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Ending Gender Inequalities: Addressing the Nexus of HIV, Drug Use, and Violence with Evidence-Based Action

April 12-13, 2016

Edited by Wendee M. Wechsberg, Stephanie Hawkins Anderson, and Brittni N. Howard

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List of Abbreviations

ACA	Affordable Care Act
AOD	Alcohol and other drugs
ARV	Antiretroviral
ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
DHAP	Division of HIV/AIDS Prevention
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
EAAA	Enhanced Assess, Acknowledge, Act
EROC	End Rape on Campus
GBV	Gender-based violence
HB2	North Carolina House Bill 2
HIVRR	HIV risk and risk reduction
IPV	Intimate partner violence
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
MSM	Men who have sex with men
NGO	Nongovernmental organization
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
PEPFAR	President's Emergency Plan for AIDS Relief
PHIT	Personal Health Intervention Toolkit
RCT	Randomized controlled trial
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SIJARIEMAS	Sistem Informasi Jejaring Rujukan Maternal & Neonatal
SMS	Short message service
STI	Sexually transmitted infection
TS	Transactional sex
UNC	University of North Carolina at Chapel Hill
USAID	United States Agency for International Development
VAW	Violence against women
WC	Women's CoOp
WHC	Women's Health CoOp
WHC+	Women's Health CoOp PLUS
WHO	World Health Organization
WINGS	Women Initiating New Goals for Safety
WORTH	Women On the Road To Health
YMSM	Young men who have sex with men
YWC	Young Women's CoOp

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Abstract

The RTI Global Gender Center held an action conference in Chapel Hill, North Carolina, on April 12-13, 2016. The overarching goals of the conference, titled *Ending Gender Inequalities: Addressing the Nexus of HIV, Drug Use, and Violence with Evidence-Based Action*, were to facilitate networking and to establish new collaborations, to broaden understanding of evidence-based science, and to address the challenges and solutions needed to scale up effective programs. Nearly 30 countries were represented, with 246 in-person attendees and 75 attending via live global streaming. The conference brought together leading gender experts, civil society members, policy makers, survivors, implementing partners, and students from around the world with the passion and commitment to make a difference in ending gender inequalities. This proceedings summarizes the 13 plenary speakers and panelists who shared their expertise on HIV, drug use, gender-based violence, campus sexual assault, policy and funding, and the need to scale up effective programs. Nine breakout sessions featured 29 talks on evidence-based research at the nexus of HIV, drug use, and gender-based violence. Additionally, 55 posters were presented. The conference concluded with actionable future steps that include priority areas and suggestions for scaling up globally.

Introduction

Wendee M. Wechsberg, Stephanie Hawkins Anderson, Brittni N. Howard, and the RTI Global Gender Center Conference Planning Committee

On April 12 and 13, 2016, the RTI Global Gender Center hosted a first-of-its-kind action conference on ending gender inequalities at the nexus of HIV, drug use, and gender-based violence (GBV). The action conference was designed to help and encourage attendees to network and establish new collaborations, broaden understanding of evidence-based science, and address the challenges and solutions needed to scale up effective programs. It often takes nearly two decades to translate research into practice. Consequently, generating actionable solutions and expanding our knowledge of successful intervention implementation and how it can be done at a faster pace on a global scale is essential. Generating solutions and expanding knowledge starts with greater understanding of what the problems are, what proven programs and interventions are available, and the right tools and strategies for wide-level implementation.

The conference brought together leading gender experts, civil society members, policy makers, survivors, implementing partners, and students from around the world who have both the passion and the commitment to make a difference in ending gender inequalities.

Why the Nexus of Gender, HIV, Drug Use, and Violence Through Evidence-Based Interventions?

Addressing gender inequality at the nexus of HIV, drug use, and GBV through evidence-based interventions is vital in achieving global equality. The importance of scaling up proven research, practices, and programs is becoming increasingly critical every day.

Gender inequalities continue to foster power dynamics that put individuals at greater risk of exposure to HIV, drug use, and violence.[1] Worldwide, women constitute more than half of all people living with HIV, and the majority living with HIV/AIDS live in Sub-Saharan Africa. Among childbearing women, HIV/AIDS is the leading cause of death.[2] Globally, one in three women experience physical or sexual violence, most often perpetuated by an intimate partner.[3] Women who experience intimate partner violence (IPV) are 1.5 times more likely to acquire HIV and other sexually transmitted infections (STIs), and almost twice as likely to have alcohol use disorders, than women who do not experience IPV.[4] These cyclical risks and inequalities have created a global crisis impacting all genders, and must be challenged, addressed, and ultimately changed. The fight to do so must be a strategic one, addressing the syndemic of HIV, drug use, and violence through proven multifaceted gender-sensitive and culturally sensitive approaches—not later, but now.

