or are adapted to accommodate different languages and dialects, to ensure full engagement in these processes?
- Do we enable women, in all their diversity, to engage safely (e.g. discussion and planning groups based on gender, age and other self-identified identities)?^{xii,106}
- Have we adequately budgeted for the meaningful involvement of key affected women so that we are not relying on voluntarism and unpaid work?
- Have we built in and budgeted for mentoring, training and technical support to build the skills and capacity of communities to meaningfully engage in and drive the programme?

7. Evidence-informed

A final core value of the ALIV[H]E Framework is that work should be evidence-informed. There is a growing body of evidence for effective strategies for preventing and responding to the intersections of VAW and HIV. Programming should build on and adapt these approaches. These questions look at how we can strengthen the evidence base at different stages of our work.

- How does the evidence base support the work we want to do?
- Are there components within our initiative that are missing from the evidence base? Can we contribute something new to the evidence base?
- Does our work enhance or deepen understanding of the intersections between violence and HIV and/or VAW risk?
- Does our initiative collect data on factors for vulnerability (e.g. HIV status, disability, sexuality, poverty, sell sex)?
- Is there a conscious effort to document and disseminate lessons learnt? Is this built into the programme?

xii. The Link Up tool, *Aiming High: 10 strategies for meaningful youth engagement*, offers guidance on the engagement of young people in HIV planning and programming. This tool could be adapted to other populations. Available at: www.aidsalliance.org/our-priorities/744-aiming-high-10-strategies-for-meaningful-youth-engagement

Step 5

Step 5: Expanding and strengthening the evidence base

In the following two actions we will look in more detail at how we think about change and how we monitor and evaluate our work. Action G helps us to think through some of these issues and links the application of the evidence base in our work to evaluating our work, so that we can improve the evidence base.



Action G: cross-checking processes and our organization's capacity

Work through these questions to identify how we monitor and evaluate our work:

- Do our programme activities fit within the existing evidence base? Or do they address a gap in the evidence base?
- Do we have systems for monitoring and evaluating our programme?
- Is our organization able to evaluate work in a way that is gender-sensitive and seeks to measure transformative processes in terms of gender and social norms?
- Do we have the capacity for the collection and analysis of data disaggregated as relevant (e.g. age, sex, gender, geography, socio-economic status, religion, ethnicity, etc.)?
- Are we familiar with, and can we use, gender-transformative indicators?
- Do our programme activities include the collection of evidence on women's experiences of HIV and/or VAW risk and vulnerability?
- Can we measure the changes we want to see? Are we telling a story that will produce compelling evidence?

For more details on *who* measures change and *how*, see Part 3, Step 7.

Bringing it all together: the ALIV[H]E Windmill of Change

In Section B we used the *16 ideas* wheel (see Figure 6) to explore the four quadrants of the change matrix. However, these diagrams are static images, whereas change is always moving. A wheel is a great symbol to use, but unless a wheel moves it is not much use to anyone. Here, we present a version of the *16 ideas* wheel that is more like a windmill.

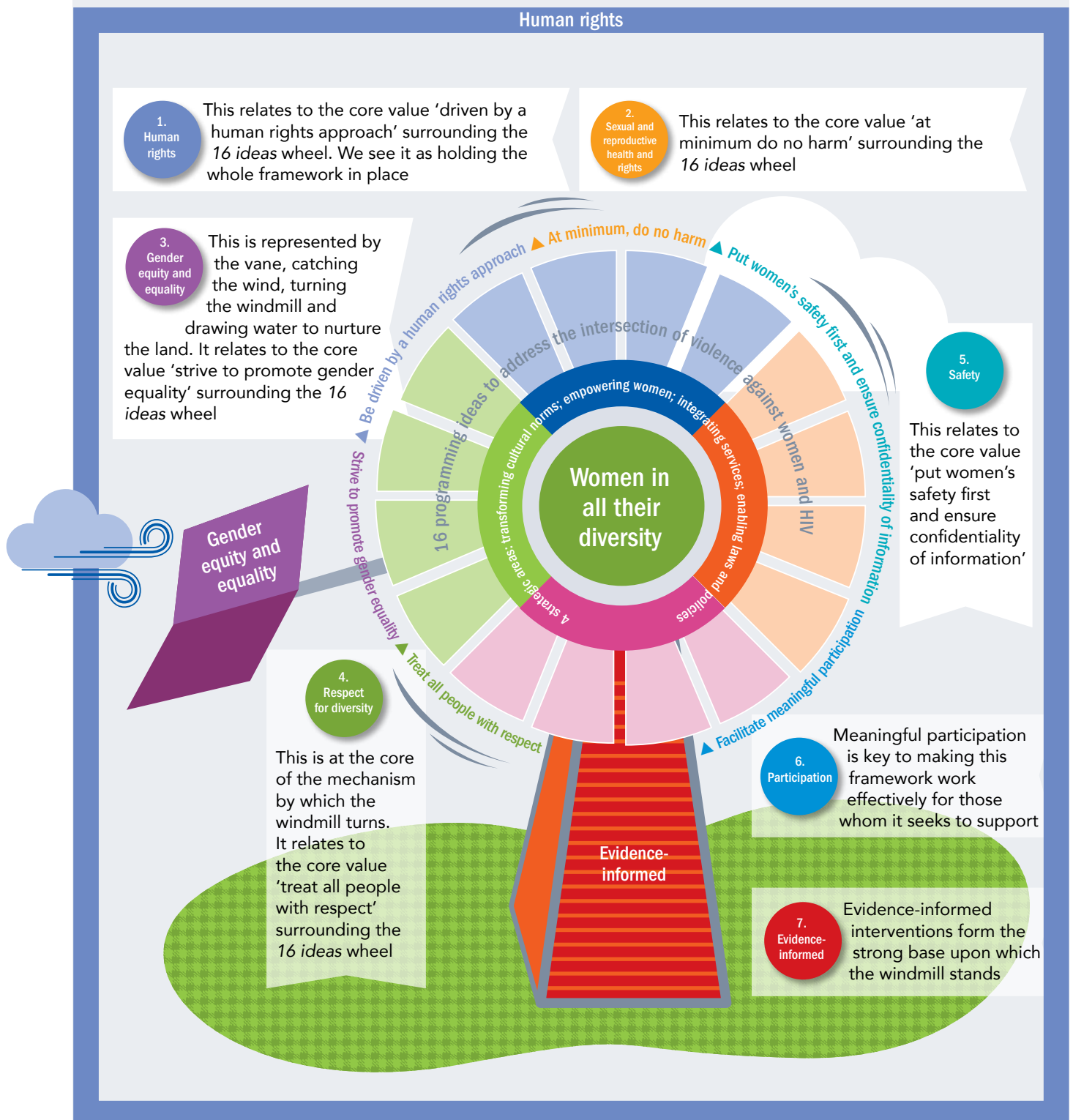
The ALIV[H]E Framework seeks to help the *16 ideas* wheel turn by applying the core values, described in Part 1, to the outside, placing women, in all their diversity, at the centre and seating the wheel on a strong framework of evidence. It is this combined action that creates change.

The windmill and its parts

This type of windmill is wind-powered using a vane. It pumps water from deep in the ground to irrigate the land, grow crops and supply drinking water for people and animals. The blades move when the large vane catches the wind and therefore the windmill moves on both a vertical and horizontal axis.



Figure 8: ALIV[H]E Windmill of Change



Key results from Section C

By the end of this section, we should have completed Steps 4 and 5 and Actions F and G with the community where we work:

Action F: reviewed our values checklist.

Action G: cross-checked our processes and our organization's capacity.

When you have completed these two actions, you are ready to move on to Part 3, where we will look at how to measure the change we want to see *in* and *with* the communities where we work. We will begin by exploring the theory of change.

Part 3

Measuring change



Introduction

Part 3 explores how to think about the change we want to create, how to measure this change and how to align with global indicators. By thinking about what we want to change and how to measure it, we hope to enhance and improve the work we do and start to demonstrate the impact our work has.

To do this, we will first explain what a theory of change is and why it is important to have one for your planning cycle. We will then demonstrate how our work contributes to the overall efforts to reduce VAW and HIV by using a theory of change. In Step 6 we will present a generic theory of change, linking the four strategic areas of the *16 ideas wheel*, the Windmill of Change and a related results matrix.

The ALIV[H]E Theory of Change

A theory of change is an attempt to articulate our beliefs about why change happens; what pre-conditions need to be met in order for change to come about; and, on this basis, what actions need to be implemented to enable these 'pathways of change' to occur. It can help us to assess and understand what we are seeking to do and how we see it working. Also, donors often require applicants to provide a theory of change, so it is helpful to know how to develop one.

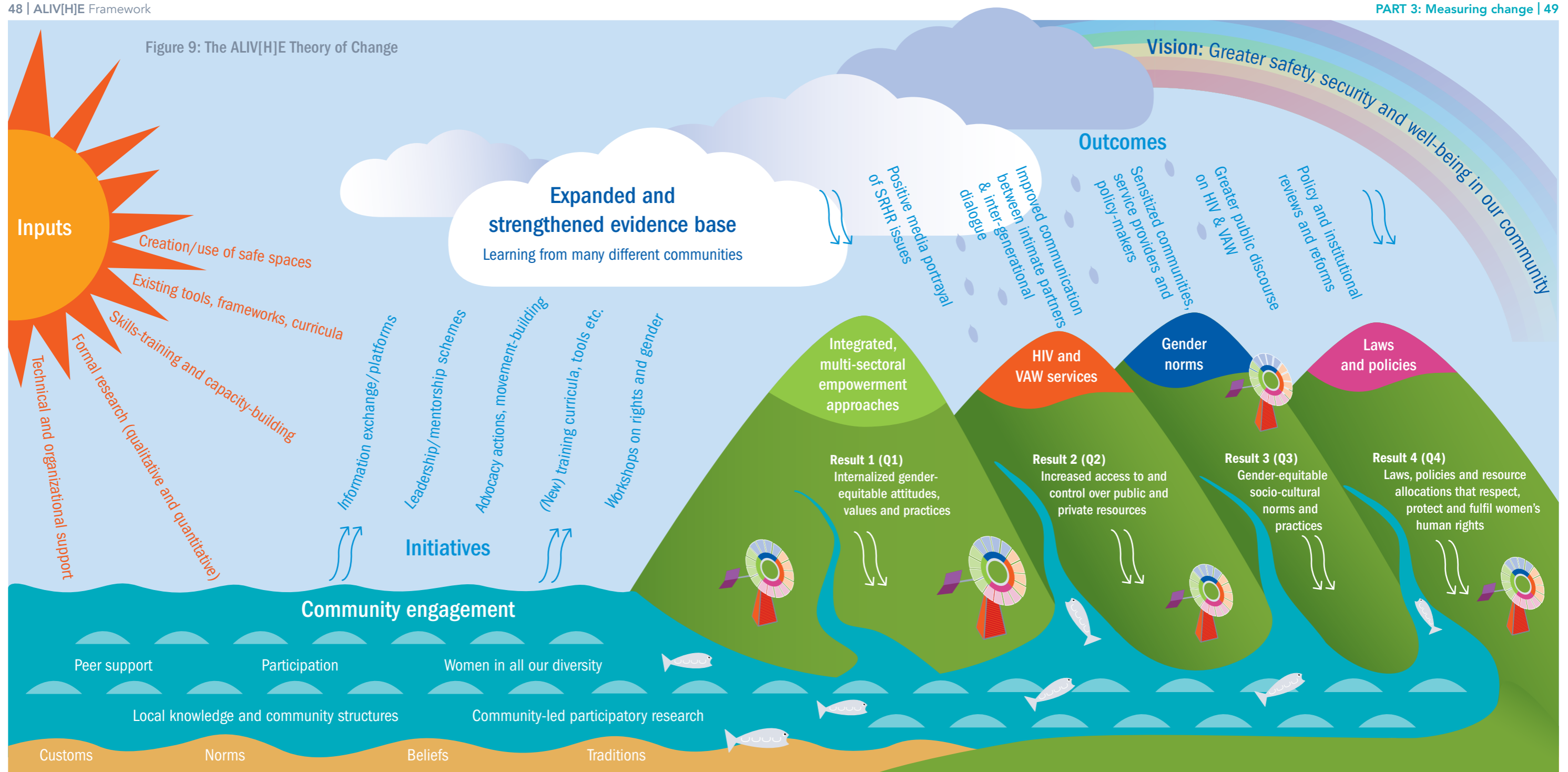
“A Theory of Change is essentially a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. It is focused in particular on mapping out or ‘filling in’ what has been described as the ‘missing middle’ between what a programme or change initiative does (its activities or interventions) and how these lead to desired goals being achieved.”

CENTRE FOR THEORY OF CHANGE¹⁰⁷

Developing a theory of change usually starts with identifying the desired vision or goal and then the different 'building blocks' that need to be in place for this vision to be realized. This process helps identify the strategies and activities that will be most appropriate to reach the end goal. You can also work backwards through time, from imagining that you have achieved the vision.

Some theories of change are presented in a text or narrative form. Others are presented as a flow diagram. While this can make them easier to understand, they suggest that change is only in one direction, like the arc of an arrow flying through the air. In practice, we know that changing behaviour and attitudes can have periods of stillness and periods of rapid movement and that change can also be iterative and multi-directional.

The ALIV[H]E Theory of Change offers an alternative and more cyclical version, using the metaphor of a landscape and its weather system. It builds on the theory of change developed by the Bridging the Gaps alliance in relation to the health and rights of key populations.¹⁰⁸ Community members could draw their own local landscape, perhaps replacing the sea with a river and the mountains with hills, trees or buildings. In this way, people can think through how the theory of change connects to their own lives and the world around them.



This theory of change illustrates how all the elements fit together. It starts on the lower left-hand side with the community, and moves clockwise in time.

The vision is overarching. It is what we aspire to for all our communities.

The community: The sea and sea bed represent our communities, in all their diversity, and the collective knowledge, tools, values and beliefs (represented by the sea and shifting sands on the sea bed) that make up its existing resources. This is where our work should begin – to build on the resources that already exist.

