



Financial resources required to achieve universal access to HIV prevention, treatment, care and support

Integrating the prevention of violence against women and PEP
into the HIV Programmes: preliminary framework and
proposed next steps

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Methodological Annex - I

Introduction

UNAIDS are in the final stages of an exercise to project the costs of mounting a comprehensive response to the HIV epidemic for 2009 – 2015 in low and middle income countries (LMICs). Using the Global Resource Needs Model, that has previously been used to project the costs of reaching the UNGASS targets¹, initial projections of the costs of HIV prevention, care, and orphan and vulnerable children support for HIV/AIDS. The advisory board met from the 3-4th May 2007 to review the preliminary projections, and to identify any required changes or additions to the activities being costed. As part of the new additions to the model, the Advisory Board agreed that costs towards addressing gender based violence should be included in the 2009 – 2015 projections.

Towards this end, after providing a brief overview of the current GRN model, this paper presents a brief summary of evidence of effective models to prevent intimate partner violence and sexual violence against women in LMICs; a summary of models of intervention being implemented in more than one LMIC; and evidence about the costs of such activities targeted at different groups. Drawing upon these models – and in particular – what is known to be effective, and acknowledgement of the fundamental need to address current gender norms, power dynamics and constructions of masculinities as part of an effective response to both HIV and violence against women, this paper presents a proposal for how to incorporate a response to violence against women and girls into the current GRN model. Due to the severe time constraints associated with this exercise, there has not been time for extensive consultations regarding the proposal. Given this, the limitations of the current approach are identified, and a proposal for future costing initiatives is made.

Methods to project the resources needed to respond to HIV: the Resource Needs Model

The Resource Needs Model (RNM)² calculates the total resources needed for prevention, care, and orphan and vulnerable children support for HIV/AIDS³. Building upon previous work by Kumaranayake and Watts; Swartlander; and Boule and Cleary; the Resource Needs Model developed by Bollinger, Stover, Boule and Cleary is being used to project

¹ Swartlander et al. (2001) "Resource Needs for HIV/AIDS," *Science* 292:2434-2436, 29 June 2001.

² Bollinger L., Stover J., Boule A and Cleary S (2006) Resource Needs for HIV/AIDS: Model for Estimating Resource Needs for Prevention, Care, and Mitigation

the resources needed to respond to HIV from 2009 – 2015. A similar framework was also used by Mills et al to estimate the resources associated with the Macro-Commission on Health.

The current RNM model contains three sub-models:

- The ***prevention model***, that calculates the cost of specific prevention interventions and allows the user to specify up to five additional priority populations such as prisoners, migrants, or truck drivers. The specific interventions are:
 - General population
 - Mass media
 - Community mobilization
 - Priority populations
 - Youth focused interventions
 - Interventions focused on sex workers and their clients
 - Workplace programs
 - Harm reduction for injecting drug users
 - Interventions focused on men who have sex with men
 - Service delivery
 - Condom provision
 - Improving STI management
 - Voluntary Counseling and Testing
 - Prevention of mother-to-child transmission
 - Health care
 - Blood safety
 - Post exposure prophylaxis
 - Safe injection
 - Universal precautions

- The ***care and treatment model***, which estimates the cost of care and treatment programs, including:
 - Anti-retroviral therapy (ART), including laboratory tests for monitoring ART and treatment of OIs while on ART
 - Care and prophylaxis in the absence of ART
 - Diagnostic HIV testing
 - Home-based care
 - Palliative care

- Tuberculosis treatment
- Nutritional support
- ART provider training
- The **mitigation model**, which calculates the cost of interventions to support orphans and vulnerable children (OVC):
 - Educational support
 - Health care support
 - Family/home support
 - Community support
 - Administrative expenses

For each form of intervention, the annual resource estimates by country are estimated by multiplying estimates of:

- the size of the population targeted by the specific intervention;
- the coverage target for the intervention in that year; and
- the unit cost of delivering the intervention in that country.

The final projected expenditure for any specific program is a combination of these three elements. Country by country, the resource Needs Model (RNM) calculates the total resources needed for prevention, care, and orphan and vulnerable children support for HIV/AIDS on a national level. National level estimates are then aggregated to obtain regional and interventional resource targets.

The GRN model provides an important estimate of the scale of resources required to address HIV in LMICs, that can be used at the international, regional and global level to gauge the adequacy of current levels of funding, and to advocate for increased investment. Although a process of consultation and validation with national partners is used to validate the model, the projections will always be limited by the forms of cost data available. Gaps include difficulties in costing changes in structural factors (such as legal reform or policy change); and a lack of evidence about the degree to which there may be economies of scale or scope associated with the large scale implementation of interventions.