Conference Objectives

Conference attendees actively participated in multilevel collaborative sessions that discussed common challenges and barriers to scaling up proven interventions and programs, and equipped participants with problem-solving tools to implement the strategies with the best evidence.

The objectives of this action conference were to

- enhance knowledge of evidence-based research and practice to reduce HIV, drug use, and GBV;
- expand collaborative networks to identify successes and challenges in evidence-based research and practice; and
- create a roadmap for facilitating greater implementation success in local and global markets.

We hope that these proceedings can help with the development of creative and effective solutions for greater implementation success globally by reaching key populations. The proceedings contain summaries of the talks and poster abstracts.

Our hope is to continue the commitment to ending gender inequality at the nexus of HIV, drug use, and GBV.

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PLENARIES

Welcome

The *Ending Gender Inequalities: Addressing the Nexus of HIV, Drug Use, and Violence with Evidence-Based Action* conference opened with remarks from the RTI President and CEO, Dr. Wayne Holden. In welcoming the attendees to North Carolina, Dr. Holden noted that RTI is opposed to the HB2 law that was put in place a few weeks before the conference and added that RTI fully supports gender equality and is a values-driven organization committed to improving the human condition. He went on to note that RTI is fully committed to ending gender inequality. He thanked the attendees for coming to the conference and noted that he was sure the dialogue over the course of the next 2 days would generate many important ideas, directions, and actions people would feel motivated to take regarding research, programs, and advocacy as they relate to the conference.

Why Gender Inequality Is #SmartDev

Susan Markham, MA

Ms. Markham noted the importance of exploring the nexus of HIV and AIDS, drug use, and violence, and said that we talk about all of these topics separately but rarely find ways to discuss how they link to one another. Discussions that include the nexus of HIV and AIDS, drug use, and violence can help us better address these challenges around the world, especially for women and girls.

Ms. Markham described why and how including gender at the center of these conversations is critical for our success. The United States Agency for International Development (USAID) promotes the belief that gender equality and women's empowerment is not simply a part of development, but instead is at the core of development. Health and violence affect women and men differently, and the approach we take with our work should reflect this. Women and girls are often the first affected by poor governance, lack of resources, and inequitable gendered norms. Globally, young women between 15 and 24 years of age are more than three times more likely to be HIV positive than young men. In many parts of the world, access to HIV testing is also a challenge for young women. The connection between HIV, drugs, and violence is a global phenomenon preventing people, especially women and girls, from living healthy, productive lives free from violence.

Ms. Markham posed the question, "How do we take these challenges and address the root causes?" First, we invest in education. We know that advancing girls' education can unlock human potential on a transformational scale. Countries that invest in girls' education have lower maternal and infant deaths, lower rates of HIV and AIDS, and better childhood nutrition. Yet around the world, 62 million girls are not in school. An estimated 100 million will drop out before completing primary school. USAID invests $1 billion annually in education programs. Last year, USAID was one of the founding agencies for "Let Girls Learn," which was launched by President and Mrs. Obama to ensure that adolescent girls get a quality education by addressing the obstacles that keep them from enrolling in school. Second, we must continue our work to reduce

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GBV. GBV halts progress in every area. It not only increases the risk of HIV, but also undermines societies, costing millions in productivity. USAID works to prevent and respond to GBV in more than 40 countries worldwide in every region where they work. Third, we must work to connect women to technology. Women in developing countries are 25 percent less likely to be online that men, and 200 million fewer women have access to mobile phones. Technology has the power to create connections, foster learning, increase economic growth, and provide life-saving information. It can also help change social norms and stereotypes and reduce inequality. USAID is investing heavily in science, technology, innovation, and partnerships in all of their work. Ms. Markham noted that we must also be careful to specifically design mobile technology and applications for women and girls. Fourth, we should promote economic opportunity. Women are key drivers of economic growth. To end extreme poverty, feed the planet, and build vibrant economies, women and girls must gain access to capital, land, markets and training, and leadership opportunities. Women impacted by violence, HIV, and drug use often struggle to find jobs, have lower economic productivity, and may find it hard to go to work. Loss of income as a result of these burdens has a lasting impact on families and communities.