Inputs: The sun represents the inputs or new resources that we will contribute to support communities.

Initiatives: The evaporation of water from the sea represents the initiatives that will be created by combining the *existing* and *new* resources. The initiative feeds into the evidence base.

Evidence base: This is represented by the clouds and is created from documented experiences of using similar initiatives. When we find positive experiences and outcomes we feel more confident about whether an initiative could be suitable for scale-up and replication, leading to adaptation and larger-scale projects and programmes. When we experience challenges and less successful outcomes, we can consider changing our approach.

Outcomes: These are represented by rain falling from the clouds (evidence base) onto the mountains. Outcomes are the things that need to happen in order to bring about the changes we want to see and are the pre-conditions for lasting positive change (e.g. sensitized communities, service providers and policy-makers; improved communication between intimate partners and greater inter-generational dialogue; more public discourse on HIV and VAW, positive media coverage of SRHR issues; policy and institutional review and reform).

Strategic areas: These are represented by the mountains and correspond to the four areas in the *16 ideas wheel*: multi-sectoral empowerment programmes, HIV and VAW services, laws and policies, gender norms.

Results: These flow down the mountains, into rivers and meet in the estuary and represent the four quadrants of the change matrix. They are what we need to achieve in each community to reach our vision. The rivers connect the mountains back to the sea (our community), which is where we began.

The fish represent the practice and advocacy of community members and their supporters, who swim upstream to change and influence norms and practices on the ground. Their work helps grow and strengthen the existing evidence base.

The ALIV[H]E Windmills of Change are harnessing the values of this framework to the *16 ideas wheel* to drive positive change for women and girls.

Section D: Measuring change

This section includes **Steps 6** and **7** and **Actions H** and **I**. It aims to:

- present a change matrix linked to both the ALIV[H]E Framework and the ALIV[H]E Theory of Change
- present an indicator bank, corresponding to each of these areas of change
- provide guidance on different approaches and methods for M&E
- present a results chain to show how programmatic results contribute to national and global targets.

Remember!

If you feel that you do not have sufficient technical, human or financial resources, could you find other organizations to partner with? Could you refer to this framework to show a donor what you would like to do and the support you need to do it?

Do we have other ideas to move this forward?



Key messages

- Measuring activities and the impact of our work is important for many reasons: it ensures our work stays on track; that we include women in all their diversity; and can demonstrate how change happens.
- It is vital to link our work to what is important in our community and ensures that it is informed by evidence.
- Once we demonstrate results, we can then feed them into and influence other local, national or global initiatives, such as PEPFAR or the Global Fund, to ensure alignment and complementarity.

Measuring impact

Changes relating to HIV and VAW can be hard to measure, especially in the short- to medium-term. The long-term impacts we hope to see include a reduction in HIV and VAW, with outcomes that may include changes to laws, policies and resource allocations. These long-term outcomes are beyond the scope of many CBOs to measure. In addition, changes in the informal quadrants (quadrants 1 and 3, relating to personal and societal beliefs, norms and practices) have fewer global indicators, despite their huge influence on behaviour change.

This section explores the results we might expect to see from our work. It offers suggested indicators for how we could measure these results, including tools and approaches for gathering data. It also shows how our work fits into a results chain, so although we may not see any impact – in terms of reducing HIV or VAW – we can see how our results contribute towards national and global targets. The section also suggests indicators and approaches for developing an M&E framework and plan, tailored to your programme.

Aligning with national and global targets and indicators

There are a variety of international targets related to HIV and VAW responses. Progress towards these targets is measured using comparable indicators. For instance, UNAIDS has the Fast-Track treatment targets of 90-90-90 (90% of people with HIV know their status, 90% of those who know their HIV status are receiving treatment and 90% of those achieve viral suppression) by 2020. Further, the 10 Fast-Track commitments, drawn from the 2016 Political Declaration on HIV and AIDS, include commitment 4 to 'Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and

key populations by 2020'.²⁵ The 2016 WHO 'treat all' guidelines are designed to support the achievement of the 90-90-90 targets.¹⁰⁹

These global targets provide an opportunity for us to align our vision and programme results to these globally recognized goals. In so doing, we can start to articulate how our work contributes to these wider processes, even if at the individual level we may not be able to show direct change in relation to broad global targets. Wherever possible, we should use tried and tested indicators to measure progress towards these targets.¹¹⁰

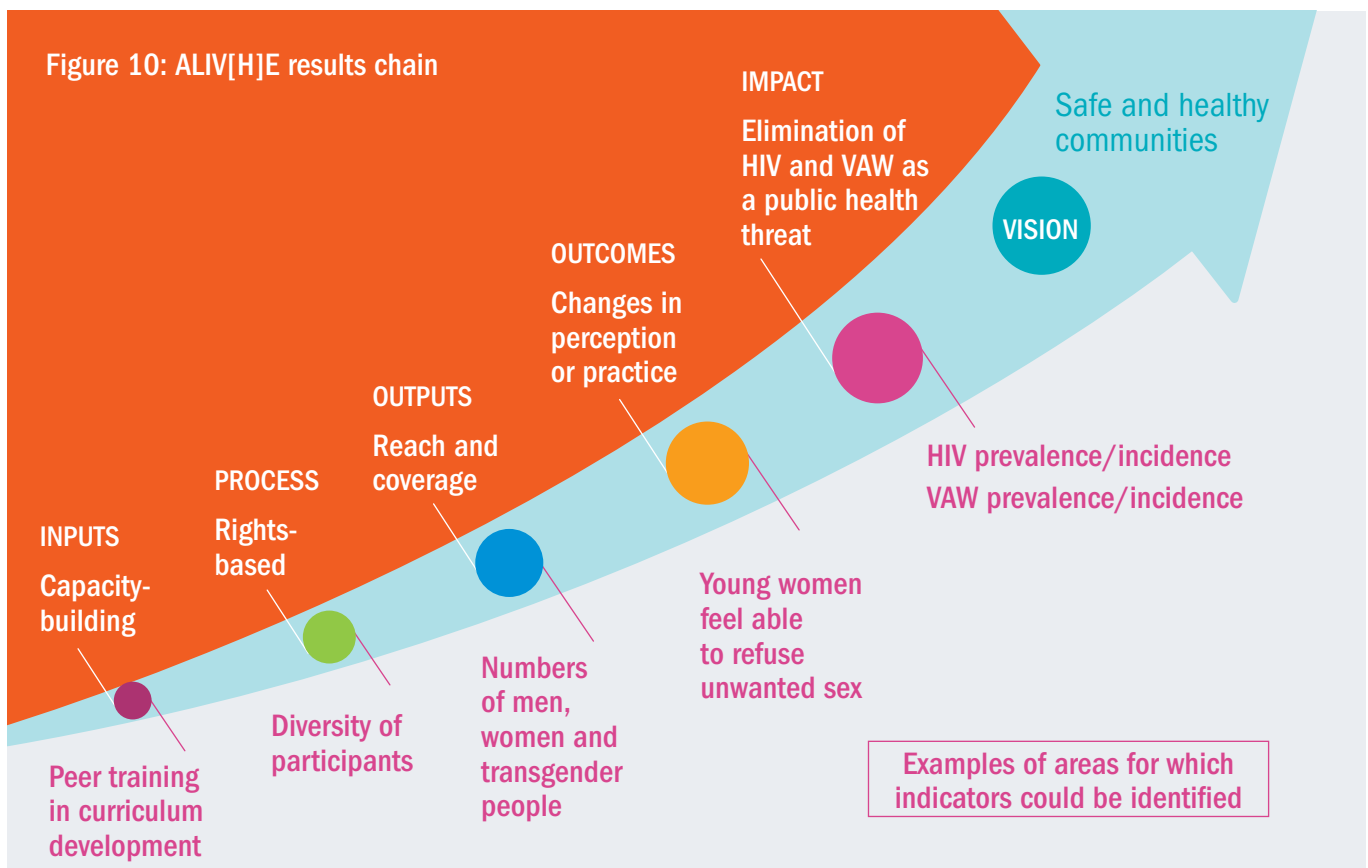
It is important to know and understand both global indicators and your country's national and sub-national targets and indicators. This is so you can use them:

- to hold your government to account for action (or inaction) in relation to the specific indicators that they have agreed to try and change. (See the note on page 50 if you have concerns about technical capacity)
- in your M&E framework (as part of the vision or big building blocks) to demonstrate to others, including funders and government, how your programmatic work has the potential to feed into wider change and contribute to national and sub-national targets, programmes and positive health outcomes.

More information on global and national indicators can be found in Annexes 5 and 6.

Using a results chain

To make connections between global and national indicators and our own work, it may be helpful to develop a results chain (see Figure 10). This connects with the ALIV[H]E Theory of Change and the change matrix. It helps you to demonstrate how your programmatic work contributes, over time, to the wider systemic change towards which we are all working.



Step 6

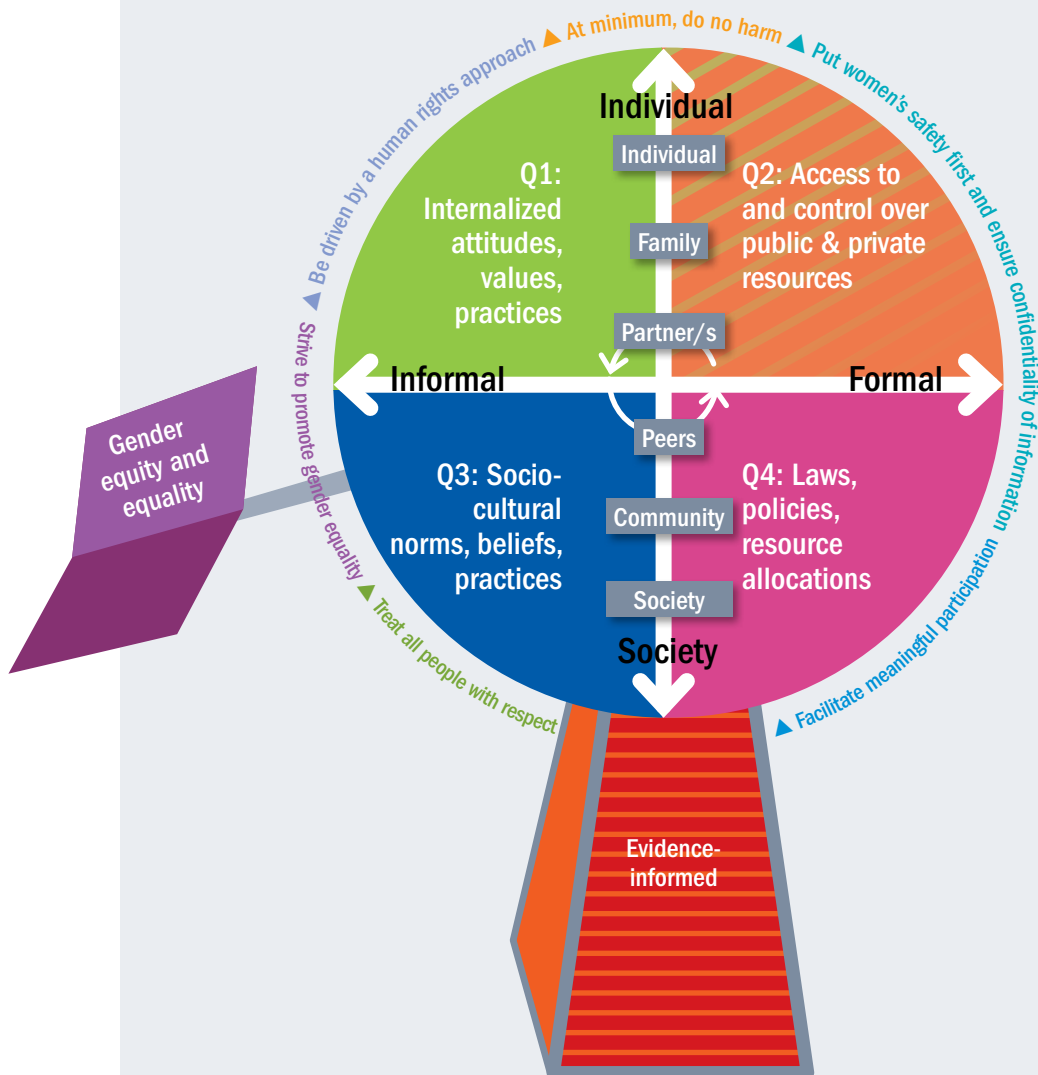
Step 6: Establishing an M&E framework

This step builds on the ALIV[H]E Theory of Change and the actions that you have taken so far. Developing a monitoring and evaluation (M&E) framework will help you to identify the changes you want to see happen through your work and then be able to measure them.

Results matrix

The results matrix, in Figure 11, links the four results in the 'estuary' of the ALI[V]E Theory of Change (pages 48-49) to the ALIV[H]E Windmill of Change (page 45). We have done this by combining the quadrants of the change matrix (page 22) with the four strategies from the 16 ideas wheel (page 10) and our ALIV[H]E Windmill of Change.



Figure 11: Results matrix





Remember, few, if any, programmes are likely to be working in all four quadrants, but as the sections are overlapping and mutually reinforcing, programmes working mainly in one quadrant may still influence (an)other(s).

Because the matrix is made up of two axes (between individual and societal on the vertical axis, and between informal and formal on the horizontal axis), there can be some overlap and/or ambiguity about where specific changes should sit. For example, household decision-making could be seen as an informal practice between couples or families, situated in the top left quadrant. On the other hand, it also has to do with how resources are allocated at the household level, so could be situated in the top right quadrant. This may depend on the nature of decision-making (e.g. whether to use a condom, send girls to school, spend money on healthcare or who does the housework). In addition, societal factors (laws and norms) will also have an impact on individual or household decision-making and ability to access resources. The circle of arrows in the middle of the matrix remind us that all four areas are interrelated.