Current evidence on effective responses to intimate partner (IPV) and sexual violence against women

A recent expert review of evidence of effective responses to IPV and sexual violence against women⁴ highlighted the degree to which the field is in its infancy, and the limited evidence base on effective interventions, even in industrialised countries⁵. The forms of intervention reviewed and discussed at the meeting were:

- Early childhood programmes (e.g. home visiting, parenting programmes)
- In and out of school-based interventions for promoting gender equality, communication, non violence
- Interventions working with men and boys to promote male ownership of issue and new models of masculinity.
- Community mobilisation to promote social change
- Structural change to address alcohol, women's legal rights, contexts of risk
- Economic development activities (particularly for women)
- Media and its portrayal of women, gender relations, acceptability of violence
- Legal reforms and strengthened criminal justice responses.

Much of the evidence of intervention impact reviewed was from industrialized countries, with limited information from LMICs being available. In some cases – such as early childhood programmes – there is some evidence of impact on later experiences of violence, but the potential model of delivery in less well resourced settings was not clear. In other examples, such as attitudes towards the acceptability of violence – although there is strong evidence of the association between community attitudes condoning some forms violence and the levels of violence occurring, but limited evidence of the impact on violence perpetration of media campaigns.

At the meeting, the possibility of identifying a package of interventions that WHO could recommend to governments and Ministries of Health was discussed. Given the limited evidence base, it was agreed that at this stage it is more feasible to identify key principles that should guide decision making, and then list a range of intervention options for governments to consider. The following key principles were identified:

Key principles in programming to address intimate partner and sexual violence against women:

- The importance of addressing VAW prevention in its own right, as well as a

⁴ Primary prevention of intimate partner violence and sexual violence. WHO Expert Meeting. Geneva 2 – 3rd May 2007.

⁵ Wathen CN, MacMillen HL (2003) Interventions for violence against women: scientific review. JAMA February 5th. Vol 289 (5).

mechanism to reduce risk of ill health (including HIV)

- Central importance of involving men, and addressing gender equality and constructions of masculinities
- Importance of interventions across lifespan and across sectors
- Value of individual and contextual/structural interventions
- High prevalence highlights need to integrate VAW prevention where possible into existing activities/programmes – including HIV
- Recognise potential dangers of badly conceived or poorly implemented interventions
- Expertise of women's groups, and model of implementation in partnership with civil society / women's groups

Evidence of effective violence prevention interventions in LMICs

When considering the range of potential interventions to integrate into the GRN, it is important to build upon existing models of intervention that are already being implemented in LMICs. A range of strategies are being used to address and respond to women's experiences of violence – including advocating for legal reform; the provision of counselling and legal advice; shelters; hotlines; women run police stations; and anti-violence campaigns. An important international advocacy initiative is the 16 days of action against violence against women, starting on 25th November - International Day Against Violence Against Women, and finishes on International Human Rights Day on 10th December, that celebrates the anniversary of the Universal Declaration of Human Rights proclaimed in 1948. Over time the campaign has evolved, and activities for the 16 days of action are conducted in countries as far afield as Ireland, Malaysia, Zimbabwe, the UK and the USA. In each country a range of events are used to highlight the prevalence of male violence, create awareness of this violence as a human rights violation, and promote women's leadership in addressing the issue. At the 16 days of Action run over December 1st – World AIDS Day – increasingly the links between violence against women and HIV are also being highlighted as part of this campaign.

However, evidence of the impact of different responses is still very limited. Based upon a preliminary review of published and unpublished evaluation research, Table 1 summarises evidence from LMICs of interventions shown to impact on violence against women. Details of the specific interventions are given below. Where documented, their impact on HIV related risk is also reported.

IMAGE intervention

In Limpopo province in South Africa, the IMAGE study assessed the impact of a structural intervention that combined a microfinance programme with a participatory gender and HIV training curriculum (Sisters for Life), and assessed changes in economic well-being, gender equity, social capital and vulnerability to HIV and IPV. Loans were provided to poor women enrolling in the intervention. Before each loan meeting, a ten session participatory training was provided to participants. As well as improvements in economic well-being, social capital, and empowerment, among direct programme recipients, their past year experience of physical and/or sexual abuse was reduced by 55% (aRR 0.45 95% CI 0.23-0.91). Significant improvements in communication were also documented. The study provides evidence that a combined microfinance and training intervention has the potential to generate social and economic benefits, and lead to significant reductions in levels of IPV among programme participants over programmatic timeframes. (?Add the 7US Dlls/day info).

