

## Abstract

*While US government-sponsored HIV prevention initiatives have achieved notable successes, challenges remain to serving women effectively. Intimate partner violence hinders women's efforts to decrease their HIV risk behaviors. The global HIV/AIDS epidemic is often viewed as a human rights crisis. An analysis of US HIV prevention strategies based on ecosocial and health and human rights frameworks clarifies women's HIV risk practices and suggests opportunities for progress. These two frameworks help to 1) demonstrate how HIV/AIDS is a clinical manifestation of violence against women, 2) identify safety from violence as a human right necessary for well-being, and 3) suggest ways in which HIV prevention initiatives can more effectively improve women's health and fulfill their basic human rights.*

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*Bien que les initiatives de prévention du VIH parrainées par le gouvernement américain peuvent se targuer d'un succès notable, les services efficaces offerts aux femmes restent un défi. La violence de leur partenaire sexuel nuit aux efforts des femmes à réduire les comportements à risque favorisant la transmission du VIH. L'épidémie mondiale de VIH/SIDA est souvent considérée comme une crise des droits de l'homme. Une analyse des stratégies américaines de prévention du VIH basées sur les cadres écosociaux, de santé et de droits de l'homme fait la lumière sur les pratiques à risque des femmes et propose des possibilités de progrès. Ces deux structures de travail aident à 1) démontrer que le VIH/SIDA est une manifestation clinique de violence contre les femmes, 2) identifier la sécurité comme un droit humain nécessaire au bien-être, et 3) suggérer comment les initiatives de prévention du VIH peuvent bénéficier efficacement à la santé des femmes et satisfaire leurs droits fondamentaux.*

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*Si bien las iniciativas de prevención de infección por VIH auspiciadas por el gobierno estadounidense han alcanzado éxitos notables, persisten desafíos para dar servicio eficaz a las mujeres. La violencia por parte de los compañeros íntimos obstaculizan los esfuerzos de las mujeres por disminuir sus conductas que las ponen en riesgo de quedar infectadas por el VIH. La epidemia mundial de infección por VIH a menudo se considera una crisis de derechos humanos. Un análisis de las estrategias estadounidenses para la prevención de infección por VIH basado en marcos ecosociales y de derechos de salud y humanos, aclara las prácticas que colocan a las mujeres en riesgo de infección por VIH, y sugiere oportunidades para avanzar. Estos dos marcos ayudan a: 1) demostrar cómo la infección por VIH es una manifestación clínica de violencia contra las mujeres, 2) identificar la seguridad contra la violencia como un derecho necesario para el bienestar, y 3) sugerir maneras en las cuales las iniciativas de prevención de infección por VIH pueden mejorar con mayor eficacia la salud de las mujeres y satisfacer sus derechos humanos.*

# IDENTIFYING THE LINKS BETWEEN VIOLENCE AGAINST WOMEN AND HIV/AIDS: Ecosocial and Human Rights Frameworks Offer Insight into US Prevention Policies

*Michelle Teti, Mariana Chilton, Linda Lloyd,  
and Susan Rubinstein*

**H**IV/AIDS persists as a prominent public health concern in the United States. Although historically, HIV/AIDS in the US has affected more men than women, recent epidemiologic trends reveal that women bear a growing proportion of the virus' burden. The proportion of new AIDS diagnoses occurring in women more than tripled (from 8% to 27%) between 1985 and 2003.<sup>1</sup> HIV/AIDS disproportionately affects African American and Latina women, who comprise less than 25% of the US population but represent more than 82% of female AIDS cases.<sup>2</sup> These data suggest that the success of future HIV prevention efforts overall will significantly depend on how effectively prevention programs meet women's needs.