The following table contains examples of the types of results we would expect to see in each of the quadrants (see Figure 11) of the results framework in your programme. The table contains one recommended result/outcome per quadrant as well as short- to medium-term and long-term outcomes and the corresponding global indicators (where they exist) to measure them.^{xiii} See Annexes 5 and 6 for more information on indicators.

	Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
<p>Q1: Internalized gender-equitable attitudes, values and practices</p> 	Violence against women and children (including disciplining in any form) becomes less acceptable.	<ul style="list-style-type: none"> ● Number of women and men who have participated in workshops to sensitize them to the negative consequences of violence. ● Positive media representations of women's rights and discussion of negative consequences of violence against women and children. 	Proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives. <i>Compendium of Gender Equality and HIV Indicators</i>
<p>Q2: Increased access to and control over public and private resources</p> 	Women have greater control over all household resources.	<ul style="list-style-type: none"> ● Proportion of women who report being able to make decisions about financial aspects of their lives. 	Percentage of women aged 15–49 who own property or resources for production of goods, services, and/or income in their own name. <i>Compendium of Gender Equality and HIV Indicators</i>
	Women who experience violence receive comprehensive post-violence care and support.	<ul style="list-style-type: none"> ● Proportion of clinics that provide post-violence care and services. 	Number of people receiving post GBV clinical care based on the minimum package. <i>PEPFAR Indicator</i>

xiii. These include the Compendium of Gender Equality and HIV Indicators, the Gender Equitable Men (GEM) Scale, Global AIDS Monitoring (GAM) and the People Living with HIV Stigma Index. See Annexes 4–7 for more information.

	Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
<p>Q3: Gender-equitable socio-cultural norms</p> 	Reduction in HIV- or sexuality-related stigma and discrimination.	<ul style="list-style-type: none"> ● Number of people participating in community-based events (e.g. World AIDS Day, International AIDS Candlelight Memorial, young people living with HIV beauty pageant, etc.) aimed at reducing HIV- and sexuality-related stigma and discrimination. ● Positive coverage of anti-stigma events in local and national media. ● Number of women living with HIV who report experiencing HIV-related stigma in SRHR services. 	Percentage of women and men, aged 15–49, who report discriminatory attitudes towards people living with HIV. <i>Global AIDS Monitoring (GAM)</i>
<p>Q4: Laws, policies and resource allocations that respect, protect and fulfil women's human rights</p> 	Reform of the legal framework that presents obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups.	<ul style="list-style-type: none"> ● Number of efforts by women's organizations to gather robust data and/or meaningfully consult on the barriers to accessing HIV prevention, treatment and care, and SRH information and services among key affected and vulnerable women. ● Number of positive engagements with policy-makers to present data or findings. 	Are there any legal protections for key populations? <i>National Commitments and Policies Instrument (NCPI) Part A Qs 72–76 (See also additional questions on the existence of criminalization laws in NCPI Part A Qs 65– 71.)</i>



Action H: Creating your own results and indicator matrix

Now it is time to develop your own results and indicator matrix. This action will support you to do that by asking:

- What quadrant(s) of the change matrix do you want to see change in?
- What specific result(s) do you want to achieve (e.g. reduction in harmful behaviour resulting from alcohol consumption)?
- What indicators are the CBO and/or the community already using to measure this area of change?
- Are there any national or global indicators that align with this?
- What additional indicator(s) can be used to measure these results?

You can use the table below as a template to help you.

Remember to consider the importance of diversity. For simplicity and to save space, the results and indicators presented in this framework do not include disaggregation to capture specific diversities, such as living with a disability, but may be adapted to include these where relevant and appropriate. (See also Box 6.)

It is also a good idea, when possible and relevant, to use indicators that have been tried and tested and respond to indicator quality standards.

The UNAIDS series, *Monitoring and evaluation fundamentals*, gives further guidance and useful recommendations and checklists on how to build a log frame, when to use indicators, how to select indicators and use disaggregation with existing indicators. We recommend *An introduction to indicators*¹¹¹ and *Basic terminology and frameworks for monitoring and evaluation*¹¹². Throughout this section, also refer to Annex 5 and Annex 7 for further guidance.

Sample results and indicator matrix

	What are the results you want to see in each quadrant? (You do not have to work in each quadrant)	What existing indicators are the CBO and/or community using to measure this area of change?	Are there any national or global indicators and/or approaches to monitoring that align with this?
Q1: Internalized <i>gender-equitable</i> attitudes, values and practices			
Q2: <i>Increased access</i> to and control over public and private resources			
Q3: <i>Gender-equitable</i> socio-cultural norms			
Q4: Laws, policies and resource allocations that <i>respect, protect and fulfil women's human rights</i>			

“Without any legal protection, transgender people suffer further violence in detention and therefore many opt not to report abuses. Transgender women often agree to provide sexual favours to get out of an arrest, as they do not want their family members to be notified or for the news to be featured in the media.”

KHARTINI SLAMAH AND THILAGA SOCKY PILLA, MALAYSIA⁶²



Box 6: Ensuring M&E captures diversity

In any M&E framework there is a need to disaggregate the data that it generates. This ensures that diversity is at the heart of M&E and that the responses to the initiative by women who are vulnerable to VAW and HIV are identified. Diversity, such as gender identity/expression, sexual orientation, age and disability, should be considered in any M&E framework. WHO and UNAIDS, *A practical tool for strengthening gender sensitive national HIV and SRH monitoring and evaluation systems*, recommends conducting a gap analysis to identify gender-sensitive indicators, and completing a gender-sensitive data analysis of the HIV epidemic and response.¹⁰⁸ This can also be used to identify gender-sensitive indicators and provide guidance on data analysis.

Disaggregation can be done with quantitative and qualitative data. For quantitative data, disaggregation works best with larger numbers of people. If the number of people sampled is too small, the data cannot be made generalizable. For qualitative data, it is possible to understand multiple diversities, as the data provided are rich and we are not looking to generalize. However, in both quantitative and qualitative data collection, protecting the confidentiality, anonymity and, above all, safety of respondents should come before data disaggregation.

This extract, from an essay in *Women living with HIV speak out against violence*, highlights the rich insights into the complexity of women’s lives that are gained from qualitative methods.⁶²

“What do you do when you have five kids, no job and no education? Their ages range from 14 to over 50. These women have been abandoned by their husbands: they are widowed, divorced, or were subjected to early or forced marriages at the age of 13 years or less. Some of the women have a master’s degree but could not find work because of stigma and loss of self-confidence. When they say you have HIV, you’re down.

Sex workers usually try to use condoms, but many customers do not want to use them; they offer to increase the price and beat you if you refuse. What do you do when you are HIV-positive? You go alone with a man, but when you arrive in his home, there are several other men who all want to have sex with you. If you refuse, they beat you up. Last week, a girl was thrown out of the third floor and she died. I was beaten because I refused to not use a condom, but I did not want to pass on HIV.” N.D.S., SENEGAL

Step 7

Step 7: Developing an M&E plan: approaches, data collection and activities

Results are what we hope our programmes will achieve and an indicator is an attempt to measure these results. There are multiple ways of assessing each result and specific indicator. Most indicators are quantitative (although a few are also qualitative and rely on qualitative methods of data collection). However, quantitative indicators can be supplemented by qualitative data collection, and approaches for both quantitative and qualitative can be distinguished by formal and participatory methodologies. Quantitative approaches give a numerical assessment of the indicator (e.g. percentage, total figure), while qualitative approaches focus on providing an understanding of experiences and barriers or enablers of change.^{xiv,27}

Broadly, there are four different approaches to measuring results:²⁶

- **Formal–quantitative:** This approach produces numbers (e.g. 37% of women have ever experienced violence from a partner) through externally designed approaches, such as questionnaires.
- **Participatory–quantitative:** This approach also produces numbers but ensures that participants' voices are incorporated into the assessment.
- **Formal–qualitative:** A qualitative approach creates information through discussion or interviews either with an individual or in groups. It helps us to understand the process of change in the context of people's lives.
- **Participatory–qualitative:** This includes techniques, such as mapping and drawing, to produce different forms of data. The process is guided more by the participants than by outside researchers.

While it is possible to use only one approach to measure an indicator, it is more likely that any project will want to use a mix. Each approach has its own strengths and weaknesses, and more detail and examples of operationalizing these approaches can be found in Annex 7. The annex also includes information on data collection tools and the M&E approaches that are typically used with them.

Approach	Examples of tools
Formal–quantitative	<ul style="list-style-type: none"> ● WHO Violence Against Women Scale ● Gender Equitable Men Scale
Participatory–quantitative	<ul style="list-style-type: none"> ● Community collection of data
Formal–qualitative	<ul style="list-style-type: none"> ● In-depth interview guides ● Focus group discussion guides
Participatory–qualitative	<ul style="list-style-type: none"> ● Community mapping

xiv. See also the Better Evaluation website for further information.



Action I: Creating our own M&E plan

In Action H you articulated the expected results after your programme's implementation and identified the indicators that will help show these results. Your M&E plan will determine which approaches, tools and activities will be used to gather data.

- What tools and approach(es) are most appropriate to the kind of data you want to gather? (See Annex 7 for more information on approaches and tools, and additional M&E planning resources.)
- How will you collect the data? What activities will you conduct and when?
- If you have concerns about technical skills, see the note at the start of Section D.

Remember to think about how you will record and analyze the data you collect and where you will keep them, especially if the data contain confidential information.

You can use the table below as a template.

Sample M&E plan

Indicators you are using	What tools and approach(es) will you use to gather data?	Do you have the capacity to do this? (skills, human and financial resources)	How will you implement this (what activities and when?)
<i>Indicators generated by young women living with HIV in the community</i>	<i>Participatory quantitative and qualitative data using participatory learning approaches (PLA)</i>	<i>Identify trainers and funds to run a training course to support young women in PLA</i>	<i>Run a training course then conduct participatory research</i>
<i>National level indicators</i>	<i>Formal quantitative and qualitative tools</i>	<i>Work with other NGOs to train staff and community workers</i>	<i>Conduct the research with trained staff and community workers</i>
<i>Global VAW</i>	<i>Formal quantitative survey</i>	<i>Hire external research organization</i>	<i>Contracted out</i>

The implementation of our M&E plan is only the start. Once we have gathered and analyzed our data for results, the important thing is to use these data to good effect. For example, the iterative process described in this framework – reviewing, informing, implementing and evaluating our work in the community – may produce new evidence that can be used as an advocacy tool to influence decision-makers.



Box 7: Asking about experiences of violence – sensitivity and safety for participants

Asking people about their experiences of violence (as victim or perpetrator) is entirely possible. Providing that people feel safe, are assured of confidentiality and are asked in clear and direct ways, the majority of people will answer truthfully. There may be issues around 'disclosure bias', whereby people answer questions in socially-appropriate ways.

These techniques help make people feel safer and more secure, and will improve reporting:

- If people are literate, ask them to complete the questionnaire on violence themselves, rather than the researcher filling it in for them.
- Always have a same-sex person interview the participant.
- Always conduct the interview in a private space.
- Only interview one person in the household about these issues.
- Ensure that the questionnaire or interview ends with positive questions: for example, what has the respondent done to improve life for herself and/or others in similar circumstances? What positive changes would they like to see in their community or in their services in response to the challenges faced?²⁵
- Ensure professional counselling, support or referrals are available for participants if the research process raises new or upsetting issues.

Throughout, refer to the WHO recommendations in *Ethical and safety recommendations for intervention research on violence against women*.¹¹³

Key results from Section D

By the end of this section, we will have completed Actions H and I and Steps 6 and 7 with the community where we work:

Action H: created your own change matrix.

Action I: created your own M&E plan.

Moving forward with the ALIV[H]E Framework

Once we have completed all the steps and actions, we should be in a position to start implementing new work around strengthening the integration of VAW and HIV. Throughout the process, adapt your work and reflect on whether the work is reaching those who are most vulnerable and starting to achieve the changes we hope to see – adaptation and change are important components of learning.

As we move forwards, it may become necessary to think about the role of partnerships. Not every organization can do everything. Building solid partnerships with those that have skills and expertise in different areas can fill gaps in your capacity and may ensure the sustainability of your response to VAW and HIV, and that of others.

Partnerships with community groups and wider networks of women most affected by these issues are especially important in this regard. Women living with HIV, in all their diversity, have made many recommendations about how violence against them could be mitigated, or even avoided in the first place. So, it makes sense to learn from their perspectives, based on lived experience.^{40,47}

In conclusion, VAW and HIV are preventable. We know what needs to be done, and we have an increasing number of tools that support this. As we all move forward, collectively, it is important that there remains sustained advocacy locally, nationally and internationally, to ensure that women's rights, VAW and HIV remain on the agenda in a continually shifting political landscape.

Annex 1: Global reference group, consortium members and partner organizations

Global reference group



Phelister Wambui Abdalla is the national coordinator of Kenya Sex Workers Alliance (KESWA). Phelister is a single mother of two, and an active sex worker, living with HIV for 11 years. She was trained as a peer educator on HIV prevention messages by the International Centre for Reproductive Health (ICRH). When KESWA was formed, Phelister became the regional coordinator in Mombasa. Her passion and vision moved her to Nairobi to rejuvenate the organization in 2012. KESWA now includes over 60 sex worker-led organizations and strong partnerships between government agencies and other development partners. Phelister works to achieve an enabling environment that allows sex workers access to health rights and improved protection of their human rights, social justice, and inclusive participation of sex workers in planning, decision-making and advocacy.



Elizabeth Akinyi Mokkonen is the executive director of Community Fight Against GBV and HIV/AIDS (COFAS). Elizabeth is a strong advocate for human rights, women and girls, health and policies that address gender-based violence. Elizabeth has been involved locally, regionally and internationally, working to advance gender equality and equity especially for women living with HIV.



Betty Babirye Kwagala was born and lives in Uganda. She is physically disabled and living positively with HIV, and is married with two children. She has worked within the disability movement in Uganda, pioneering the disability and HIV agenda in Uganda and beyond. She has worked with TASO since 2002, and is currently the treasurer for ICW Eastern Africa and sits on the board of the National Forum of People Living with HIV/AIDS of Uganda (NAFOPHANU). Betty established a National Network of Positive Women with Disabilities of Uganda in 2014.