Stepping Stones, South Africa

Stepping Stones was originally developed for use in Uganda, and over the last decade has been used in over 40 countries, and translated into at least 13 languages. Stepping Stones uses participatory learning approaches, including critical reflection, role play and drama, and consists of 13 3 hour sessions and three peer group meetings, with themes explored including STIs, HIV, communication, and one session on gender based violence. The MRC South Africa recently completed a community randomised controlled trial to assess the impact of the second edition of the revision of Stepping Stones for South Africa⁶. Despite having a relatively small component on gender based violence, the intervention was shown to have a significant impact on male perpetration of violence, with the proportion of men in the intervention who disclosed perpetrating severe intimate partner violence (defined as more than one episode of physical or sexual IPV) being lower at 12 and 24 months ($p = 0.11$ and $p = 0.05$). Significant improvements in condom use with last partner, reductions in the number of partners and engagement in transactional sex at 12 months were also documented. Although not significant, 15% fewer HIV infections among men occurred in the intervention compared to the control arm (IRR = 0.85 (95%CI 0.6, 1.2 $p = 0.35$) and 31% fewer HSV2 infections (IRR = 0.69, 95% CI 0.47 –

⁶ Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Wood K, Koss M, Puren A, Duvvury N. (2007). Evaluation of Stepping Stones: a gender transformative HIV prevention intervention. Policy Brief March 2007,

1.03) $p = 0.07$). The study findings illustrate the impact of behavioural interventions, both to reduce men's perpetration of violence, but also on their sexual risk behaviour.

PROMUNDO Brazil⁷, The Yari-Dhosti Intervention and Mumbai⁸

In 3 low-income communities in Rio de Janeiro, Brazil, a quasi-experimental study compared the impact of different combinations of program activities targeting young men aged 14 to 25 years. One community received a series of interactive group education sessions (called Program H) for young men. Program H used a field-tested curriculum that includes a manual and an educational video for promoting attitude and behaviour change among men, which focuses on helping young men question traditional norms related to manhood and on promoting the abilities of young men to discuss and reflect on the “costs” of inequitable gender-related views and the advantages of more gender-equitable behaviors. The second group received the same group education sessions, complemented by a community-wide “lifestyle” social marketing campaign to promote condom use, using gender-equitable messages that also reinforced those promoted in the group education sessions. The third was a control community. At baseline agreement with inequitable gender norms was significantly associated with reported STI symptoms ($p < .05$), lack of contraceptive use ($p = .05$), and both physical and sexual violence against a partner ($p < .001$). A comparison of baseline and six month post-intervention results found that a significantly smaller proportion of respondents supported inequitable gender norms over time ($p < .05$), while a similar change was not found at the control site. These positive changes were maintained at one-year follow-up, with greater changes often found in the combined intervention site. At both intervention sites, reported STI symptoms decreased and condom use at last sex with a primary partner increased. After one year, the improvements in both condom use and reported STI symptoms were maintained. Logistic regression analyses found that improvements on the gender norm scale were associated with changes in at least one key HIV/STI risk outcome, and in both intervention sites, decreased support for inequitable gender norms over one year was significantly associated with decreased reports of STI symptoms ($p <$

⁷ Pulerwitz J., Barker G, Segundo M, and Nascimento M. Promoting More Gender-equitable Norms and Behaviors Among Young Men as an HIV/AIDS Prevention Strategy. Horizons and Instituto Promundo. *Mimeo document*.

⁸Ravi VK., Pulerwitz J, Mahendra V, Khandekar S, Barker G, Fulpagare P, Singh SK. (2006). Shifting support for inequitable gender norms among young Indian men to reduce HIV risk and partner violence *Horizons Research Summary*. New Delhi: Population Council. April.

.001). The study findings indicate that addressing inequitable gender norms, particularly those that define masculinity, can be an important element of HIV prevention strategies. The findings also provide empirical evidence that a behaviour change intervention focused on combating inequitable gender norms is associated with improvements in HIV/STI risk outcomes.

Adapted from the programme in Brazil, the participatory group intervention has now also been piloted with young men in Mumbai. Compared to baseline, intervention participants decreased their support for inequitable gender norms and reported less sexual harassment of girls, and there were trends toward less risky behaviours⁷. A larger evaluation, comparable to the study described above, is currently being implemented.

Soul City, South Africa⁹

In South Africa, Soul City is an entertainment-education (“edutainment”) strategy designed to disseminate messages to the public, raise debate and shift attitudes and behaviour around key health and development concerns. Soul City produces a series approximately every 18 months, and uses a range of media types (television, radio drama as well as a print serialization in national and local newspapers and outreach) to increase the coverage of its messages, as well as reinforce messages conveyed. Dramas depict the lives of ordinary South Africans with the television series set in an urban township and the radio series set in a rural village. The fourth series (SC4) focused on violence against women, HIV/AIDS, hypertension and small business and savings. SC4 comprised a 13-part prime-time television drama, a 60-part radio drama transmitted in nine languages through the public broadcaster SABC, and three basic full colour booklets, with a million of each distributed through 10 newspapers nationally. Comparing those exposed to any of SC4 to those with no exposure, in general exposure was consistently associated with improved VAW awareness and knowledge. Among viewers with primary or secondary level education, significant improvements in attitudes were also documented. The patterns were somewhat similar to the impact documented on HIV knowledge and intention achieved during the same series.

Woman focused intervention for sex works in Pretoria¹⁰

⁹ Muirhead D, Kumaranayake L,² Watts C, Scheepers E (2006). Cost-outcome analysis of a media intervention for prevention of HIV/AIDS and violence against women: The Soul City project in South Africa. *In press*.