HIV prevention strategies in the US have achieved notable successes over the past 25 years, helping to decrease the

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*Michelle Teti, MPH, is a Research Coordinator for an HIV/AIDS prevention project and a doctoral student in the Department of Community Health and Prevention at Drexel University School of Public Health, Philadelphia, PA, USA; Mariana Chilton, PhD, MPH, is an Assistant Professor in the Department of Community Health and Prevention at Drexel University School of Public Health; Linda Lloyd, PhD, MSW, MBA, is Associate Dean for Public Health Practice and Associate Professor of Management, Policy, and Community Health at the University of Texas School of Public Health, Houston, Texas, USA; and Susan Rubinstein, MPH, is Evaluator for an HIV/AIDS prevention project at Drexel University School of Public Health. Please address correspondence to the authors at [mteti@drexel.edu](mailto:mteti@drexel.edu).*

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annual incidence of HIV infection from 150,000 per year in the mid-1980s to 40,000 per year since the late 1990s.<sup>3</sup> Perinatal transmission, transmission via blood donation, and transmission associated with injection-drug needle-sharing have been greatly reduced as a result of HIV prevention efforts.<sup>4</sup>

Despite these advances, however, substantial HIV prevention challenges remain for women in the US. Women are most frequently infected via heterosexual sex (70%).<sup>5</sup> Biologically, women are more likely than men to be exposed to HIV through sexual intercourse because the lining of the vagina provides a large area of contact for infection.<sup>6</sup> Moreover, social factors further increase women's susceptibility. Jonathan Mann explained, "In each society, those people who before HIV/AIDS arrived were marginalized, stigmatized, and discriminated against became over time those at highest risk of HIV infection. Thus in the United States, the epidemic has turned increasingly towards minority populations in inner cities, injection drug users, and women."<sup>7</sup>

Women are also particularly vulnerable to HIV/AIDS because of violence. Studies of women in the general US population reveal a 22% to 31% prevalence of Intimate Partner Violence (IPV), defined as "any behavior within an intimate relationship that inflicts physical, sexual, or psychological harm."<sup>8,9</sup> In contrast, nationally representative research studies of women with or at risk for HIV indicate that these women experience significantly higher rates of violence (64%–67%).<sup>10,11</sup> IPV may hinder a woman's efforts to have safe sex, making it an especially problematic dimension of both primary and secondary\* HIV prevention programs for women.

In order to more appropriately respond to the challenges that women face in protecting themselves from HIV via heterosexual sex,\*\* it is necessary to examine existing HIV pre-

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\* Primary prevention is conducted with HIV-negative women to prevent acquisition of the virus. Secondary prevention is conducted with HIV-positive women to help these women protect themselves from further infection and prevent further transmission of the virus.

\*\* Women who identify as lesbians face different challenges to HIV prevention. This analysis focuses on women who engage in sexual intercourse with male partners, defined as heterosexual women; this activity poses the greatest transmission risk for women.

vention strategies through new and innovative frameworks. With a similar goal, Nancy Krieger and Sofia Gruskin employed ecosocial and human rights frameworks to further understand disparities in women's health regarding tuberculosis, stating, "We have found that articulating [these] frameworks and using them systematically helps to uncover gaps in knowledge and action and to set the grounds for new initiatives in research and policy."<sup>12</sup> The frameworks are equally relevant to envisioning improved HIV prevention policies for adult women in the US.

This article applies both the ecosocial and human rights frameworks, independently and together, to analyze the links among HIV risk, violence, and HIV prevention, and to justify the need for a government strategy for HIV treatment and prevention that is grounded in the imperative to respect, protect, and fulfill the rights of women. These two frameworks help us to 1) demonstrate how HIV/AIDS is a clinical manifestation of violence against women, 2) identify safety from violence as a human right necessary for well-being, and 3) suggest ways in which HIV prevention initiatives can more effectively improve women's health and fulfill their basic human rights.

Key international health leaders such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) endorse using a rights-based approach to HIV/AIDS prevention. The Declaration of Commitment on HIV/AIDS and the International Guidelines on HIV/AIDS and Human Rights were adopted at the UN General Assembly special session on HIV/AIDS in 2001.<sup>13,14</sup> These documents recognize that the full realization of human rights is an essential element of an effective global response to HIV/AIDS, set goals and objectives for governments, and identify specific actions that governments should take to respond to HIV/AIDS according to their human rights obligations.

The US government lags far behind in adopting such far reaching methodologies in its officially endorsed prevention efforts. New theoretical perspectives, such as ecosocial and human rights frameworks, are necessary to reframe HIV prevention policies to acknowledge the links between violence and HIV for women and more adequately fulfill women's rights to safety and health.