Clara Banya is the national coordinator of ICW Malawi Chapter and works in finance with the Malawi Network of People Living with HIV (MANET+). Before joining MANET+, Clara was a GIPA volunteer with the UNDP Ambassador of Hope programme, giving a face and voice to HIV and working to reduce stigma and discrimination. Clara began working in HIV, gender and women's rights in 2004 when she learnt of her HIV-positive status. She has worked to build the capacity of community-based organizations and has become a powerful advocate for programmes and policies that promote human rights, especially the rights of women and girls to access services and be meaningfully involved in the HIV response.



Jennifer Gatsi-Mallet is the director and founding member of the Namibia Women's Health Network (NWHN) and the Namibia country officer for ICW. She has been living openly with HIV for 25 years and has worked on HIV and AIDS issues since 2003, fighting for the rights of HIV-positive women around the world. Since 2008, she has campaigned for the rights of HIV-positive women subject to forced sterilization. The campaign resulted in official court hearings and in 2012 the High Court of Namibia acknowledged that the three women in the case had effectively been subjected to coerced sterilization in violation of the laws of Namibia. In November 2013, the African Commission on Human and Peoples' Rights condemned the practice of coerced sterilization of marginalized women, including women living with HIV. She has contributed to research on sexual and reproductive health and women affected by HIV.



Feli Lalrintluanga is a young widow and discovered she was living with HIV six years ago. She immediately got involved in pioneering HIV grassroots work and top-level national advocacy. Born and living in Mizoram state in Northeast India, Feli was one of the first people to disclose her HIV status in her village where HIV awareness was poor. She started sensitizing churches, educational institutions and civil society to issues around HIV by providing information and education. She is a vocal advocate for HIV prevention and support for people living with HIV to seek treatment and lead fulfilling lives.



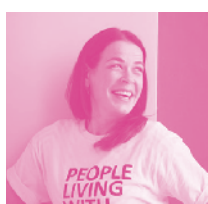
Steve Mmapaseka Letsike is an activist, feminist, leader, mentor and vibrant human rights advocate. She has high-level advocacy and policy experience and worked with a number of leading NGOs. She is the current South African National AIDS Council (SANAC) Co-Chairperson, a portfolio currently co-chairing with the H.E Cyril Ramaphosa Deputy President of the Republic of South Africa, she is also a leader and chairperson of SANAC Civil Society Forum. Steve is a founding director of Access Chapter 2 (AC2), a human rights organization with a focus on Women, LGBTI people and civil society's participation on public policy processes. AC2 is derived from South Africa's Constitution referring to the Bill of Rights: Chapter 2. Her passion for human rights includes her previous experience working with Anova Health Institute, Open Society Initiative for Southern Africa (OSISA), OUT LGBT Well-Being and Department of Social Development, her work includes working with global LGBTI, HIV, gender equality, democracy, leadership groups and she serves on many other boards, structures and networks including the Department of Justice National Task Team.



Inviolata Mmbwavi is the national coordinator of ICW Kenya. She was the first national coordinator of the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK). She has served on various local, national and international boards and steering committees, championing gender, HIV and human rights. Born and living in Kenya, she has been HIV-positive for 23 years.



Ayu Oktariani is on the board of the Indonesian Positive Women's Network and focal point for Youth LEAD and for women living with HIV in Indonesia. Ayu is based in Indonesia and works in HIV prevention for the Positive Women's Association. Her work involves providing comprehensive HIV information, and helping women develop skills to protect themselves and others from stigma, discrimination and violence, as well as to actively speak out about HIV.



Silvia Petretti is a woman living with HIV and advocate for the human rights of people living with HIV. Silvia co-founded PozFem in 2004, the UK network of women living with HIV. She has been working with Positively UK for 15 years and is now deputy chief executive officer. Silvia was chair of UK-CAB (Community Advisory Board), a national network of treatment advocates, and from 2009 to 2013 she was a community representative on the board of the British HIV Association. She is an experienced trainer and public speaker and one of the authors of the SHE toolkit. Silvia has represented at national and global foras and writes a blog about HIV and activism, Speaking Up!



Arushi Singh has worked on adolescent and young people's sexual and reproductive health and rights programming for over ten years across Asia, including with young key populations. She facilitates the adoption of sex-positive, pleasure-based approaches to SRH and HIV prevention, as well as youth leadership and youth-adult partnership



Martha Tholanah is a Zimbabwean feminist, mother and grandmother, openly living with HIV. She is a trained family therapy counsellor with over ten years' experience, plus over 20 years' experience as a medical rehabilitation practitioner. She has also developed and run health programmes in Zimbabwe for people with disabilities, LGBTI communities and with people living with HIV, with a particular focus on children, girls and women. She has a passion for community organizing and grassroots mobilization for transformation for social justice and access to basic services.



Leigh Ann van der Merwe is a coloured transgender woman born and raised in Ugie in the Eastern Cape Province of South Africa. Growing up knowing that she did not quite fit into the gender assigned to her at birth, she struggled to find her place in a very traditional and patriarchal society. Leigh Ann's own experiences of violence and discrimination prompted her to establish Social, Health and Empowerment, a feminist collective of transgender women working in southern and eastern Africa. Leigh Ann has spoken on local, regional and international platforms to address the issues affecting transgender women. She considers herself a queer 'intersectional' feminist, whose analysis is seeking to understand how factors such as race, class and the economy influences one's identity. She holds a certificate in community journalism from UNISA, is finalizing a BA in Communication Science and has published a paper on trans feminism in the *New Voices of Psychology*.

AIDS Legal Network



Johanna Kehler is a researcher and rights advocate and has worked on issues of human rights, gender and HIV for over 20 years, and since 2004 is the director of AIDS Legal Network (ALN), based in Cape Town, South Africa. Johanna has a strong background in policy analysis and rights advocacy, and has worked on various projects from highlighting gendered barriers to accessing rights and available resources; developed resource and training manuals on human rights and HIV; conducted research on stigma, gender violence and HIV; and written extensively on issues of human rights, gender, gender violence and HIV, exploring especially women's realities, risks in the context of, and the response to HIV.

Athena Network



E. Tyler Crone, MPH, JD, is a human rights lawyer by training. Tyler co-founded and directs the ATHENA Network to advance gender equality and human rights through the HIV response. Tyler has been working at the intersection of gender, human rights, HIV and sexual and reproductive health and rights (SRHR) since supporting the US State Department preparations for the 1994 International Conference on Population and Development. Tyler's most recent work focuses on advancing the integration of SRHR and HIV through a five-country project across Africa and Asia; championing the engagement of young women, in all their diversity, in shaping the post-2015 development framework; and strengthening the HIV policy framework for women, girls and gender equality in southern and eastern Africa with UN agencies, a broad range of civil society stakeholders, and academic partners with specific attention to addressing gender-based violence.



Luisa Orza has worked, for the past decade, on issues of gender and HIV. Her work has a strong focus on the SRHR of women living with HIV; building the leadership and participation of women living with HIV; and participatory, community-led monitoring and evaluation. Luisa is currently programmes director for ATHENA Network and a Salamander Trust Associate, and a trustee of STOPAIDS. She has an MA in Gender and Development from the Institute of International Development at University of Sussex (2002).

HEARD



Andrew Gibbs is a researcher with the Gender Equality and Health Programme, where the main focus of his research is around masculinities, GBV and young people's SRH. His interests include understanding how interventions work, particularly structural and economic, and how contextual factors shape intervention outcomes. He has done extensive research on understanding gender equality within policies and policy processes. He has written over 20 articles on these topics in a range of leading journals, including *PLoS Medicine*, *AIDS and Behavior* and *Social Science and Medicine*. Andrew has been involved in leading the Stepping Stones and Creating Futures intervention amongst young women and men in urban informal settlements to reduce violence and HIV risk through building gender

equality and strengthening livelihoods. He also wrote the widely cited article 'Combined structural interventions for gender equality and livelihood security' and published widely on the impact of the Stepping Stones and Creating Futures intervention on men's lives and masculinities, which forms the basis of his PhD thesis. He has an MSc in Health, Community and Development from the London School of Economics (2006).



Dr Jill Hanass-Hancock currently leads the Disability, Health and Livelihoods Programme at HEARD. Her work experience ranges from the practical side of education and educational psychology to research and policy development. She has developed expertise in the field of sexuality education, issues of vulnerable children and orphans, mainstreaming and inclusion of children with special needs, gender relations, abuse and sexual harassment as well as the socio-cultural aspects of HIV and AIDS. Over the last six years she has developed the HEARD research agenda on disability and HIV. Currently she is working on interventions addressing the SRHR of people with disabilities. The most prominent project of this research arm is the Breaking the Silence Project, Africa's first sexuality education programme that provides sexuality education in accessible formats to learners with different types of disabilities. She is also working on the disabling effect of HIV, its co-morbidities and treatment.



Samantha Willan has 15 years experience working on gender equality, sexuality and HIV, from a women's rights perspective including: global research, policy influencing, training and intervention development and implementation. Samantha has extensive experience in engaging with global and national stakeholders around gender equality and providing technical support and policy engagement across eastern and southern Africa and globally. Until very recently, Samantha was the programme lead for the Gender Equality and Health Programme at HEARD. Samantha is a board member of the Regional SRHR Program Fund Advisory Committee, the South African National Teenage Pregnancy Partnership, the Advisory Committee for Cervical Cancer and Women Living with HIV and an Associate Member of the ATHENA Network. She has an MSc in Political Science from the University of Natal (1998).

Project Empower



Nolwazi Ntini was born and raised in Lamontville, Durban, and works as an intern at Project Empower – a South African NGO working with women on issues related to HIV and violence against women. Project Empower's mission is to empower women to confront unequal power relations, as well as to balance relations that exist between men and women. They also work towards building positive relationships that will enable people to make their own choices about their lives, and live with the choices they have made. Nolwazi is studying at the University of KwaZulu-Natal for an MA in Development Studies.



Laura Washington is the director of Project Empower. Prior to this she worked for over a decade on projects for NGOs and international development agencies, addressing HIV and the human rights of young women, developing women's leadership in addressing domestic and other forms of GBV. Laura has extensive experience in both urban and rural informal settings and this experience gives her a solid understanding of the issues and challenges in addressing HIV and human rights in diverse country contexts and how HIV links with other development issues. Laura is currently studying for an MSc in Development Studies.

Salamander Trust



Sophie Dilmitis has worked for almost 20 years in pioneering grassroots work and top-level policy development focusing on women and young people in developing and developed countries. Born and living in Zimbabwe, Sophie has been HIV-positive for 20 years. She is a vocal advocate for policies and programmes that work for all women, human rights and programmes that integrate SRHR and HIV.



Alice Welbourn, PhD, is the founding director of Salamander Trust. After gaining a PhD from the Faculty of Archaeology and Anthropology at Cambridge University, based on 18 months of participatory, observation-based research in an isolated rural Kenyan community, Alice has worked internationally on gender and health for 30 years. This work has included consultancy work as a trainer in participatory learning approaches, including monitoring and evaluation, for several leading UK universities, international NGOs and DFID. Alice lived and worked in Africa for most of the 1980s. Diagnosed with HIV in 1992, she developed Stepping Stones, a participatory training package on gender, HIV, communication and relationship skills, now used worldwide. A former chair of ICW, Alice also served on the Global Coalition on Women and AIDS Leadership Council and on the UNAIDS Global Dialogue Platform of Women living with HIV.

Participating partners

Country	NGO/CBO	Contact	Research institute	Contact	UNAIDS Country Office contact
India	Positive Women's Network (PWN+)	Kousalya Periasamy	International Center for Research on Women (ICRW)	Priti Prabhugate	Anandi Yuvaraj
Kenya	Better Poverty Eradication Organisation	Mary Ndung'u, James Kariuki, Sarah Wambui, Richard Kariuki, Kennedy Ngugi	LVCT Health	Wanjiru Mukoma, Carol Ajema	Ruth Laibon
Malawi	Coalition of Women living with HIV/AIDS in Malawi (COWLHA)	Edna Tembo, Annie Banda, Stephen Iphani	Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS)	Edward Chikhwana	Isaac Offei Ahemesah
South Africa	Sex Workers Education and Advocacy Taskforce (SWEAT)	Sally Shackleton	AIDS Legal Network (ALN)	Johanna Kehler	Tabita Ntuli
South Sudan	Health Link South Sudan	Eunice Anek	Health Link South Sudan	Eunice Anek	Betty Gwodi
Zimbabwe	Musasa	Netty Musanhu, Precious Taru	Women and Law in Southern Africa (WLSA)	Slyvia Chirawu	Tamara Jonsson
	Her Zimbabwe	Daphne Jena			

UNAIDS Secretariat: Hege Wagan, Aurelie Andriamialison, Victoria Bendaud, Christoforos Mallouris, Henriette van Gulik, Yuki Takemoto, Sophia Mukasa.

Annex 2: 16 ideas programming tool

The programming tool, *16 Ideas for addressing violence against women in the context of the HIV epidemic*, identifies four strategic areas and 16 programmatic approaches:⁵

1. Empowering women and girls through integrated, multi-sectoral approaches

- Integrated economic and gender empowerment strategies
- Cash transfers – conditional and unconditional
- Increasing women’s ownership of property and assets, and securing their inheritance rights
- Integrated sex worker-led community empowerment

2. Transforming cultural and social norms related to gender

- Working with men and boys to promote gender-equitable attitudes and behaviour
- Changing unequal and harmful norms through community mobilization
- Social norms marketing, edutainment or behavioural change communication campaigns
- School-based interventions

3. Integrating violence against women and HIV services

- Addressing violence in HIV risk reduction counselling
- Addressing violence in HIV testing and counselling, prevention of mother-to-child transmission, treatment and care services
- Providing comprehensive post-rape care including HIV post-exposure prophylaxis (PEP)
- Addressing HIV in services for survivors of violence

4. Promoting and implementing laws and policies related to VAW, gender equality and HIV

- Promoting laws to address VAW and gender inequality
- Improving women’s access to justice
- Developing and implementing national plans and policies to address VAW including in HIV responses
- Addressing the intersections of VAW, harmful alcohol use and HIV risk

See Figure 2 on page 10 for an outline of the strategic areas and programming ideas, and see page 19 for a summary of the four pathways linking VAW and HIV.