¹⁰ Wechsberg, WM, Luseno WK, Lam, WKK, Parry CDH and Morojele NK (2006). Substance use, sexual risk and violence: HIV prevention interventions with sex workers in Pretoria. *AIDS and Behaviour* Vol 10(2) March 2006. 131 – 137.

Using an experimental design, 93 women who reported recent substance use and sex trading were randomly assigned to a modified standard HIV intervention, or to a woman focused HIV prevention intervention. Eighty women completed a one month follow-up interview. At baseline participants reported high rates of sexual risk and violence. At follow-up, although violence continued to be a problem, woman focused intervention participants reported being victimized less often than women receiving the standard intervention. Decreases in the proportion of women reporting unprotected sex, and daily use of alcohol and cocaine were also reported , with the increase being larger for women receiving the woman focused intervention.

Table 1: Interventions shown to impact on violence or attitudes towards the acceptability of violence against women in LMICs						
<i>Intervention</i>	<i>Setting</i>	<i>Target group</i>	<i>Key programmatic elements</i>	<i>Study design</i>	<i>Forms of impact</i>	<i>Ref</i>
IMAGE	Rural SA	Rural women	Micro-finance; 10 participatory sessions on gender, power and HIV; social mobilisation phase	CRT	55% reduction past year IPV among loan recipients. Improved HIV communication	Pronyk et al 2006
Stepping Stones	Rural SA	Young men and women	50 hour participatory activities on gender, HIV, feedback to community	CRT	Impact on male perpetration of violence, condom use, number of sexual partners and levels of transactional sex.	Jewkes et al 2007
Promundo	Urban Brazil	Young men	Comparison of two forms of intervention: 1) Series of interactive group education sessions to promote attitude and behaviour change, focusing on helping young men question traditional norms related to manhood and promoting abilities of young men to discuss and reflect on “costs” of inequitable gender-related views and the advantages of more gender-equitable behaviors. 2) Same group education sessions, reinforced by community-wide “lifestyle” social marketing campaign to promote condom use, using gender-equitable messages	Before/After study	In intervention community significantly smaller proportion supported inequitable gender norms over time ($p < .05$). At both intervention sites, reported STI symptoms decreased and condom use at last sex with a primary partner increased. Inequitable gender norms associated with violent behaviour. Generally the intervention effects were larger in the setting where the education session is reinforced by complementary mass media.	Puleritz et al 2007
Pretoria	Urban SA	Women in sex	Explicit gender focus integrated	Individual	Woman focused intervention	Wechsberg

sex work intervention		work	into one-on-one for sex workers using drugs, including personalised assessments of risk, used to inform goals to help negotiate risk reduction; strategies to reduce risk of violence, and how to access community resources.	RCT	participants victimized less often than women receiving standard intervention. Decreases in unprotected sex, daily use of alcohol and cocaine, with the increase being larger for women receiving the woman focused intervention	WM et al 2006.
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Promising interventions

There are also a number of promising interventions to prevention of intimate partner and sexual violence, that are being implemented in a number of LMICs, which are well documented, although not formally evaluated, and which explicitly address violence and the contexts which perpetuate violence. Although not exhaustive, Table 2 summarises approaches implemented in more than one LMIC country, and which focus on different groups, but where to date we have not been able to identify published evaluation data.

These include:

Raising Voices – using a participatory process to engage communities and key informants in that community to analyse the social costs of violence and gender inequality, and to go through a process of change.

Men as Partners –this program aims to place the needs of men--as both partners of women and as individuals--on the agenda of health care providers across the globe. The activities aim to meet men's reproductive health needs by providing services for men and by educating them about issues such as sexually transmitted infections (STIs), gender-based violence, and contraceptive options.

Safer Schools Programme (SSP) – currently implemented in Jamaica, Malawi and Ghana, The purpose of the SSP is to create safe environments for all girls and boys that promote gender-equitable relationships and reduce sexual and gender based violence, resulting in improved educational outcomes and reduced negative health outcomes. Using a social mobilization approach, working at multiple levels, the ?SSP aims to prevention, reporting and response; take a gendered approach working with men and boys not only as perpetrators but also as potential victims as well as partners; have at least minimal support services in place before encouraging victims to come forward; and build on existing programs.

*Profamilia*¹¹ - training for health workers to screen for and deal with violence.

Sonagachi.- The Sonagachi project with sex workers in Calcutta, India includes not only efforts to reduce STIs and promote condom use but also community mobilization of sex workers as peer educators focusing on their overall health, social and economic well-being and human rights. Sonagachi organises sex workers into collectives and promotes sex worker solidarity as one way of addressing women's risk of violence¹².

Addressing violence against women as part of a comprehensive HIV response

In considering what this may mean for a national AIDS budget and plan, it is useful also to review the recent South African National AIDS plan, which explicitly includes a response to violence against women¹³. The elements included in their AIDS strategy Key Priority Area 1 linked to responding to violence against women are to:

- accelerate programmes to empower women and educate men and women on women's rights and human rights;
- develop a comprehensive package that promotes male sexual health and which addresses gender and gender-based violence;
- introduce programmes and strategies to address stereotype gender identities that contribute to gender-based violence;
- increase the accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support.