Actionable Charge to the Field

Finally, we must empower women as decision makers and leaders. Despite representing half of the global population, women comprise less than 20 percent of the world's legislatures. Women are largely absent from national and local decision-making bodies; they struggle to have a voice in peace building and are excluded from political processes. Women's meaningful participation in politics affects both the range of policy issues that are considered and the types of solutions that are proposed. Gender must be at the center of our conversation over the next 2 days and around the world with regard to development.

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Biological Strategies to Prevent HIV Transmission: Special Considerations for Women

Myron S. Cohen, MD

Dr. Cohen started his talk by describing his presentation as a primer in biology and an update in where we are and what we are trying to accomplish. Dr. Cohen noted that HIV transmission is vertical from mom to baby and that transmission has come under significant control over the years because of many breakthroughs in public health. The most significant challenge remains with sexual transmission of HIV. He shared that transmission always takes a discordant couple. Everyone in a relationship is either in concord and positive, in concord and negative, or discordant.

In terms of transmission, what we are really concerned with in male transmission is the foreskin, which is the main site where a man acquires HIV. The cervix is likely the main site for female acquisition. In both males and females, the rectum is another important site for transmission. The transmission of HIV is much higher with anal intercourse than vaginal intercourse.

Five main prevention strategies are outlined below.

1. The first thing we do is create behaviors that reduce risk (e.g., help seeking and male circumcision). Condoms alone, although they are critically important and should be deployed, are not enough.
2. Another approach is trying to treat our way out of the epidemic. The current worldwide policy of 90-90-90 is an ambitious treatment target to help end the AIDS epidemic. By 2020, 90 percent of all people living with HIV will know their HIV status; 90 percent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90 percent of all people receiving antiretroviral therapy will have viral suppression. Research that will soon be published will document why it is believed that universal test and treat is an incredibly wise public health policy.
3. Using antiviral treatment as a pre-exposure prophylaxis is a prevention strategy with significant attention. Gender differences appear to exist in the pharmacobiology or pharmacodynamics of these drugs. Dr. Cohen noted that we should not assume that the trials that work for men will work the same for women.

   There are two types of topical agents used in antiviral treatment. One is tenofovir gel, which women place in their vagina to prevent HIV acquisition. The results have been incredibly mixed and will not be moving forward. The alternative, dapivirine rings, has attracted a lot of attention. The rings should be placed on the endocervix and are supposed to remain in place for a month to prevent HIV acquisition. A recent and forthcoming paper describe the benefits of this treatment. No benefits were found for young women under age 21. For women between 21 and 25 years of age, the benefit was between 37 and 50 percent. The upper limit of the benefit is unknown. For example, do these topical agents have a benefit up to 50 percent? If they do, should we be developing them?

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4. Injection drugs (cabotegravir and rilpivirine). One shot lasts approximately 8 weeks. We do not understand these drugs as well in women as we do in men. Implantable devices are also used for delivering antivirals.
5. The antibody-mediated immunity strategy includes both active and passive immunity. Active immunity is created by injection of an immunogen (vaccine) that stimulates antibodies that prevent an infection. With this approach, boosters are needed to maintain the immune response. Passive immunity results from infusion of antibodies that would or could be stimulated by a vaccine. With this approach, antibodies can last many weeks. Dr. Cohen highlighted that a new study that is just beginning includes 1,300 women and 2,600 men across the globe to explore the antibody-mediated immunity strategy.

Actionable Charge to the Field

We have spent 25 years understanding HIV transmission, and that leads us to prevention strategies. We are always looking to prevent an HIV-infected person from transmitting HIV to their HIV-negative partner.

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The HIV IPV Nexus: What Do We Know? What Works? And Where Next?

Rachel Jewkes, MD, MSc

Dr. Jewkes acknowledged that intimate partner violence (IPV) is a global problem: one-third of women globally have experienced physical or sexual IPV in their lifetime. There is wide regional variation in lifetime and past-year exposure. The strongest evidence we have comes from two studies that look at HIV acquisition in IPV-exposed women in South Africa and Uganda who were HIV negative.

In a South African study, women who experienced low power within their relationship had about a 50 percent increased acquisition rate for HIV over 2 years of follow-up compared with women who had more power in their relationships. Even after taking that into account, women who experienced IPV similarly had an increased risk of HIV acquisition. This was remarkable similar to the research from Uganda, which found almost identical increased risk for HIV acquisition. We know that in some settings, women who experience IPV are at much higher risk for HIV acquisition.