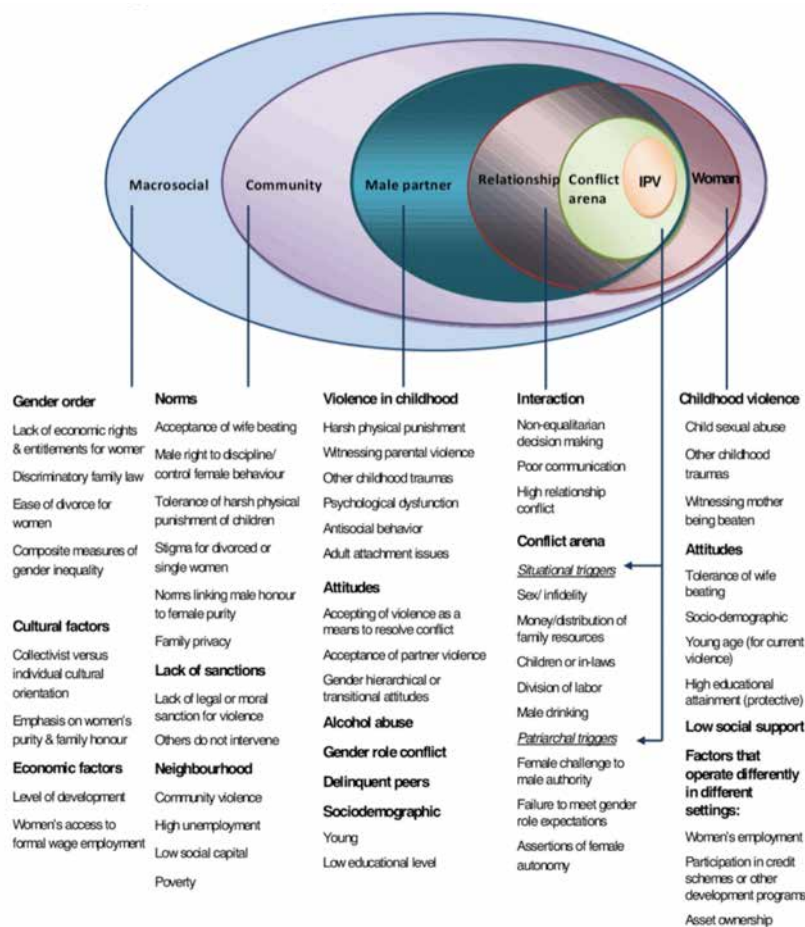
Annex 3: Alternative representations of effective implementation processes

Other useful frameworks regarding VAW and HIV have been developed. The key framework is the social-ecological model, which uses overlapping circles to describe the different spheres of influence in an individual's life. The diagrammatic work by Lori Michau *et al* is also very useful for identifying the complexity of factors, relating to VAW, on the axis between individual and wider society. However, these frameworks are less useful for understanding the axis between informal and formal areas of influence. This is why we have opted to work with the Gender at Work change matrix, which portrays not only the individual–societal axis but also the informal–formal axis of attitudes, beliefs and practices.

The ecological model

The ecological framework in Figure 12 was developed and revised by Lori Heise, drawing on earlier studies, thinking and renditions of the ecological model.^{xv,114} Some organizations use this model as their theory of change.

Figure 12: Revised conceptual framework for partner violence



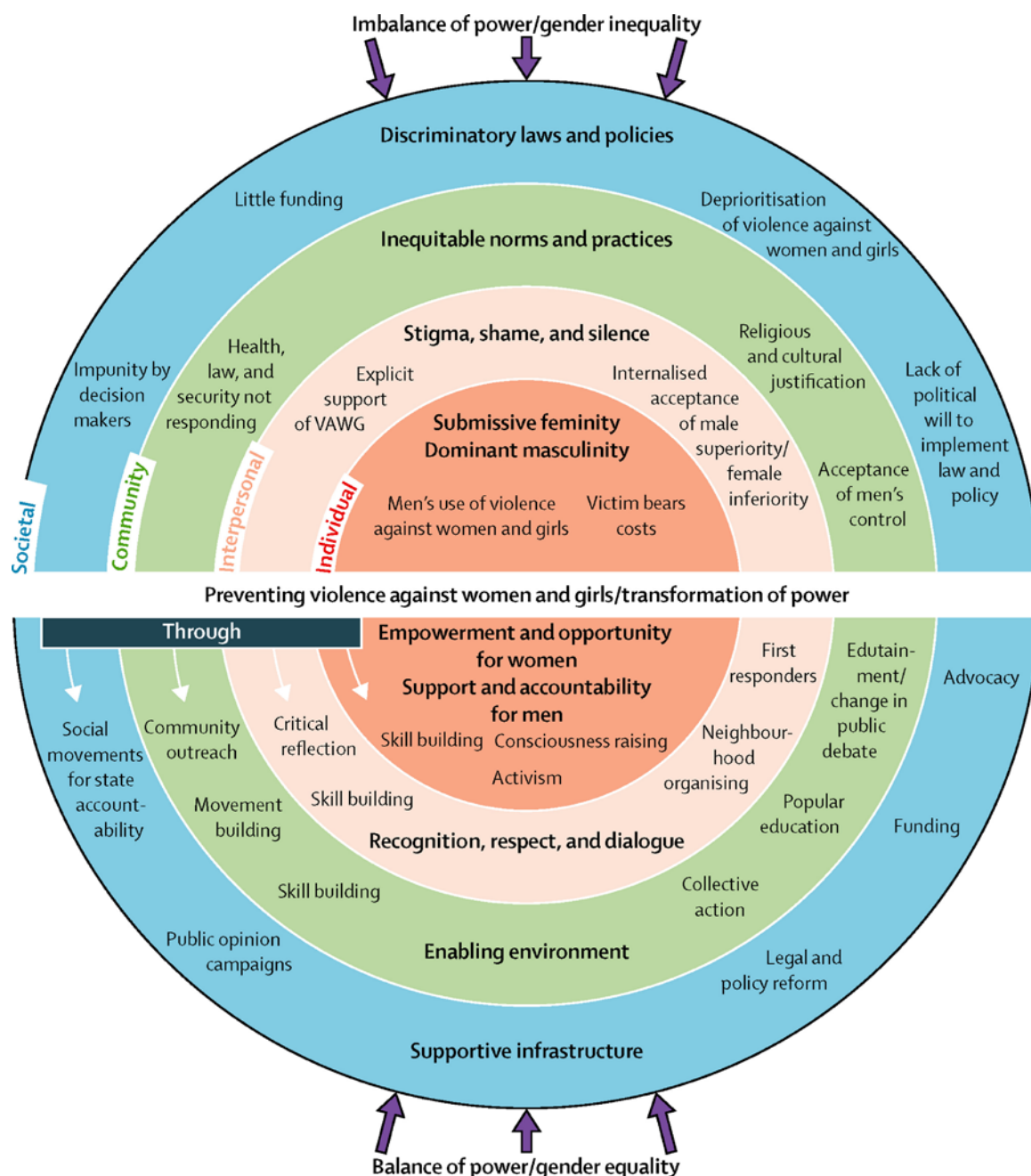
Source: Heise, L. (2011) *What works to prevent partner violence: an evidence overview*. STRIVE Research Consortium

xv. For more information see: www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html

Transformation of power across the ecological model

Michau and colleagues built on Heise's ecological model to show how women's power can be transformed. It can be useful to compare your programme to this model to check whether your programme has the potential to transform gender power relations.⁸

Figure 13: Transformation of power across the ecological model

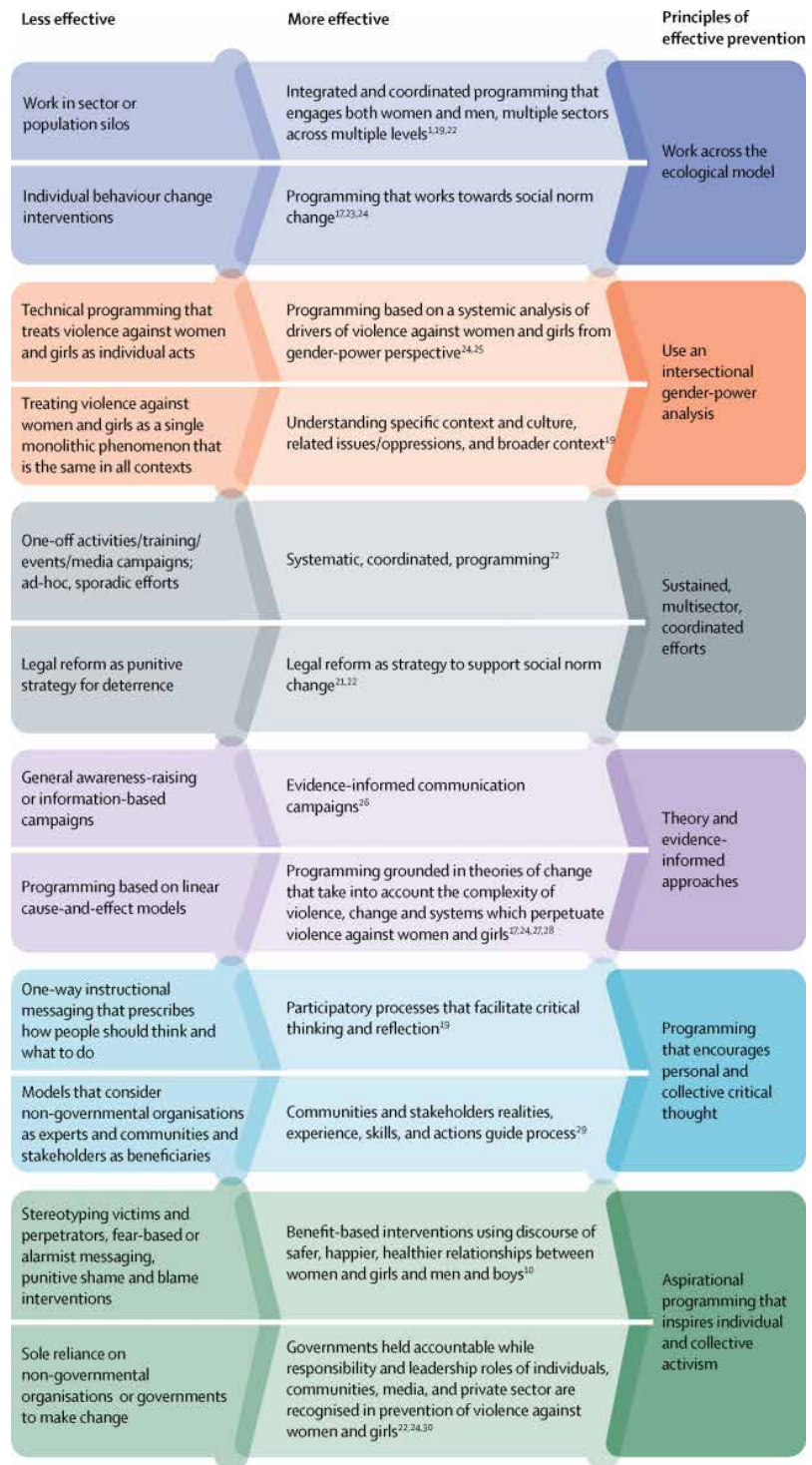


Source: Michau, L. et al (2015) 'Prevention of violence against women and girls: lessons from practice'. *The Lancet*.

Figure 14 identifies, more or less, the effective programming principles in response to VAW and HIV linkages. This is a useful checklist tool to ensure that the characteristics of your programme all fall in the centre column.

Source: Michau, L. et al (2015) 'Prevention of violence against women and girls: lessons from practice'. *The Lancet*.

Figure 14: Principles for effective programming



Additional diagrammatic representations for understanding the direct and indirect pathways between VAW and HIV, including the experience of violence in conflict or humanitarian settings, are considered in STRIVE's *Greentree Report II*.⁵⁴ The report examines global evidence on the prevalence of VAW and its association with HIV to hypothesize a more nuanced understanding of the risk factors contributing to the direct and indirect pathways between VAW and HIV. These pathways include genital injury (direct), alcohol consumption, childhood trauma and a cluster of risk factors associated with violent men. It goes on to consider approaches to address VAW and HIV intersections in different contexts and populations, and to priorities in research and action.

Annex 4: Key resources for understanding your context

There are many ways of gaining an understanding of the relationship between VAW and HIV within specific groups of women and adolescent girls in your communities. They take time and resources but can help expand the understanding of who are the most vulnerable and why.

The below resources and tools can be used to gain an understanding of the context in which you work, in regards to the HIV and VAW intersect.

Some of these resources, such as Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) or the National Commitments and Policies Instrument (NCPI), are accountability tools that the civil society sector working on women's rights can (and should) engage with to hold governments to account to address VAW and HIV. These tend to be broad level tools that provide an overview of a country or a region and the specific issues relating to VAW and/or HIV through statistical analysis or within policy. Others are a mixture of tools and methods that can be used by civil society to gather data and knowledge, especially at the local level. These can also be used for both analysis and advocacy, but are not accountability tools.