In addition, within Key Priority Area 4: Human and Legal Rights, activities identified include to mobilise society to stop gender-based violence and advance equality in sexual relationships.

Within this, activities identified are to:

- reduce poverty amongst women;
- ensure that existing laws and policies that protect women and girls from gender-based violence are implemented;
- respond adequately to the needs of women in abusive relationships; and
- ensure that laws, policies and customs do not discriminate against women and girls.

¹¹ Living Up to Their Name: Profamilia Takes on Gender-based Violence. Issue No. 18 ISSN: 1097-8194

¹² Violence against women and HIV/AIDS: critical intersections. Violence against sex workers and HIV prevention. WHO Information Bulletin Series Number Three.

¹³ South Africa National AIDS Council. HIV AND AIDS AND STI STRATEGIC PLAN FOR SOUTH AFRICA, 2007-2011 March 2009. Draft 9.

Responding to violence against women and girls: activities to include in current GRN

Drawing upon existing evidence of the impact on violence of preventive interventions that meaningfully engage in issues of power, gender and relationships; evidence of the models of intervention being implemented with different target groups and the associated unit costs; and drawing from the South African National AIDS plan about the ways in which this may translated into national level activities; it is proposed that the current UNAIDS costing includes the following:

1. Ensuring the explicit inclusion of strengthened programming on gender, violence, coercion and masculinities in all areas of HIV prevention activity currently included in the UNAIDS Global Resource Need Projections.

- *Rationale:* The scale of violence against women, evidence of its underpinning by gender inequalities; social norms that condone violence; and constructions of masculinities that support violence; and evidence of the impact that interventions that work with women and men to address violence suggests that the meaningful inclusion of these issues into a range of HIV prevention programmes that work with men and women, girls and boys could have a substantial impact on the levels of violence against women (and HIV) globally. The scale of HIV prevention being budgeted for within the GRN provides an important opportunity to massively scale up gender-focused initiatives that have the potential to impact on population levels of violence.
- *Activities to be included in costing*
 - Integration of participatory activities on sexuality, gender and coercion as part of lifeskills / HIV education activities for in and out of school youth (I wonder here whether there is any costing on sexuality education programmes that could be considered - this could begin to address some of the other concerns)
 - Integration of participatory activities for men into workplace HIV programmes
 - Integration of participatory activities for women into workplace / development programmes
 - Integration of participatory activities on gender into social mobilisation interventions.
 - Annual national campaign to challenge gender stereotypes, and acceptability of violence, to complement more targeted activities.

2. Strengthening the ability of services providing VCT and PMTC services to provide gender sensitive services, including providing advice and support to women fearing or disclosing

violence; and to assist in their referral to support services¹⁴

- *Rationale:* given evidence of the high prevalence of violence during pregnancy in many settings, and the relationship between HIV testing and violence for women, activities to strengthen health workers ability to provide gender sensitive services, including to discuss and respond to cases of violence within testing and counselling and MTCT initiatives, and to refer women to NGOs providing services to women experiencing violence should be supported^{15, 16}.
- *Activities to be included in costing*
 - Sensitisation and training activities on violence against women for health providers at PMTC/ testing and counselling sites (e.g. add on a module on gender and vaw to training on testing and counselling)
 - Support for the improved referral of women reporting violence to services

3. Incremental cost of ensuring that interventions working with sex workers include programming to address sex workers risk of violence from clients, their partners, and men in positions of authority.

- *Rationale:* given evidence of high levels of violence that sex workers experience, and the many ways in which violence impacts on sex workers ability to negotiate safer sex, it is important that HIV programmes are explicit about sex workers' risk of violence; seek to address the contexts of violence in which sex workers work; and are able to refer women to NGOs providing support to women experiencing violence if requested.
- *Activities to be included in costing*
 - Addition to existing programmes targeting sex workers and their clients of activities to explicitly discuss gender inequality and violence issues, and to address the contexts of HIV risk for sex workers / vulnerable groups

4. Increase the accessibility and availability of comprehensive sexual assault care including PEP and psychosocial support

- *Rationale:* in settings where the HIV epidemic is generalised, women and men who have been raped may become HIV infected. The prompt provision of testing, post-exposure prophylaxis (PEP) with antiretrovirals and appropriate psychological support is likely to reduce their risk of HIV acquisition. In settings where HIV is not generalised, funding to ensure that appropriate

¹⁴ Bott S., A. Guedes, and A. Guezmes. Forthcoming. "The health service response to sexual coercion/violence: Lessons from IPPF/WHR member associations in Latin America." In *Sex Without Consent: Young People in Developing Countries*. Eds. S. Jejeebhoy, S. Iqbal and T. Shyam. London: Zed.