The Demographic and Health Study has generated substantial attention because it is a large survey that has been increasingly measuring exposure to IPV and exposure to controlling behaviors in many counties. Dr. Jewkes noted that it is important to consider both direct and indirect HIV transmission pathways. The direct transmission comes about when a woman is coerced into sex by a man in the context of rape. If he has HIV, then she has a risk of direct acquisition of HIV during the rape. In terms of understanding the nexus of violence against women (VAW) and HIV, the contribution of this pathway is small. Indirect transmission is much more important. We know that gender and relationship power inequality and rape, child sexual abuse, and IPV are circular problems. Having been abused as a child increases a woman's likelihood of being exposed to more inequitable relationships, more control and violence in relationships, and further experience of sexual abuse as an adult, and all of these experiences perpetuate the same cycle of abuse in the next generation. Experiencing these factors can cause psychological distress, reduced protective powers, and more risky sex, which ultimately can lead to HIV acquisition. Adding to this, men who perpetrate IPV have a higher HIV prevalence. The drivers of IPV perpetration by men include poverty, childhood abuse exposure, alcohol/drug abuse, depression, frequent quarrelling, and a cluster of factors indicative of entitled gender-inequitable masculinity (e.g., more partners, transactional sex, controlling behaviors, gender-inequitable attitudes).

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Dr. Jewkes noted that although the field has been underfunded, during the past 10 to 15 years there has been a small but growing body of evidence to guide our future actions. Four general areas of intervention have strong evidence of effectiveness:

- Women's economic empowerment combined with gender-transformative approaches (e.g., microfinance, cash transfers, and so on)
- Group-based gender-focused interventions (e.g., Stepping Stones)
- Social norm change in communities, focusing on women/girls and men/boys (SHARE in Uganda, One Man Can in South Africa, SASA in Uganda)
- School-based (in class or after-school) curriculum interventions (4th R curriculum in Canada, PREPARE curriculum in South Africa)

After describing the areas that have strong evidence of effectiveness, Dr. Jewkes described what the field should be doing now. She highlighted that we should focus on scaling up effective interventions to prevent violence, support innovation and adaptation of effective intervention modalities for new settings, and ensure that primary prevention is rolled out against a backdrop of scaled-up resources for women and girls experiencing abuse (e.g., shelters, women's nongovernmental organizations (NGOs) and counselling services, legislation, and legal protection/redress). Dr. Jewkes noted that we are trying to move the field forward, and she described the next steps for research in four areas:

- Investment in research, so that we can better understand how interventions work and can be optimized
- Economic analysis to deepen understanding of the cost-effectiveness of interventions and cost changes as interventions are scaled up
- Delivery platforms for scaling up interventions of known effectiveness and generating evidence of impact at scale
- Research on new modalities of intervention and their contributions, including
  - substance abuse prevention and depression treatment,
  - parenting intervention to prevent child abuse and protect children, and
  - whole-school interventions.

Actionable Charge to the Field

As Dr. Jewkes concluded her talk, she said she hoped that she gave the audience a lot to think about, it was exciting that everyone had come together, and there were so many connections. She also noted that we cannot solve the problem of VAW without being able to address substance abuse, and we will not be able to get on top of the HIV epidemic until we address the problems of substance abuse, gender inequity, and GBV.

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Challenges at the Nexus of HIV, Drugs, and Violence: The Need for Gendered Interventions and Actionable Solutions

Wendee M. Wechsberg, PhD

Dr. Wechsberg's presentation began with a description of the context associated with the nexus of HIV, drugs, and violence for women. She shared that globally, 16 million women are living with HIV; violence against women and girls increases their risk of acquiring HIV; substance abuse is one of the major causes of GBV; women's involvement in drug use and the drug trade reflects the decreased economic opportunities and lower political status that women face in everyday life; women and adolescent girls who use substances are especially vulnerable; stigma among women who use drugs is higher than among men; and women have poor access to prevention, treatment, and care. Dr. Wechsberg added that gender inequality leads to compromising behaviors. She described some of the main reasons we need gendered interventions for women using alcohol and other drugs (AOD), including extreme poverty and other social determinants; biological and anatomical vulnerabilities; health and gender disparities; lack of access to services and discrimination within services; stigma as a drug user; a woman's role in society; women's lack of power; GBV; and cultural norms and sexual expectations.