Population-based surveys

Population-based surveys have sought to assess HIV and VAW in the general population. These surveys enable us to look at an issue countrywide. Examples include the Demographic and Health Survey (DHS), which many countries undertake on a regular basis. A full list of countries, latest reports and specific analyses of HIV and VAW from these data are available at: <http://dhsprogram.com> and data from the DHS can also be accessed through the DHS Program STAT Compiler: www.statcompiler.com

Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)

If your government has ratified CEDAW, it is obliged to report to the committee every four years on its progress towards fulfilling the obligations of CEDAW. In addition, many civil societies undertake a shadow CEDAW report that is not necessarily sanctioned by their government. The Office of the United Nations High Commissioner for Human Rights (OHCHR) provides useful information on governments' responses to violence and HIV: www.ohchr.org/en/hrbodies/cedaw/pages/cedawindex.aspx

The Unzip the Lips tool, *Unzipping CEDAW: A guide to the rights of key affected women and girls*, provides guidance for community engagement with, by and for women and girls living with HIV and from key populations, to understand and advocate for CEDAW with regard to its implementation and monitoring within these communities. Available at: www.aidsdatahub.org/sites/default/files/publication/Unzipping-CEDAW.pdf

National Commitments and Policies Instrument (NCPI)

Every two years, UNAIDS collates and publishes country responses to the NCPI. These provide an overview of policies and laws related to the HIV epidemic. The NCPI consists of two parts; a survey that governments report on, and a corresponding set of questions for civil society and other non-governmental partners to report against. The NCPI forms part of the Global AIDS Monitoring (GAM) reporting (see Annex 5).^{xvi} www.unaids.org/en/dataanalysis/knowyourresponse/ncpi/2014countries

xvi. Note: GAM reporting is every year, whereas NCPI is included in the GAM report only every two years.

Gender Assessment Tool

UNAIDS has developed the Gender Assessment Tool (GAT) and implemented gender assessments in more than 40 countries. The tool enables countries to review the HIV epidemic context and response from a gender perspective and analyze how to strengthen the response. GBV is addressed as part of Step 11.4 in the GAT. Contact your country UNAIDS office to see if an assessment has been done. The tool is available at: www.unaids.org/en/resources/documents/2014/20140505_JC2543_gender-assessment

Together for Girls

The Together for Girls (TfG) partnership has developed data collection tools and data sets for sharing data on the prevalence of violence against children and its long-term impacts, using Violence Against Children Surveys (VACS) among others. For more information on VACS, visit: www.cdc.gov/violenceprevention/vacs/

Large-scale research has been undertaken in Cambodia, Haiti, Kenya, Malawi, Swaziland, Tanzania and Zimbabwe. TfG provides technical support to countries wishing to undertake a survey and launch a comprehensive response. The TfG knowledge centre includes technical guidance and frameworks for action, as well as external resources for advocacy and programming across a range of areas, including health, ending child marriage, sexual violence, and adolescent girls. www.togetherforgirls.org/knowledge-center/

People Living with HIV Stigma Index

The People Living with HIV Stigma Index provides a tool that measures and detects changing trends in relation to stigma and discrimination experienced by people living with HIV. In the initiative, the process is just as important as the product. It aims to address stigma relating to HIV while also advocating on the key barriers and issues perpetuating stigma – a key obstacle to HIV treatment, prevention, care and support. Since the project started in 2008, more than 70 countries have completed the study. More than 1,500 people living with HIV have been trained as interviewers and 85,000 people living with HIV have been interviewed. The Stigma Index questionnaire has been translated into 54 languages: www.stigmaindex.org

International Men and Gender Equality Survey

The International Men and Gender Equality Survey (IMAGES) is a questionnaire that collects data on men's attitudes, including on gender equality and VAW. It has been run in six countries and used as a basis for further surveys globally. It includes a range of indicators: <http://promundoglobal.org/programs/international-men-and-gender-equality-survey-images/>

Asia Data Hub

The HIV and AIDS Data Hub for Asia Pacific is a useful platform through which additional resources, such as survey reports and other data collection methods described above, can be found. Resources include data that could be useful in understanding HIV and GBV linkages as they relate to specific sub-populations of women in the Asia-Pacific region, including various data slide sets for public use: www.aidsdatahub.org/Thematic-areas

kNOwVAWdata

kNOwVAWdata is a United Nations Population Fund (UNFPA) initiative to support and strengthen sustainable regional and national capacity to measure VAW. From 2016 to 2019, the kNOwVAWdata initiative will conduct VAW surveys and analysis in the Asia-Pacific region. The initiative will also ensure sustainability, including by strengthening capacities of national institutions to collect and analyze data, in particular by using internationally recognized, best practice survey methodologies. <http://asiapacific.unfpa.org/publications/knowvawdata-project-overview>

Annex 5: Key global indicators

These resources provide lists and definitions for existing indicators, which may be relevant for the M&E of VAW and HIV programmes.

Global AIDS Monitoring

Guidance for Global AIDS Monitoring (GAM) (previously known as Global AIDS Response Progress Reporting) provides a list and definitions of key indicators for monitoring progress towards the commitments in the 2016 Political Declaration on HIV and AIDS. GAM provides clear indicators for countries to report on annually. It is recommended that national governments integrate these indicators within their national HIV monitoring systems.

GAM includes the National Commitments and Policy Instrument (NCPI), which collects data on national laws and policies related to the HIV response every two years.

Data reported by countries through GAM are available at: <http://aidsinfo.unaids.org/>

Global AIDS Monitoring 2017: Indicators for monitoring the 2016 United Nations Political Declaration on HIV and AIDS is available at: www.unaids.org/sites/default/files/media_asset/2017-Global-AIDS-Monitoring_en.pdf

Compendium of Gender Equality and HIV Indicators

This is a list of global indicators from different sources, put together by MEASURE Evaluation and UN Women following a multi-stakeholder collaborative process. The selection of indicators are those which collectively recognize the role of gender inequality as a driver of HIV and measure changes in gender-related aspects of the response (i.e. they are gender-sensitive indicators). The compendium is organized around five areas, including the underlying determinants of HIV – such as legal and policy frameworks and gender norms – programmatic interventions and populations requiring special attention. Indicators related to VAW include:

- Percentage of eligible rape survivors who report to health facilities within 72 hours and received appropriate medical care.
- Number of HIV service providers trained to identify, refer and care for VAW survivors.
- Proportion of law enforcement units following a nationally established protocol for VAW.
- Proportion of people who know any of the legal rights of women.

Compendium of Gender Equality and HIV Indicators is available at: www.measureevaluation.org/resources/publications/ms-13-82

PEPFAR global indicators

The United States President's Emergency Plan for AIDS Relief (PEPFAR) provides global guidance to shape its programmes. It has indicators that span from site level to national level targets. There is specific guidance on indicators, updated annually, and also guidance on an integrated gender strategy. In addition, PEPFAR also released specific indicator guidance for DREAMS, for example:

- Number of people completing an intervention pertaining to gender norms that meets minimum criteria.
- Number of people receiving post-GBV care.

All indicators and detailed explanations are available at: www.pepfar.gov/documents/organization/263233.pdf

World Health Organization Core Health Indicators

WHO has released 100 indicators prioritized by the global community around health. These include the standardized measure of recent IPV. The *Global Reference List of 100 Core Health Indicators* is available at: www.who.int/healthinfo/indicators/2015/en/

Global Fund Core Indicators

The Global Fund's *Modular Framework Handbook* includes lists of indicators to monitor progress in HIV, tuberculosis and malaria programmes and at a national level. These include indicators for outcome and coverage. Coverage includes indicators, such as percentage of other vulnerable populations reached with HIV prevention programmes defined package of services. Indicator guidance is available at: www.theglobalfund.org/media/4309/fundingmodel_modularframework_handbook_en.pdf

Demographic and Health Surveys

Demographic and Health Surveys (DHS) are undertaken by many countries and provide data on a series of indicators that include women's empowerment, access to resources and VAW. Indicator guidance is available at: <http://dhsprogram.com/>

SRHR and HIV Linkages Compendium

The *SRH and HIV Linkages Compendium*, developed by the Inter-Agency Working Group on SRH and HIV Linkages, contains a focused set of indicators and related assessment tools that have relevance to tracking the links between SRH and HIV programmes at national and sub-national levels. Each indicator includes an overview, brief description of its relevance to SRH and HIV linkages, and a hyperlink to a detailed definition. All the indicators in this compendium have passed through a rigorous evaluation, based on the indicator standards of the UNAIDS Monitoring and Evaluation Reference Group. The compendium is available at: http://srhhivlinkages.org/wp-content/uploads/SRH-HIV-Linkages-Compendium_rev.pdf

Database of SRHR indicators

Another source of SRHR indicators is the Asian-Pacific Resource and Research Center for Women (ARROW) database on SRHR indicators. ARROW have also produced the *Advocate's Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights*, which includes indicators on (among others): adolescent birth rate; availability and range of adolescent sexual and reproductive health services; and availability of sexual and reproductive health services at different levels of care. Available at: http://arrow.org.my/wp-content/uploads/2015/04/Advocates-Guide_SRHR-Indicators_2013.pdf

The database can be accessed at: www.srhdatabase.org

Annex 6: Results matrix and illustrative indicators

The table below provides illustrative indicators relating to the theory of change/results framework. It gives examples of indicators that link desired results to global indicators on HIV and VAW prevention, where available. Where these are drawn from existing sources, they are mentioned in the table. Further information on these and additional sources for global indicators are listed in Annex 5. You can select and adapt results and indicators from the relevant quadrants to develop your own indicator frameworks (see Part 3, Step 6, page 55).

Choosing your indicators: asking the right question

For each outcome in your theory of change, ask yourself, what needs to happen for this outcome to be realized? This will help you to define your activities and key indicators.

For each step, try to identify a **maximum** of two indicators. (Bear in mind that some indicators may involve asking multiple questions to answer them accurately.) Think about whether the indicator is likely to show change over the timeframe of the project. For example, the number of people who have 'ever' experienced violence will not change in the course of six months, but the number of people who experienced violence 'in the last three months' could show change.

Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
Q1: Internalized <i>gender-equitable</i> attitudes, values and practices		
More women and men have a better understanding of what constitutes violence against women and girls and are able to identify and name experiences of violence in all its forms.	<ul style="list-style-type: none"> ● Number of women and men participating in workshops, dialogues, and other events, that discuss the theme of VAW and gender equality (from a women's rights perspective). ● Number of women and men able to name different types of violence (e.g. sexual, physical, emotional, financial, institutional) and identify violence in a range of case scenarios. 	
Violence against women and children becoming less acceptable.	<ul style="list-style-type: none"> ● Number of women and men expressing attitudes that are respectful of women's and children's rights. ● Positive media representations of women's rights and discussion of negative consequences of violence against women and children. 	<ul style="list-style-type: none"> ● Percentage of women and men who say that wife beating is an acceptable way for husbands to discipline their wives. <i>Compendium of Gender Equality and HIV Indicators 1.4.1</i>
More women and men feel able to ask their partner to use a condom, and are comfortable to use one.	<ul style="list-style-type: none"> ● Women report being able to negotiate condom use with their male sexual partners. 	<ul style="list-style-type: none"> ● Percentage of people who report condom use at last sex with a non-regular partner. <i>Global AIDS Monitoring (GAM)</i>

Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
Q1: Internalized <i>gender-equitable</i> attitudes, values and practices		
<p>More women are aware of their human rights and how the law works to protect them, including what they should do in the event of a rights violation.</p>	<ul style="list-style-type: none"> ● Number of adults and children reached by an individual, small group or community level intervention or service that explicitly addresses the legal rights and protections of women and girls impacted by HIV. <i>Compendium of Gender Equality and HIV Indicators 1.4.7</i> ● Number of individuals reached by the programme become empowered to claim their rights (e.g. reporting GBV cases, requesting services for the first time). <i>AmplifyChange indicator</i> 	<ul style="list-style-type: none"> ● Percentage of people who know any of the legal rights of women. <i>Compendium of Gender Equality and HIV Indicators 1.4.6</i>
<p>Couples and/or parents and children are better at communicating with each other in a respectful way and can talk about things to do with sex and sexuality.</p>	<ul style="list-style-type: none"> ● Women report having more skills in assertive communication. ● Women and men report being able to discuss a wider range of issues with their partner and children than previously, including talking about sex and sexuality. 	
<p>Men and women share household tasks and childcare more equally.</p>	<ul style="list-style-type: none"> ● Women report spending less time on household tasks. ● Women report that men are more willing to take on domestic tasks and childcare than before. 	<i>Gender Equitable Men (GEM) Scale</i>
<p>Women and men make more joint decisions about how household resources should be spent.</p>	<ul style="list-style-type: none"> ● Proportion of women who know how much their partner earns. ● Proportion of women who report being able to make decisions about financial aspects of their lives. 	<i>GEM Scale – component on decision-making in households</i>
<p>Girls, young women and women have greater ability to make and enact decisions in all areas of their lives (e.g. health, livelihoods, marriage and childbearing).</p>	<ul style="list-style-type: none"> ● Women report being able to envisage a positive change in their lives. ● Proportion of women who report being able to make decisions about financial aspects of their lives. 	

Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
Q2: Access to and control over public and private resources		
Women have greater control over all household resources.	<ul style="list-style-type: none"> ● Proportion of women who report being able to make decisions about financial aspects of their lives. 	<ul style="list-style-type: none"> ● Percentage of women aged 15–49 who own property or resources for production of goods, services, and/or income in their own name. <i>Compendium of Gender Equality and HIV Indicators 1.5.1</i>
More women have access to and make use of services (could apply to health, education, financial services including credit, and social justice mechanisms, including complaints procedures).	<ul style="list-style-type: none"> ● Number of women reporting use in the last three months of SRHR services, information and products. ● Proportion of clients who felt comfortable discussing their sexual practices with providers at facilities. <i>Gender and HIV Compendium</i> ● Women have access to credit systems. 	
SRHR is seen as relevant to men and not just something for women.	<ul style="list-style-type: none"> ● Number of visits made by young men to specialized SRH services. <i>Compendium of Gender Equality and HIV Indicators 2.4.1</i> 	<ul style="list-style-type: none"> ● Availability of accessible, relevant, and accurate information about SRH, which is tailored to young men. <i>Compendium of Gender Equality and HIV Indicators 2.4.3</i>
Male and female condoms are easier to get hold of and more people use them.	<ul style="list-style-type: none"> ● Knowledge of a formal source of condoms among young people. <i>Compendium of Gender Equality and HIV Indicators 4.2.2</i> 	<ul style="list-style-type: none"> ● Adolescent fertility rates. <i>Compendium of Gender Equality and HIV Indicators 5.2.1</i> ● Young people who have an STI. <i>Compendium of Gender Equality and HIV Indicators 5.1.2</i> ● Percentage of respondents who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months (disaggregated for 15–24 years old). <i>GAM 3.18 Condom use at last high-risk sex</i>
There are more integrated HIV/SRHR services.	<ul style="list-style-type: none"> ● Increased range (number of different types) of SRHR services, information and products available. ● Number of HIV and SRHR service providers sensitized around SRHR and HIV linkages. 	<ul style="list-style-type: none"> ● Extent to which health facilities delivering HIV services are integrated with other health services. <i>NCPI Part A Q142</i>

Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
Q2: Access to and control over public and private resources		
More women and men access post-GBV care services.	<ul style="list-style-type: none"> ● Number of HIV and SRHR service providers sensitized around GBV and HIV linkages. ● Police report better referral systems to care services for survivors of GBV. 	<ul style="list-style-type: none"> ● Number of people receiving post-GBV care. <i>PEPFAR core indicators</i>
More women are aware of and use redress mechanisms and more women report violence.	<ul style="list-style-type: none"> ● Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses the legal rights and protections of women and girls impacted by HIV. <i>Compendium of Gender Equality and HIV Indicators 1.4.7</i> 	
More girls can go to school.	<ul style="list-style-type: none"> ● Greater acceptability of girls' school attendance. 	<ul style="list-style-type: none"> ● Total primary net enrolment ratio in primary education <i>Compendium of Gender Equality and HIV Indicators 1.5.3</i>
More women living with HIV are retained in healthcare.	<ul style="list-style-type: none"> ● Percentage of adults and children living with HIV known to be receiving ART 12 months after starting. <i>GAM</i> 	<ul style="list-style-type: none"> ● Number and percentage of people living with HIV who have suppressed viral loads at the end of the reporting period. <i>GAM</i>
Q3: Gender-equitable socio-cultural norms, beliefs, practices		
Violence against women in all/any diversity seen as unacceptable under any circumstances by men and women alike.	<ul style="list-style-type: none"> ● Portrayal of VAW in media ● Number of people participating in multi-stakeholder community dialogues on how to prevent and address VAW. 	<ul style="list-style-type: none"> ● Proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives. <i>Compendium of Gender Equality and HIV Indicators 1.4.1</i> <i>GEM Scale</i>
Reduction in HIV- or sexuality-related stigma and discrimination.	<ul style="list-style-type: none"> ● Number of people participating in community-based events (e.g. World AIDS Day, International AIDS Candlelight Memorial, young people's beauty pageant, etc.) aimed at reducing HIV- and sexuality-related stigma and discrimination. ● Positive coverage of anti-stigma events in local and national media. 	<ul style="list-style-type: none"> ● Percentage of women and men aged 15–49 who report discriminatory attitudes towards people living with HIV. <i>GAM</i>

Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
Q3: Gender-equitable socio-cultural norms, beliefs, practices		
	<ul style="list-style-type: none"> ● Percentage of women living with HIV who report having been denied SRH services because of their HIV status in the last 12 months. <i>People Living with HIV Stigma Index</i> 	
Reduction in harmful alcohol consumption.	<ul style="list-style-type: none"> ● Number of people (disaggregated by sex, age and stakeholder group) participating in multi-stakeholder community dialogues on alcohol reduction. 	<i>WHO's Alcohol Use Disorders Identification Test (AUDIT) scale</i>
More men in traditionally female caring, support or volunteering roles.	<ul style="list-style-type: none"> ● Number of men doing home-based care, nursing, peer education and outreach in the community, etc. 	<i>GEM Scale</i>
More women involved in community decision-making.	<ul style="list-style-type: none"> ● Local traditional leaders actively supporting women's participation in local council elections. ● Number of women leading community-based initiatives. 	<i>GEM Scale</i>
Q4: Laws, policies and resource allocations that respect, protect and fulfil women's human rights		
Supportive national framework for women's equality within HIV plans, including budgets.	<ul style="list-style-type: none"> ● Number of positive engagements by women's groups for gender budgeting within the national strategic plan (NSP) and Global Fund grant. ● Women's civil society participation in the policy and budgetary process (e.g. Joint Annual Reviews, development of health sector strategic plans, national delegations on the country's HIV/GBV/SRHR commitments). 	<ul style="list-style-type: none"> ● If there is a national strategy or policy guiding the HIV response, does it include gender-transformative interventions, including interventions to address intersections of GBV and HIV? If yes, does it include a dedicated budget for implementation of the gender-transformative interventions? <i>NCPI</i>
Reform of legal framework that presents obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups.	<ul style="list-style-type: none"> ● Number of efforts by women's organizations to gather robust data/ meaningfully consult on barriers to accessing HIV prevention, treatment and care, and SRH information and services among vulnerable and key affected populations. ● Number of positive engagements with policy-makers to present data/ findings. 	<ul style="list-style-type: none"> ● Are there any legal protections for key populations? <i>NCPI Part A Qs 72-76</i> (See also additional questions on the existence of criminalization. laws in <i>NCPI Part A Qs 65-71</i>)

Results	Indicators for short- to medium-term outcomes	Global indicator for long-term outcome that this feeds into upstream
	<ul style="list-style-type: none"> ● Number of women supported to engage in NSP review and development processes (note: it is important to name the resources and ways in which they have been supported). 	<ul style="list-style-type: none"> ● If there is a national strategy or policy guiding the HIV response, does it integrate inputs from a multi-sectoral process, including various government sectors as well as non-governmental partners? <i>NCPI</i>
Q4: Laws, policies and resource allocations that <i>respect, protect and fulfil</i> women's human rights		
More women from relevant populations meaningfully involved in research, M&E and advocacy.	<ul style="list-style-type: none"> ● Number of women engaged in research, monitoring and advocacy (disaggregated by key populations). 	
More protections for women in laws, including by-laws, and in the interpretation of laws regarding their equal property and inheritance rights; equal rights in marriage and cohabitation, and protection of rights with respect to separation, divorce, widowhood and child custody.	<ul style="list-style-type: none"> ● Women's rights groups invited to provide recommendations to the new draft policy on protecting women's rights to land and inheritance. ● Number of women reporting rights violations with regard to the ownership and inheritance of land and property. 	<ul style="list-style-type: none"> ● Existence of laws and policies that support women's equality throughout a spectrum of legal frameworks. <i>NCPI Part A, Section 4 on gender equality</i>
Greater implementation of all national, regional and international legislation and commitments that promote women's and girl's sexual and reproductive rights.	<ul style="list-style-type: none"> ● Number of women's organizations involved in monitoring the implementing of government commitment around gender equality and women's and girls' SRHR (i.e. CEDAW or ICPD shadow reporting). 	
Young women have greater visibility and voice in spaces where decisions are made, ranging from the household to national and global policy domains.	<ul style="list-style-type: none"> ● Number and type of engagement by young women in decision-making spaces disaggregated by domain. 	
Women's rights organizations are adequately resourced and supported.	<ul style="list-style-type: none"> ● Proportion of women's organizations reporting adequate resources to implement operations. ● Ratio of paid time to voluntary time in women's rights organizations. 	

Annex 7: M&E approaches

In conjunction with the broad level data provided through global indicators (see the section ‘formal-quantitative’ on page 81), we recommend that these are supplemented through qualitative and participatory approaches that enable us to understand how the big challenges set out in national documents are experienced in real life by women and adolescent girls in all their diversity. Through such approaches we can understand women’s lives more completely, identify local differences and also identify specific opportunities for change that may not be apparent through large-scale data.

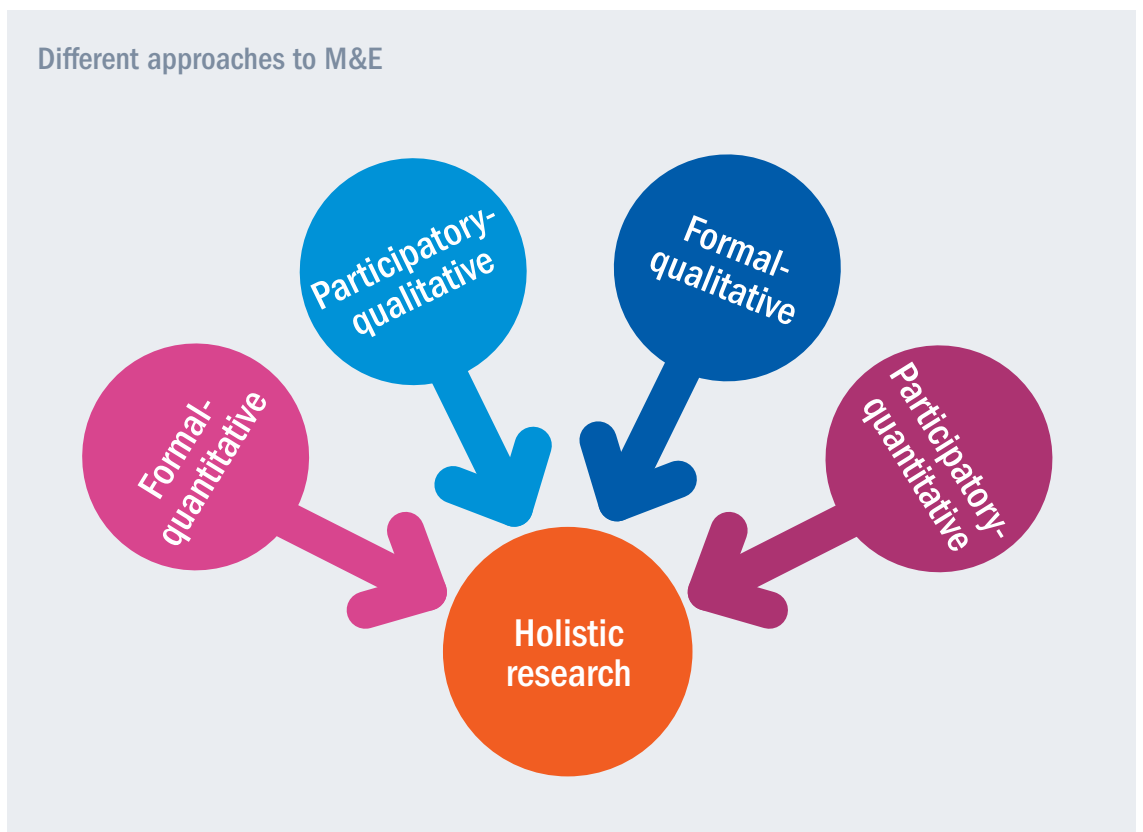
This annex provides a simple overview of quantitative, qualitative, formal and participatory approaches to M&E, with examples of data-gathering tools and methods under each approach. Together these could form a mixed-methods approach to your M&E.^{xvii,26} This can also help you to develop the details of your M&E plan (see Part 3, Step 7 on page 58).

	Qualitative (voices)	Quantitative (measurement)
<p>Participatory^{xviii,79,80,81}</p> <p>Community participants take the lead in deciding what gets discussed/ measured, and in data collection and analysis.</p>	<p>Examples: body mapping, seasonal calendars, community diagramming</p> <ul style="list-style-type: none"> 👍 Enables voices of participants to be heard and promotes the agency of the community member as researcher – the process itself is empowering. 👍 Enables participants to generate knowledge that they feel is important. 👍 Enables ‘unintended’ or unexpected consequences to emerge. 👎 When people are asked to tell their stories by those involved in delivering programmes they may tend to tell positive stories and not describe the challenges of programmes. 👎 Can make comparison across settings challenging. 	<p>Examples: social maps, empowerment matrix, perception scorecards, citizen report cards</p> <ul style="list-style-type: none"> 👍 Enables voices of participants to be heard and promotes the agency of the community member as researcher – the process itself is empowering. 👍 Places value on local knowledge. 👍 Can be used to ‘quantify’ qualitative changes in areas like empowerment, participation and accountability, creating space and legitimacy for ‘difficult to measure’ changes. 👎 Tend to be small-scale and unrepresentative samples. 👎 Results may only be seen as valid at local level but difficult to generalize or compare across time and space.

xvii. For a discussion about the effectiveness of this combination of approaches, see: Raab M and Stuppert W. ‘Review of evaluation approaches and methods for interventions related to violence against women and girls (VAWG)’. Department for International Development. 2014.

xviii. For examples of participatory approaches, see: Ellsberg M and Heise L. ‘Researching Violence Against Women: A Practical Guide for Researchers and Activists’. WHO, PATH. 2005; Loewenson et al. ‘Participatory Action Research in Health Systems: A methods reader’. Equinet. 2014; and Welbourn A. ‘A Rough Guide for CBOs: participatory approaches to working on sexual and reproductive health and human rights to promote safety in the context of gender-based violence in communities’. Salamander Trust. 2015.

	Qualitative (voices)	Quantitative (measurement)
<p>Formal</p> <p>Outside organizations undertake M&E and decide the broad terms of what gets discussed and measured.</p>	<p>Examples: focus groups, in-depth interviews, ethnography</p> <ul style="list-style-type: none"> 👍 Enable voices of participants to be heard. 👍 Enables unintended or unexpected consequences to emerge. 👍 Can hear from participants about processes of change and resistance. 👎 Participants may feel they have to provide positive stories only. 👎 Can make comparison across settings challenging. 	<p>Example: structured questionnaires</p> <ul style="list-style-type: none"> 👍 Can align questions and approaches to gather data for global and national indicators. 👍 Can be comparable across different contexts and countries if carefully designed. 👍 Can (if used with correct research design) generate very strong evidence of impact. 👎 Generating strong evidence can be costly with large sample sizes needed (large number of participants) and complicated to administer. 👎 Can be hard to understand and interpret. 👎 Cannot tell why things did or did not change.