## Key Concepts of Frameworks

### *Ecosocial Theory*

Ecosocial theory reveals the intimate connection between inequities and health by explaining how humans embody as well as physically and symptomatically display the world in which they live. Briefly, the core constructs of ecosocial theory are:

- **Embodiment:** Embodiment is one's literal biological incorporation of the surrounding environment. Bodies and symptoms reveal connections between individuals and the society in which they live; thus, individual biology cannot be understood without considering an individual's history and place in society.<sup>15</sup>
- **Pathways of embodiment:** These are ways in which societal power arrangements and vulnerable and protective aspects of biology become embodied.<sup>16</sup>
- **A cumulative interplay between exposure, susceptibility, and resistance is expressed in pathways of embodiment:** Each factor is expressed at multiple levels and in multiple domains.<sup>17</sup>
- **Accountability:** Refers to "who and what are responsible both for social inequities in health and the ways in which they are — or are not — documented, analyzed, and explained."<sup>18</sup>

### *Application of Human Rights Norms*

Human rights are internationally recognized norms, initially outlined in the Universal Declaration of Human Rights (UDHR) and reiterated in covenants and treaties that translate this declaration into specific, legally binding obligations to promote and protect human rights.<sup>19</sup> Similar to the ecosocial framework, the human rights framework used in public health seeks to identify and hold accountable those who are responsible for health inequities and human rights violations. This framework calls on governments to legally and politically respect, protect, and fulfill human rights related to a particular health problem.<sup>20</sup> Specifically, "fulfilling the right means the state has to take all appropriate measures—including but not limited to legislative, administrative,

budgetary, and judicial — toward fulfillment of the right, including the obligation to promote the right in question.”<sup>21</sup> A health and human rights framework is based on the premise that there are identifiable links between health and human rights:

- Health policies and programs can protect or violate human rights in the way they are designed and implemented;
- The neglect or violation of human rights leads to poor health outcomes; and
- The promotion of human rights promotes health.<sup>22</sup>

Ecosocial and human rights approaches overlap: they both focus on monitoring population health and exploring accountability for health determinants. In the same way that the health and human rights framework seeks to determine who and what is responsible for health patterns, ecosocial theory supplies the theoretical understanding of the tangible link between state and societal structures and individual health. It does so by considering how “social relations and ecologic conditions literally incorporate themselves into the body throughout the life course” and seeks to explore how “developmental and evolutionary biology interact with social, economic, and political conditions to explain population patterns of health, disease, and well-being.”<sup>23</sup> While ecosocial theory, however, is concerned with which conditions are embodied, how they are embodied, and how social inequalities in health can be measured, the health and human rights framework focuses on state responsibility for laws, policies, and practices that influence the ways in which human rights are linked to health.<sup>24</sup>

Here, these frameworks are applied, independently and together, to the analysis of HIV prevention programs for adult women in the US to explain:

1. The connection between HIV and violence via embodiment;
2. Freedom from violence as a human right;
3. The ways in which current strategies do not adequately fulfill women’s human rights; and
4. Lessons learned for new US HIV prevention policies and programs, based on ecosocial theory and health and human rights frameworks.

## **Embodiment and the Violence-HIV Connection**

Violence has severe health effects. Women who experience IPV are more likely to have poor health than women who have not experienced IPV. Specifically, violence can result in injuries, chronic pain, disability, gastrointestinal disorders, infertility, and sexually transmitted infections, as well as rape-related pregnancy and unsafe abortions.<sup>25, 26</sup> Violent experiences are linked to substance abuse, depression, anxiety, eating and sleep disorders, feelings of shame and guilt, phobias and panic disorder, physical inactivity, poor self-esteem, post-traumatic stress disorder, psychosomatic disorders, and suicidal behavior, which, in and of themselves, are each linked to additional health complications.<sup>27</sup>

Considering the depth and severity of the health consequences of IPV, the notion of embodiment provides a useful framework to comprehend the ways in which violence enters and influences a woman's entire being. Applying the theory of embodiment appropriately conveys the magnitude of the lasting effects of violence, which are only touched upon by verbal description, medical records, hospitalization rates, and death certificates. Krieger and George Davey Smith describe the adverse physical and psychological effects of childhood sexual abuse as an example of the way in which women embody gender relations.<sup>28</sup> Similarly, it is helpful to view HIV as an embodiment of gender inequity and subsequent IPV. As established above, violence plays a key role in women's HIV risk practices. The multiple ways in which violence directly and indirectly increases a woman's vulnerability and susceptibility to HIV are described in further detail below.