Dr. Wechsberg described some of the guiding principles of gendered prevention interventions and offered the Women's Health CoOp (WHC) as one actionable solution for women at the nexus of HIV, drugs, and violence. Since 1998, the WHC has been implemented with numerous populations in multiple countries and cultures. The WHC is an evidence-based intervention grounded in an empowerment framework that combines education with skills building and personalized risk assessment and action plans. It has been adapted in many countries throughout the world and has had a positive impact on several epidemics (AOD, HIV, and GBV). Dr. Wechsberg acknowledged that 30 years into the HIV epidemic, improvements are being realized. She provided guidance on how the field could achieve 90-90-90 with women by 2020, which included being innovative and using the NIH Seek, Test, Treat, and Retain paradigm. However, there is still a need to scale up evidenced-based and informed interventions and programs that empower key populations to reduce risk. We still need to develop structural interventions that increase education and economic development, and we need to improve access to sexual and reproductive health, encourage access to linkages for other health services for comorbid conditions, and integrate and implement interventions in settings and venues where women can be reached with global partners.

Actionable Charge to the Field

Dr. Wechsberg concluded by saying that we live in a multicultural, global community. She added that there is hope, and solutions with gendered, evidence-based interventions have been adapted, tested, and implemented to address the nexus of HIV, drugs, and violence. Now, we need to act to scale them up.

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Microfinance for HIV Interventions for Female Sex Workers with Substance Use and GBV History: A Promising Evidence-Based Model

Nabila El-Bassel, PhD

Dr. El-Bassel's presentation focused on microfinance as a structural intervention for HIV and GBV among female sex workers who use drugs. She described microfinance as one of the fastest-growing strategies to address poverty and HIV in developing countries and as an important structural intervention. She added that structural interventions are designed to address the physical, social, and economic risk environments that create vulnerabilities for HIV acquisition and transmission. Female sex workers with a history of substance use face vulnerabilities such as lack of access to education, living in poverty, unemployment, gender inequalities, GBV, stigma, and harsh drug- and sex work–related policies. Dr. El-Bassel summarized a systematic review that included 15 studies focused on microfinance strategies for HIV risk and risk reduction (HIVRR), HIV testing, and adherence. The populations targeted in these studies included low-income women, high-risk youth, and female sex workers. She reported that the HIV outcomes associated with these studies found that microfinance plus HIVRR compared to HIVRR alone had better outcomes. She also noted the lack of biological assessments of HIV and other sexually transmitted infections (STIs), and that our understanding of the mechanisms between microfinance and HIVRR is limited.

Dr. El-Bassel also described the Undarga trial in Mongolia. The study components included evidence-based HIVRR, financial literacy, business development, mentoring, and matched savings. This study, funded by the National Institutes of Health (NIH R01DA036514-01A1), found that matched saving and asset building, paired with financial literacy and small business development, can lead to sexual risk reduction without microlending. Study findings also revealed an increase in women's confidence in themselves, in their future, and in their negotiations with banks and with employment. Two major challenges were identified: opening a business is difficult; and stable employment with vocational training is needed. Dr. El-Bassel also described the evaluation of a microfinance intervention for high-risk women in Kazakhstan, and noted that the challenges confronted in this study included the cultural perspectives on saving, limited familiarity with the banking system, fear of regulation, lack of legal documents, being HIV positive (because HIV-positive women are barred from manicure/pedicure training), stigma, and access to services.

Actionable Charge to the Field

Dr. El-Bassel concluded her presentation by acknowledging that the goal of ending the HIV/AIDS epidemic cannot be achieved without attention to women who use drugs and without structural interventions.

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Addressing Gender Inequality in Global Health

Eric Goosby, MD

Ambassador Goosby introduced his presentation by providing the audience with a global summary of the AIDS epidemic through 2015. There are a total of 36.9 million people living with AIDS and 2.6 million of them are children under age 15 years. Approximately 2 million people were newly infected with AIDS in 2014. Of this total, 220,000 were children under age 15. In 2014, approximately 1.2 million deaths were attributed to AIDS with 150,000 of these deaths among children under age 15. According to 2015 results of the President's Emergency Plan for AIDS Relief (PEPFAR), 68.2 million people were tested and counseled for HIV, 9.5 million men, women, and children are on treatment, and 5.5 million orphans and vulnerable children received care and support services. Ambassador Goosby shared the challenges PEPFAR experiences related to gender equity: HIV is the leading cause of death and disease in women of reproductive age in low- and middle-income countries; 60 percent of the people in Sub-Saharan Africa living with HIV are women; in some countries, the prevalence among women 15 to 24 years of age is, on average, three times higher than among men of the same age; systematic disadvantages expose adolescent girls and young women to risk of HIV at increasingly early ages, when they are at great biological and social vulnerability; and many girls forced into sexual activity and marriage are vulnerable to unintended pregnancy, HIV, sexual violence, and exploitation.