Examples of approaches

Formal–quantitative

Typically, formal–quantitative approaches tend to use indicators that seek to produce a number (e.g. percentage, score) that can be compared across different times or places. This is important for generating large-scale evaluations and providing a measure of overall impact. Because they enable comparison across different contexts, there have been attempts to provide global and national guidance on measuring key indicators using formal–quantitative approaches (see Annex 5). These approaches, for example, seek to ask participants involved in an initiative a series of questions about their knowledge, attitudes and practices (behaviour).

Formal–quantitative approaches, for instance, translate concepts such as gender norms into measurable approaches to enable people to answer a series of questions (see box below on GEM Scale). This provides a formal–quantitative assessment of gender norms.

The Gender Equitable Men (GEM) Scale

This scale seeks to measure gender equity between women and men. It was first developed for use in Brazil and has since been used globally, including in Ethiopia and South Africa. It comprises of around 24 questions that ask about the acceptability of violence, sexual relationships and domestic work: for example, ‘There are times when a woman deserves to be beaten.’ There are four responses, each scored: ‘Strongly Agree’ (1), ‘Agree’ (2), ‘Disagree’ (3), ‘Strongly Disagree’ (4).

When a person has answered all the questions, the scores are added up. In this case, high scores represent greater gender equity. In this way, they translate a complicated concept, such as gender norms, into a single number that can potentially be compared across different settings and times.

For more information, see the Gender Scales Compendium: www.c-changeprogram.org/content/gender-scales-compendium/gem.html

Other formal–quantitative approaches seek to measure behaviour and experience. A key measure, in the context of VAW and HIV, is the prevalence of physical and/or sexual IPV in the past 12 months. This can be measured through the WHO developed and validated questionnaire (see box below). This and other similar measures have been used globally to produce comparable data across different countries to understand the wide variations in prevalence and causes of recent IPV.^{xix,51}

WHO Violence Against Women Instrument

WHO has developed a standardized questionnaire for assessing physical and sexual IPV experienced by women in the past 12 months. Women are asked a series of nine questions about their experiences of physical violence in the past 12 months by a current or previous husband, partner or boyfriend.

Five of these questions include ‘being pushed or shoved’ and ‘threatened with or actually had a knife or gun used’. And four questions about sexual violence in the last 12 months, include, ‘Forced to have sex when you did not want to’.

xix. For instance, Heise and Kotsadam have compared women’s recent experiences of IPV (in the past 12 months) across 44 countries to show that norms justifying wife beating and norms related to male dominance over women are all closely associated with higher rates of recent IPV.

Women can answer either: 'No', 'Once' or 'Many times'. Any 'yes' answer on any of the nine questions is then classified as a woman having experienced physical and/or sexual violence in the past 12 months. For men, it is possible to reword the question to ask about their perpetration of violence.

This is one method through which data can be collected to respond to the indicator on prevalence of recent IPV among women aged 15–49, included as a key measure in Global AIDS Monitoring.

For more information, visit: www.unaids.org/en/dataanalysis/knowyourresponse/globalaidsprogressreporting

Formal–qualitative

We define formal–qualitative approaches as ones that typically involve the researchers setting the parameters of the questions and discussions. Broadly, they include interviews or focus groups and ethnography.

Formal–qualitative approaches provide different types of information, but importantly they allow those who are involved in the initiative to describe their lives and the experience of being part of the initiative, in their own words. Well-trained fieldworkers will be able to elicit detailed stories and understandings (though, typically, less likely to produce numerical results or statistics) about any topic that is chosen. Qualitative methods are useful for eliciting more nuanced detail around the experience of participants (the quality of the initiative, programme or service), and to ask questions about enablers and barriers to provide more understanding on why something works or doesn't work.

In addition to enabling comparisons across different contexts, these approaches also enable comparability within the same context over time to measure change. These approaches can also be useful for local level efforts in addition to global monitoring.

Repeated in-depth interviews

As part of the qualitative evaluation of *Stepping Stones and Creating Futures* in Durban's informal settlements, the team undertook repeated in-depth interviews with participants.¹¹⁵ They randomly chose 20 men and interviewed them before the intervention started, just after it finished and six months later. Those doing the interviews had topic guides that guided the discussions and interviews. While participants could talk about anything they felt was important, it was shaped by the interests and concerns of the researchers.

Through repeated interviews the team could trace changes in individual men's lives, what worked well in the intervention and the challenges that young men faced in trying to change in an informal settlement.

Participatory–qualitative

It can often be helpful to conduct participatory and formal qualitative interviews and/or focus groups, or processes, before formulating questions for formal quantitative surveys. In this way, researchers can elicit more context-specific and appropriate questions for the formal quantitative process.

These approaches provide greater scope for participants to shape the issues covered, and the discussion, from their own perspectives. This approach provides important insight into the different (and sometimes competing) priorities that exist among different community members (typically working in sex/gender and age-disaggregated groups and then coming

together to share the results). This disaggregated process is an important element of the participatory methodology. Data from this approach may point to what needs to be addressed, *and measured*, through an initiative.

Qualitative participatory techniques use a range of different methods, including diagrams, maps and pictures, that participants complete as a group to share information and to reach consensus. Agreed priorities from each group are then shared with the whole community to build understanding of each others' realities. Discussion often accompanies the drawings and maps so that an outsider can understand the context. These tools can also elicit different forms of knowledge. Examples of methods to elicit and understand women's own knowledge and perspectives include: body mapping, community mapping, transect walks, seasonal calendars, daily calendars, etc.^{79,80,81}

Participatory—quantitative

This approach allows participants to identify both what to measure (i.e. participants select or define indicators) and the baseline against which change is measured. In some cases this approach can be useful for quantifying qualitative outcomes, such as empowerment, which is typically hard to measure by the use of scales or scorecards, as it may be composed of various aspects. The participatory process of data gathering or counting often also provides rich qualitative data and analysis to complement and provide context to the numbers. Processes that are partly or wholly community-owned and led can be empowering in and of themselves, and foster community-based 'diagnostics' to resolve areas that are seen to be lagging behind or 'failing'. In some cases, participatory statistics have been used alongside more formal/ extractive quantitative approaches and have been seen to produce very similar results.

SMART and SPICED indicators^{116,117}

We are often asked by donors to provide SMART (Specific, Measurable, Attainable, Realistic and Time-bound) indicators. But, are these enough to develop relevant and effective programmes? Indicators created by community members, through participatory processes, can often enrich our understanding of the priorities of women facing violence, compared with what outsiders might think their priorities are, or should be.

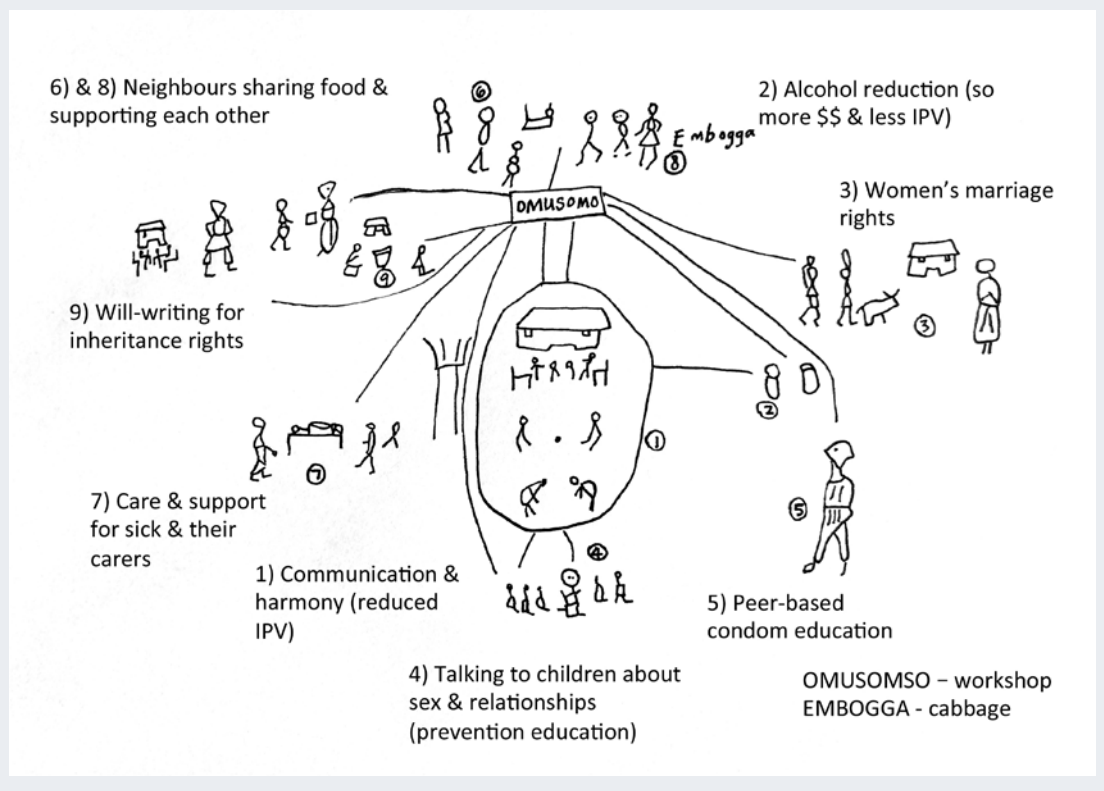
For example, outsiders might want to include within the project timeframe, priority indicators that emphasize a woman's 'disclosure' of her HIV status to her partner and her adherence to medication. These could be measured through SMART indicators. However, 'disclosing' her HIV status to her partner and having her medication discovered may make her vulnerable to IPV and potentially lose her children. *Her* top priority might be staying safe so that she can keep her children safe and, therefore, avoiding 'disclosure' and taking medication.

Indicators derived from her perspective could be identified as SPICED (Subjective, Participatory, Interpreted, Cross-checked, Empowering, Diverse and Disaggregated) indicators. These SPICED indicators are closer to the priorities and desires of the woman than the SMART indicators, which, despite the researchers' good intent, have a limited understanding of any potential violence.

Developing SPICED indicators through participatory qualitative M&E processes can help us to develop programmes that would first address the violence itself, together with those whose lives we seek to support. Such programmes are likely to need more time to implement, but are ultimately likely to be safer, more sustainable and more effective in the long-term.

The diagram below was drawn by a group of older women in Buwenda, Uganda in 1995 (before ART was available), 16 months after a *Stepping Stones* workshop.¹¹⁹ It shows the positive changes in the women’s lives since the workshop. The annotated notes were added later to summarize what the women had depicted in the drawings and in their local language. The NGO staff were struck by the rich diversity of issues identified by the women, covering a wider range than they anticipated.

This diagram could be used to construct a set of SPICED indicators for work with other communities on VAW and HIV. However, SMART and SPICED characteristics are not mutually exclusive and can complement each other. Ideally, we would move towards a process where all indicators have both SMART and SPICED characteristics: whereby they have been developed in a participatory way through the process described here, to reflect and account for local priorities and desires. For example, the SPICED indicator ‘neighbours sharing food and supporting each others’ could then be defined in a SMART way as ‘the extent to which individuals have felt comfortable sharing their food and supporting each other over the past year’ with a score of 0–10.^{xx,118}



xx. See webinar 4 of the ALIV[H]E series for more discussion of this.

Scorecards to assess health and education services in the Maldives

A longitudinal study in the Maldives used perception scorecards to assess user satisfaction with health and education services at three points along an implementation timeline. The scorecards were used as part of, and in parallel with, a survey questionnaire and focus group discussions. The group-based activity generated data that could be triangulated with the survey data, and also prompted evaluative discussions that helped to explain the satisfaction scores.

The group discussions also generated solution-oriented thinking among project participants, and motivated education and service providers to address perceived areas of dissatisfaction with innovative and creative responses. At the second and third implementation of the scorecards, participants were shown the group-generated data as well as the survey-generated data and invited to compare data sets, challenge researchers' conclusions, and consult on the differences to improve researchers' understanding of the data.¹²⁰

Participatory methods

There is growing evidence of the importance of participatory research in effective policy and programme development. There are many participatory methodologies that enable people who are most affected to have a voice. Specific resources include:

- Participate initiative – a network of organizations undertaking participatory research to understand and shape policy. <http://participate2015.org>
- Whiteford, L., Vindrola-Padros, C. (2015) *Community Participatory Involvement: a sustainable model for global public health*.
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- Welbourn, A. (2015) *A Rough Guide for CBOs: participatory approaches to working on sexual and reproductive health and human rights to promote safety in the context of gender-based violence in communities*. Salamander Trust.
- Better Evaluation – online resources include participatory approaches to evaluation. www.betterevaluation.org/

We also recommend AWID's *Thirteen insights for women's organizations on strengthening M&E for women's rights*¹²¹ and Raab and Stuppert's²⁶ *Review of evaluation approaches and methods for interventions related to violence against women and girls* on the benefits of mixed methods approaches (combining participatory and formal approaches with both qualitative and quantitative tools) for the effective evaluation of programmes designed to reduce VAW.

Annex 8: References

See also Action H and Annexes 4–7 for additional useful resources.

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Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
AUDIT	Alcohol Use Disorders Identification Test
AWID	Association for Women in Development
CBO	community-based organization
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DHS	Demographic and Health Survey
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
GAM	Global AIDS Monitoring
GAT	Gender Assessment Tool
GBV	gender-based violence
GEM	Gender Equitable Men [Scale]
GIPA	greater involvement of people living with HIV
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IMAGES	International Men and Gender Equality Survey
IPV	intimate partner violence
M&E	monitoring and evaluation
MDG	Millennium Development Goal
MIWA	meaningful involvement of women living with HIV
NCPI	National Commitments and Policies Instrument
NGO	non-governmental organization
NSP	national strategic plan
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PrEP	pre-exposure prophylaxis
SDG	Sustainable Development Goal
SMART	specific, measurable, attainable, realistic, time-bound
SPICED	subjective, participatory, interpreted, cross-checked, empowering, diverse and disaggregated
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
SWIT	sex worker implementation tool
TfG	Together for Girls
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
VACS	Violence Against Children Surveys
VAW	violence against women
WHO	World Health Organization