First, women can acquire HIV or other sexually transmitted infections (STIs) directly through forced sex.<sup>29,30</sup> Certain types of sexual activity are riskier than others, and violent sex may be likelier than non-violent sex to transmit infections.<sup>31</sup> After talking with HIV-positive women with violent partners, Bronwen Lichtenstein concludes that a relationship with an abusive partner is equivalent to being "injected with the virus," describing abused women as "mostly too poor, terrorized, addicted, or isolated to leave an abusive relationship," regardless of the consequences.<sup>32</sup>

Second, it may be unsafe for women to demand safe sex. When compared to non-abused women, victims of IPV report fewer positive expectations related to condom use and prefer to use other protective methods, such as spermicide.<sup>33, 34</sup> Women experiencing IPV are also less likely to actually use condoms and more likely to experience violence as a result of using both male and female condoms, when compared to women who are not experiencing IPV.<sup>35-38</sup>

Third, the effects of violence may lead women to take part in risky sexual behaviors; women who have experienced sexual or physical violence are more likely than women who have not to report more sexually transmitted infections (STIs), and to engage in HIV risk behaviors.<sup>39-42</sup> For example, women who have experienced violence trade sex for money, partner with high-risk men, and use drugs and alcohol more than women who have not experienced it.<sup>43-51</sup> In turn, substance abuse can increase HIV risk by leading to more risky sex, the exchange of sex for drugs, and the reliance on unhealthy coping mechanisms that impair women's ability to make clear decisions.<sup>52</sup>

Fourth, the effects of violence on women's mental health can indirectly lead to HIV through influencing women's behavior. Decreased confidence, self-esteem, and self-worth, as well as increased anxiety and depression may make it difficult for women with violent histories to talk to their partners about sex or even learn to use safe sex skills, which may lead to high rates of risky activities.<sup>53</sup> Women may also feel responsible for their own abuse and may not have the sense of self worth necessary to protect themselves by asking their partners to use condoms.<sup>54</sup> Victims of violence can learn to be helpless if they are subjected to ongoing situations with limited control over their choices or their own bodies. They therefore may lack confidence to assert their needs and rights. Women may also not see the need to protect themselves since traumatic experiences often limit a woman's ability to perceive danger.<sup>55, 56</sup> As a result, women with abuse histories may couple with harmful partners in dangerous situations, without fully acknowledging the risk, or without the ability to minimize it. Additionally, many abused women disassociate to successfully cope with abuse. By blocking out their emotions, experiences, and



feelings, these women numb themselves, which can affect their ability to perceive danger or lead them to take part in dangerous behaviors to regain feeling.<sup>57,58</sup>

In similar ways, once a woman becomes infected with HIV, violence can impede her efforts to have safe sex. Further, once a woman is living with HIV, she also faces the threat of HIV/AIDS-related stigma and discrimination. Therefore, HIV can, in turn, increase a woman's vulnerability to violence. Direct violence can result from HIV status disclosure.<sup>59-61</sup> HIV can be used as a weapon of power and control to keep women in violent relationships. Karen McDonnell et al. found similar lifetime rates of physical and sexual abuse among HIV-positive and at-risk HIV-negative women but concluded that HIV-positive women experience abuse differently. A more common theme among HIV-positive women was the direct association between a woman's HIV status and the reasons that she stayed in her relationship. As one woman noted, "After I found out I was positive, I let him do what he wanted. It didn't make a difference. I was just going to stay."<sup>62</sup>

### **The Health and Human Rights Framework: How Violence Violates Women's Rights**

Human rights are guaranteed by numerous documents and identified in different categories, including civil and political rights and economic, social, and cultural rights. Rights are interdependent and interrelated.<sup>63</sup> For example, violence is a violation of human rights and also violates other human rights. If a woman suffers violence, several of her rights as described in the UDHR may be violated, including the right to be free from cruel treatment, to freedom of movement, and to freedom of opinion.<sup>64</sup> Yet most obviously, experiencing violence violates women's right to health and safety. Multiple international human rights documents and action plans describe states' responsibility to protect citizens' rights. Table 1 presents examples of key human rights documents and primary articles/paragraphs that promise the protection of women's health and safety.