¹⁵ Fonck K, Kidula EL, Ndinaya-Achola J, Temmerman M (2005) Increased risk of HIV in women experiencing physical partner violence in Nairobi, Kenya. *AIDS and Behaviour Vol 9(3) Sept. 335 – 9.*

¹⁶ Maher JE, Peterson J, Hastings K, Dahlberg LL, Seals B, Shelley G, Kamb ML. Title of article is missing *Journal of Acquired Immune Deficiency Syndromes. Vol 25(3) Nov 2000: 276 – 282.*

guidelines for PEP provision are follow are neededd¹⁷.

- *Activities to be included in costing*
- Comprehensive provision of post-rape care, including PEP where required. The costing should not only include the costs of PEP medications, but also other medications (including emergency contraception), HIV and pregnancy testing, counselling provision and training for counsellors (post-trauma, adherence, medication, etc.) and follow up.

5. Funding to support and strengthen the capacity of local organisations working on violence against women to create effective partnerships with groups working on AIDS, and have sufficient resources to enable them to advise and/or support initiatives to address violence against women within HIV planning and programming

- *Rationale:* in many countries globally, there are women's NGOs working to address violence against women. These groups have substantial expertise in addressing issues of violence and gender equality, and it is important that their expertise be used to advise and/or jointly support programming. These groups are often also the main source of support for women who are experiencing violence. It is important that some HIV funding is used to ensure their meaningful partnership with HIV programmes in an ongoing manner.
- *Activities to be included in costing*
- Programmatic support as 10% of total on GBV

6. National level programme costs:

Rationale: national level programme costs are needed to help ensure that senior staff are sensitised to the issues of gender equality, violence against women (and other groups) and how these intersect with HIV/AIDS, as this central commitment has been shown to be an important factor influencing the success of gender equality programming. Given the limited evidence about available effective interventions, resources to support the adaptation, testing and evaluation of pilot interventions is also needed, along with the monitoring and evaluation of ongoing interventions.

- *Activities to be included in costing*
 - Sensitization of core senior HIV/AIDS personnel on gender equality/inequality and specifically

¹⁷ Smith D, Grohskopf LA, Black RJ, Auerbach JD, Veronese F, Struble KA, Cheever L, Johnson M, Paxton LA, Onorato IM, Greenberg AE Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States Recommendations from the U.S. Department of Health and Human Services. MMWR January 21st 2005. 54(RR02); <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm>

VAW and its relevance to HIV prevention and AIDS control programmes

- Costs to support the development & evaluation of promising interventions to reduce VAW and HIV
- Monitoring and evaluation
- Capacity building

Evidence of unit costs for violence programming

Table 2 summarises current evidence of the unit costs of interventions to address violence against women, linked to the forms of activity identified above. The proposed method to include this into the existing GRN calculations is also given. Given the relatively limited evidence base on costs, PPP weightings will need to be used to adjust the unit costs for different settings, and the costs will need to be inflated to the years used in the resource needs calculations.

Table 2: Evidence of unit costs of interventions to prevent violence against women in LMICs						
Activities in costing	Target group	Unit cost (US\$ Year of constant prices)	Source data for costing	Costing	Ref	Proposed method to Include in GRN model
Addition of participatory activities on gender equality, power and violence to micro-finance initiative. This included training sessions using adult education techniques to address issues such as gender roles, cultural beliefs, relationships, communication, IPV and HIV and development of village-level action plans.	Women in income / employment schemes	\$7 per woman reached (US \$2004) Micro-financing activities were self-financing and so are not included in costing.	IMAGE intervention, rural South Africa	Incremental economic costing of adding activities to existing micro-finance initiatives and extrapolated beyond trial to scaled up implementation. Includes annualised capital costs of start-up.	Ferrari et al 2007	Include in workplace initiatives for 20% of women in employment.
Participatory activities on gender equality, power and violence. Community workshops to discuss cultural and gender issues, relationships, and HIV/AIDS, through drama, song, dance, and other participatory activities.	Community mobilisation	\$597,000 per community of 250,000 adults, training 40 men and 40 women per community, over 4 years. Costs \$0.30 per beneficiary per year (US\$ current dollars from costs incurred between 1997-2001, financial costs including adaptation of stepping stones, facilitators and transport)	Stepping Stones Mozambique	Total financial costs (NOTE WAS HARD TO ESTIMATE RECIPIENTS)	World Bank 2003 ¹⁸	Addition to: - community mobilisation programmes targeting adult men and women. - activities engaging with out of school youth.
Women in Development/Safe Schools Program. Development of curriculum materials and training workshop	Youth in schools	\$250,000 per programme (US\$ 2006)	Safer Schools Ghana	Financial costs incremental to existing school-based programmes	DevTech 2007	Addition to AIDS education programmes for youth in schools.