Human Right	Document	Specific Article/ Paragraph	Text Summary
Health	Universal Declaration of Human Rights (UDHR)	25	Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family. <sup>65</sup>
Health	International Covenant on Economic, Social, and Cultural Rights (ICESCR)*	12	Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. <sup>66</sup>
Safety	UDHR	3	Everyone has the right to life, liberty, and security of person. <sup>67</sup>
		5	No one should be subjected to cruel treatment. <sup>68</sup>
Safety	International Covenant on Civil and Political Rights (ICCPR)*	7	Everyone has the right to life, liberty, and security of person. <sup>69</sup>
		9	No one should be subjected to cruel treatment. <sup>70</sup>
Safety	Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*	3	States parties shall take in all fields, in particular in the political, social, economic, and cultural fields, all appropriate measures, including legislation, to ensure the full development and advancement of women. <sup>71</sup>
Safety	Millennium Development Goals	3	Promote gender equality and empower women. <sup>72</sup>
Safety	Beijing Declaration and Platform for Action	29	Prevent and eliminate all forms of violence against women and girls. <sup>73</sup>
Safety	Vienna Declaration and Program of Action	18	Gender-based violence and all forms of sexual harassment and exploitation, including those resulting from cultural prejudice and international trafficking, are incompatible with the dignity and worth of the human person, and must be eliminated. <sup>74</sup>
* Legally binding			

**Table 1:** *Relevant Standards Relating to Health and Safety in Human Rights Documents.*

The principles listed in these documents define rights that enhance well-being and should be embraced by all nations. Governments can freely decide to become parties to

international human rights treaties, which are binding to governments that sign *and ratify* them. If a government only signs a treaty, then it is simply expressing its agreement with the principles but does not intend to be held accountable to uphold the principles. The US is only a signatory of both CEDAW and the ICESCR. While this is a positive assertion that the US supports these critical human rights documents, ratifying them would be an essential step toward prioritizing the protection of women's human rights and the promotion of their health.

There is some recourse for making a grievance against the US government for lack of attention to violence in the context of HIV prevention. The US has ratified the ICCPR. Thus, the US can be held responsible for assuring the right to women's safety (Articles 7 and 9).<sup>75</sup> This means that government programs are obliged to take all possible steps to protect and fulfill these rights. As demonstrated below, standard US prevention efforts currently do not take into account violence. These rights are not adequately respected, protected, or fulfilled by government-sponsored HIV prevention programs for women.

### **Current US HIV Prevention Policies**

The US employs a three-part approach to HIV prevention, which consists of prevention activities directed toward at-risk populations; HIV counseling, testing, and referral services; and prevention activities directed at improving the health of HIV-positive persons and preventing further transmission.<sup>76</sup> Prevention programs and related activities focus on modifying the primary behaviors that transmit HIV, including unsafe sex and unsafe injection practices.<sup>77</sup>

The Centers for Disease Control and Prevention (CDC) is charged with leading HIV prevention efforts in the US, although this agency collaborates with numerous federal, state, and local partners.<sup>78</sup> In 2001 the CDC published a national HIV prevention plan that focused on reducing the number of new infections in the United States and eliminating racial and ethnic disparities in new HIV infections. The plan listed six guiding principles for US HIV prevention programs, including, "Respect for human rights: the CDC places pre-eminent value on human rights in the de-

velopment of its HIV prevention programs and expects grantees to do the same.<sup>79</sup> The CDC, however, does not provide grantees in prevention programs specific instructions about how to address human rights issues such as violence against women. Despite the vast government resources devoted to public health infrastructure in the US, there are currently no standard, comprehensive HIV prevention policies in place to guide the specific content of prevention programs for adult women.

Several key departments in the Department of Health and Human Services (DHHS), however, support evidence-based HIV prevention programs that help HIV-negative and HIV-positive women modify their unsafe sex and injection behaviors (behavioral interventions). These include the CDC, the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMSHA).<sup>80</sup>

The CDC disseminates the results of successful behavioral interventions by summarizing effective programs through reports and websites. These initiatives are particularly important to HIV prevention program planners because government funding opportunities encourage the replication of these interventions or the use of their core elements.<sup>81</sup> In the absence of a universal policy that guides the content of prevention programs, these reports serve as examples of the HIV prevention skills and behaviors prioritized for US adult women.

For example, one such report is the Compendium of HIV Prevention Interventions with Evidence of Effectiveness; another is Replicating Effective Programs/Diffusion of Effective Behavioral Interventions (REP/DEBI).<sup>82, 83</sup> Together, these reports provide HIV prevention program planners with model HIV prevention interventions for different HIV-negative and HIV-positive populations at risk for HIV: drug users, heterosexual adults (the category that includes women), men who have sex with men, and youth.<sup>84, 85</sup> Skills promoted in the interventions for heterosexual adult women are condom use, condom negotiation, decision-making, cognitive coping skills, sexual assertiveness, sexual communication, needle cleaning, planning skills, skills to identify risk behaviors and triggers to risks, and problem-solving.<sup>86-94</sup> Programs for HIV-

positive women additionally help women living with HIV disclose their HIV status to their partners.<sup>95,96</sup>

While the impressive interventions and skills described in the Compendium and REP/DEBI are evidenced to effectively decrease sexual risk behaviors, they do not address the potential impact of violence on women's risk behaviors. If there is to be a concerted, effective action to reduce HIV among US women, then the government must develop a standard for best practices that includes attention to violence prevention and integration of violence prevention into HIV prevention activities.

### **US Prevention Efforts' Failure to Adequately Fulfill Women's Rights**

Both the Compendium and REP/DEBI combine heterosexual men and women into one prevention category. These groups need distinct prevention strategies, however, because they need different skill sets to protect themselves from HIV and other STIs. For example, heterosexual men need to use condoms, while heterosexual women need to safely convince men to use condoms. Key program skills are not specific to women who experience violence, even though a large percentage of women report this history, which is overwhelmingly connected to their risk behaviors.

Certain skills may lead to safer sex, but, if learned and utilized, they can also increase a woman's risk of violence. Several aforementioned studies indicate that women fear asking their partners to use condoms and often suffer physical and sexual abuse as a result of such efforts. Because women may not be able to safely practice these skills, they may never effectively integrate them into their lives. The interventions in the Compendium and REP/DEBI are described as effective for increasing episodes of safe sex and women's use of specific skills. We still do not fully understand how to measure and address the costs that women must endure to meet these goals, however, nor do we know whether women can maintain them over time.

As stated above, a woman who is exposed to violence may utilize unhealthy coping styles that make it difficult for her to truly integrate new risk reduction skills. For example, a woman in a violent relationship may have learned that

being passive and acquiescent has saved her from abuse. She may therefore be reluctant to act assertively. Her capacity to think clearly may also be impaired by past or continual stress. This often leads victims of violence to make decisions based on impulse and the need to protect themselves from violence, versus using careful decision-making processes prescribed by risk prevention programs.<sup>97</sup> A successful intervention, then, should teach skills that can be used by women in a variety of contexts, including violent relationships.

Lastly, current emphasis on condoms and negotiation skills and neglect of violence draws attention and resources away from acknowledging and treating the complex root causes of HIV among women, which include the violation of women's right to emotional, physical, and sexual safety.

### **Lessons Learned for HIV Prevention Policies in the United States**

Together, ecosocial and human rights frameworks suggest opportunities to strengthen US HIV prevention policies to more effectively meet women's needs. Embodiment places violence and its effects as central to women's vulnerability to HIV, enabling real and complex causes of HIV and sexual risk practices to be explored and addressed. Ecosocial theory recognizes the various levels of women's risk, such as environmental, social, individual, and biological. Only through understanding these connections can comprehensive and appropriate HIV prevention policies be developed.

Framing initiatives based on the importance of protecting human rights makes a compelling statement about the government's commitment to protecting and promoting women's safety and health. The US can follow international examples such as the Declaration of Commitment on HIV/AIDS and the International Guidelines on HIV/AIDS and Human Rights.<sup>98, 99</sup> Guideline eight specifically indicates that "states, in collaboration with and through the community, should promote a supportive and enabling environment for women, children, and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services, and support to community groups."<sup>100</sup> HIV prevention interventions based on the integration of human

rights and ecosocial frameworks can fill existing gaps in HIV prevention policies and programming by ensuring a standard through which prevention programs are accountable to protect women from HIV and violence, and by addressing the multiple layers of women's risk behaviors, including violence and its effects.