Participation of men in gender-focused violence and HIV/AIDS prevention activities using group education and life-style social marketing.	In and out of school youth	\$84 per participant for 6 month course (group education) \$138 per participant for 6 month course and life style social marketing (US\$ current between 1999 and 2003)	PROMUNDO Brazil	Total financial costs. Very intensive programme based on 28 hours of contact time in 6 months. Cost per participant per hour was \$3.01 and \$4.96 (with social marking) Could reduce costs by reducing contact time.	Pulerwitz et al 2006	Addition to AIDS education programmes targeting out of school young men. Possibly include in budget for training of peer educators.
Creation of enabling environment for empowerment and violence prevention among women and men in sex work	Women and men in sex work	\$35,555 to add to sex worker peer education programme targeting 6000 sex workers (US \$1998)	SONAGACHI India	Incremental and economic.	Gonzales et al 1999 ¹⁹ .	Calculate cost per sex worker and include as part of programmes working with female and male sex workers.
Integration of a gender perspective into health services (and building capacity on VAW for testing and counselling providers and policymakers)	Women attending testing and counselling, VCT or MTCT	\$23,148 per NGO (US\$ current between 2001 and 2003)	PROCOSI, Bolivia	Economic costs, including design, production and distribution of IEC materials, design and implementation of skill-building workshops, overall supervision and support of project activities.	Palenque et al 2004 ²⁰	Add to testing and counselling, VCT and MTCT costs. Calculate average cost assuming NGO serves approximately 10,000 clients per year for cost of \$2.31 per client.
Mass media programme using television, radio and print for HIV	General population	\$0.22 per person reached (US\$ 1999)	Soul City, South Africa	Full economic costing.	Muirhead et al 2002 ²¹	Addition to existing mass media costs.

¹⁹ Gonzales, V., H. Grosskurth, L. Guinness, V. Pangare and G. Sethi (1999). Mid Term Evaluation of West Bengal Sexual Health Project, Report submitted on behalf of International Family Health to Department of International Development, UK.

²⁰ Palenque E, Montaño E, Vernon R, Gonzales F, Riveros P, Bratt B (2004). Effects and Cost of Implementing a Gender-Sensitive Reproductive Health Program

²¹ Muirhead D, Kumaranayake L, Watts C. (2002). "Economically evaluating the 4th Soul City Series: Costs and impact on HIV/AIDS and violence against women." Johannesburg: Soul City Institute for Health and Development Communication.

prevention and violence prevention.							
Provision of post- sexual assault health services for rape, including PEP	Rape survivors attending health services.	\$196 per woman treated (including follow-up visits) (US\$2004)	South Africa National cost estimates	Economic costing, incremental to hospital facilities	Muirhead et al 2006.	Replace current PEP costs with this, which incorporate more comprehensive services.	

Coverage targets

A central input in the GRN tables are estimates of the coverage targets to be achieved by 2015, building up from estimates of the current coverage of interventions. Table 3 shows preliminary proposed target levels for each of the interventions proposed above, for each of the specific behavioural groups included in the GRN model. For practical reasons, the format for the target provided is in the same format as those currently used in the GRN model. For example, for schools programmes the targets are for numbers of teachers trained, rather than for children in school receiving the education. In addition, as the proposed interventions aim to build off the existing infrastructure of HIV and health service implementation, they are largely incremental activities to be added to existing HIV prevention activities. For this reason, the proposed target levels by form of intervention are presented as a percentage of those receiving the specific HIV services, rather than as an absolute percentage.

Table 3: Coverage targets for integration of responses to violence by 2009 - 2015					
Intervention		Coverage target for 2015, by stage of HIV epidemic as a proportion of those currently receiving interventions			Comment
Target group	Source of costs	Low-level	Concentrated	Generalised	
Youth interventions					
In School					
Primary school teachers receiving training on HIV	SaferSchools	100%	100%	100%	Addition to current primary school HIV programmes.
Secondary school teachers receiving training on HIV	SaferSchools	100%	100%	100%	Addition to current secondary school HIV programmes.
Out of school					
6 – 11 year olds	Stepping Stones	10%	10%	30%?	Targets seeking to create critical mass – depending upon what adding to, could aim to train all peer educators.
12 – 15 year olds	Stepping Stones	10%	10%	30%?	Targets seeking to create critical mass – depending upon what adding to, could aim to train all peer educators

Services providing HIV testing and counselling to women					
VCT providers	PROCOSI	20%?	20%?	20%?	Targets seeking to create critical mass of expertise
PMTCT providers	PROCOSI	20%?	20%?	20%?	Targets seeking to create critical mass of expertise
Workforce with peer education					
Males	Promundo or Stepping Stones	20%	20%	20%	??Target most at risk males or peer educators
Females	IMAGE or Stepping Stones	20%	20%	20%	Target poorest ?20% of workforce or peer educators
Mass media					
Additional annual campaign	Soul City / general campaign costs	1	1	1	Additional annual campaign
Community mobilisation					
	Stepping stones	10%	10%	30%	Of people in community mobilisations / or peer educators if this model of mobilisation being used.
Post rape services, including PEP					
Rape	SA National plan	100%	100%	100%	As with universal precautions.
Interventions focused on sex workers and clients					

% sex workers in contact with programme with HIV	Sonagaati	100%	100%	100%	Enhancement of current HIV activities in all settings
National level activities					
Core support to women's NGOs with expertise working on violence against women and girls	10% of GBV HIV funding	10%	10%	10%	
Sensitization of core senior personnel on gender and violence	PROCOSI	20%	20%	20%	High level commitment shown to be central to successful intervention implementation.
Funding to support development & evaluation of promising interventions					Target of programmatic budget or other R and D cost? ?Cost of adaptation and implementation of 3 successful interventions (egIMAGE, Stepping Stones & PROMUNDO) in 2 districts in countries with a generalised epidemic.
Monitoring and evaluation		10%?	10%?	10%?	Target fixed from start. Use same percentage figures as for other HIV programmes.

Capacity building		As in other progs	As in other progs	As in other progs	
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*As in other GRCC programmes

Other activities not included, but essential to an effective response to violence against women

If the proposed activities were funded, it would result in a substantially improved and scaled up response to violence against women, that is likely to have a marked impact on gender relationships and levels of HIV transmission. However, the interventions proposed are not exhaustive, and there are many other activities that would also impact on the scale of violence against women; affect women's ability to protect themselves against HIV; and that would reduce the burden of HIV on women.

These include:

- Legal reform to ensure gender equality, and make violence against women illegal
- Economic empowerment activities for women
- Investment to ensure that girls and boys can stay in school until secondary level education.

Although the budget includes funds for women's organisations working on violence against women, it also does not explicitly include budgets to provide support to women experiencing violence – including health care, psychosocial support, protection, shelters, hotlines and counselling and legal services. In all areas of the world, such programmes are generally under-funded, with the levels of demand always out-reaching need.

Steps for costing

- Informal review by advisory group of assumptions, unit costs and coverage targets'
- Development of costing figures by Futures Group.
- Review by UNAIDS, CW, LK and CGM, plus advisory group for work.
- Finalisation with accompanying document about methods and limitations.
- Support for further evaluation and development work.

ANNEX I

Interventions to promote gender equity, prevent violence against women and provide post-exposure prophylaxis (PEP) to women who have been raped

The updated GRN estimates include resources to promote gender equality, prevent violence against women, and provide PEP to women who have been raped. Drawing upon recent research evidence about the impact on violence and HIV risk behaviours of participatory interventions on gender; evidence about existing models of intervention in LMICs and their associated unit costs; and recognising the high levels of violence against women globally; the current costing largely focuses on using the infrastructure of HIV programmes to explicitly engage in issues of power, gender, masculinities and violence. Table * shows the estimates of resource needs associated with:

- the integration of participatory activities on gender equality, sexuality, and coercion in HIV education programmes for schools (in established epidemics);
- the provision of participatory activities on gender equality to out of school 16 year old youths (in established epidemics);
- the integration of participatory activities on gender, violence and HIV into workplace / development programmes with women;
- training to strengthen the ability of VCT and PMTC services to provide gender sensitive services, including advice and support to women fearing or disclosing violence; and to assist in their referral to support;
- the inclusion of participatory activities on power and gender equality into community mobilisation interventions;
- support for interventions working with male and female sex workers to address the contexts of violence in which sex workers work and live, that would create an enabling environment for HIV prevention;
- an annual national campaign to challenge gender stereotypes and the acceptability of violence, to complement more targeted activities;
- funding to support the comprehensive provision of post-rape services, including post-exposure prophylaxis (PEP) with antiretrovirals and appropriate psychological support in settings where the HIV epidemic is generalised, and to ensure that appropriate guidelines for PEP provision are followed in other settings;
- support for women's NGOs working to address violence against women, to

- engage in meaningful partnership with HIV programmes at a national level.
- support for capacity building, and the development, piloting and evaluation of promising interventions.

This is the first time that responses to gender inequality and violence against women have been explicitly costed, and the interventions included are not exhaustive. Other activities that would also impact on the scale of violence against women and affect women's ability to protect themselves against HIV, thereby contributing to reduce the burden of HIV on women include: legal reform to ensure non discrimination against women (e.g. on property and inheritance rights, divorce, etc.) and make violence against women illegal; economic empowerment activities for women; and investment to ensure that girls and boys stay in school until secondary level education.

The costing has focused thus far on interventions to change gender power dynamics, including through addressing masculinities, which have the potential to impact on HIV both directly through changing sexual behaviour and relationships and through the prevention of violence (with the exception of PEP). Although the costing includes funds for women's organisations working on violence against women, it includes only limited support to women experiencing violence and seeking help (such as health care, psychosocial support, protection, shelters, hotlines and counselling and legal services). Future estimates of resource needs would be improved with better evidence on the economic costs of such programmes, and the impact on women of different forms of activity. Given the relative infancy of our knowledge of what interventions are most effective to address violence against women and HIV, funds for piloting the monitoring and evaluation of promising interventions has also been included.