Table 2 explains policy suggestions generated from using ecosocial and health and human rights frameworks to analyze HIV prevention.

HIV prevention best practices include skill teaching combined with education on multiple levels (individual, group, community).<sup>101</sup> The above-mentioned concepts represent innovative approaches generated from the integration of health and human rights and ecosocial frameworks and a combination of best practices from two disciplines. Violence prevention best practices include a focus on primary prevention to uproot the causes of violence and on structural-level collaborations that better meet the needs of violence victims.<sup>102</sup> Because IPV and HIV are interrelated, proposed solutions require integration and collaboration. Further research is needed to understand what women who experience violence need in order to reduce their risks, how different and novel theories can provide the foundation for innovative programs, and how seemingly diverse disciplines and practices can collaborate to create solutions. Applying human rights and ecosocial frameworks offers both an innovative approach and a starting point for further exploration.

## **Conclusion**

For violence victims and survivors, current HIV prevention strategies such as those promoted by US government-sponsored initiatives may actually do more harm than good. In order to become truly effective tools in the fight against HIV/AIDS, interventions need to address the links between violence and risk. Since its start, HIV/AIDS has most severely impacted those who face discrimination, stigma, and lack of decision-making power.<sup>103</sup> The current epidemiology of HIV/AIDS reveals the connection between social inequities and health. Prevention policies must be re-framed to adequately confront this connection. It is clear that those whose basic rights, such as the right to safety, are

Suggested HIV prevention policy changes	Insight offered by ecosocial and human rights frameworks
<b>US government-sponsored HIV prevention programs should:</b>	
Create comprehensive HIV prevention policies that guide the content of HIV prevention programs; women's programs should be required to address violence and the basic rights/needs of women;	This change will better enable government programs to respect, protect, and fulfill women's rights relating to safety and health.
Conduct further research with HIV-positive women who experience violence to elucidate safe risk reduction practices; and	This change will help ensure that HIV prevention programs do not violate women's rights and/or put women in more danger by recommending unsafe strategies. It will also ensure the design of programs that respect, protect, and fulfill basic rights.
Conduct further research on female-controlled barrier methods, such as microbicides, to prevent HIV and other STIs, to give women safe and additional options for HIV prevention.	This option would better equip government-sponsored HIV prevention programs to protect, respect, and fulfill women's rights to safety and health.
<b>US government-sponsored HIV prevention programs should:</b>	
Include violence screening for participants;	Embodiment clarifies the serious effects of violence on women. All of the specific prevention measures listed will promote numerous basic rights outlined in international human rights treaties and declarations, including women's right to health, an adequate standard of living, safety, and freedom from discrimination, violence, and cruel treatment.
Form collaborations at the structural level that help women readily access referrals such as medical, legal, and housing services;	
Provide women with opportunities to receive additional individual-level support and mental health counseling;	
Teach skills specific to abused women, such as skills to help women understand how their experiences with violence affect their risk behaviors, and skills to create safety plans;	
Involve prevention staff who are trained and qualified to appropriately address violence; and	
Evaluate programs in ways that consider both sexual risk reduction and safety from violence; evaluation instruments should capture women's experiences with violence.	Prevention programs need to be accountable by documenting and analyzing information about violence as well as HIV risk behaviors. These findings will help ensure that programs ensure women's rights.

**Table 2.** *Integrating Human Rights and Ecosocial Frameworks.*



violated, are more vulnerable to acquiring HIV and less equipped to manage the virus and change their sexual risk behaviors if they become infected.<sup>104</sup> Ecosocial theory helps explain how HIV results from the way women incorporate their surroundings and experiences, including gender discrimination that leads to violence. It facilitates an analysis of the ways in which prevention policies impact health. A health and human rights framework calls on governments to legally and politically respond to inequality to protect health. Together, these frameworks offer insights and lessons learned to form the basis of HIV prevention policies that more appropriately respond to the HIV/AIDS epidemic among US women.

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