Ambassador Goosby also described PEPFAR's Gender Strategy that was designed to address these challenges. The strategy includes increasing gender equity in HIV/AIDS programs and services, including access to reproductive health services; reducing violence and coercion; engaging men and boys to address norms and behaviors; increasing women's and girls' legal protections; and increasing women's and girls' access to income and productive resources, including education. He added that PEPFAR has invested significant resources in developing evidence-based tools to improve the health of women and girls and improve gender equality; strengthen surveillance efforts to ensure that girls and young women are represented in research; and disaggregate data by sex and age to track service uptake and provision. Ambassador Goosby concluded his presentation by describing the DREAMS Initiative. The goal of DREAMS is to help girls develop into Determined, Resilient, Empowered, AIDS-free, Mentored and Safe women. DREAMS was a partnership launched in 2014 to reduce HIV infections among adolescent girls and young women in 10 Sub-Saharan African countries. DREAMS involves delivering a core package that combines evidence-based approaches that extend beyond the health sector, addressing the structural drivers that increase women and girls' HIV risk, including poverty, gender inequality, sexual violence, and a lack of education.

Actionable Charge to the Field

Ambassador Goosby noted some lessons learned look to the future. Science must drive decision making, collaboration is critical, barriers need to be broken down, services need to be integrated, and we must work to reduce stigma (e.g., injection drug users [IDUs], sex workers).

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Drug Use, Gender, and HIV—The Challenge of Evidence-Based Responses to Global Health and Security

David Wilson, PhD

Dr. Wilson presented on evidence-based responses to the global health and security challenge of drug use. Dr. Wilson opened his presentation by stating that drug use underscores the importance and challenges of evidence-based programming, and highlights the centrality of multiple overlapping vulnerabilities. He discussed the multilevel areas of health, security and gender burden, domestic ownership and financing, optimized investment costs, institutional mechanisms, and major opportunities to invest for impact to adequately address drug use.

Drug use is a major source of global disease burden, as HIV rates remain high among both male and female injecting drug users. Dr. Wilson discussed the influence of drug use on countries in Eastern Europe and Central Asia. These regions have had the least progress against drug use and the fastest and only growing HIV epidemic in the world. Dr. Wilson stated that in Vietnam, HIV prevalence among sex workers is almost wholly a function of injection drug use. He added that drug use is linked to economic crisis and recession. Dr. Wilson stressed the need to address the challenge of strengthening domestic ownership and financing. Many countries are still relying on external financing, especially for the highest-impact interventions. However, optimized costs of managing this challenge are not prohibitive. The World Bank created an allocative deficiency tool to optimize the costs of managing interventions. Dr. Wilson shared that by allocating efficiently, we can have a major impact without immense resource constraint. He further expressed the importance of institutional mechanisms for sustainability of programs and the necessity of establishing governments as civil partners. Dr. Wilson discussed major opportunities to invest for impact, including in the highest-impact interventions, integration in usual health care, supportive context and civil society partnerships, procurement, and delivery and demand creation.

Actionable Charge to the Field

Dr. Wilson concluded his presentation with a discussion of the importance of action over inaction. He stated that inaction is not the equivalent of doing nothing, and although it is difficult to reverse an epidemic, investment in harm reduction can be both effective and cost-effective. By investing in the best-evidence interventions and programs, social benefits exceed investments and profit entire populations, resulting in a global best buy.

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PANELS

Panel 1

After "The Hunting Ground": Campus Sexual Assault—Policy to Programs to Evaluation

This panel served as a platform for experts to discuss current challenges and barriers in identifying and preventing campus sexual assault. Panelists discussed the magnitude of this issue and strategized new pathways and solutions that engage students, faculty, administrators, and the wider community.

Specifically, speakers discussed existing data on campus sexual assault, viable school and government policy options, and developing strategies to ensure that evidence-based interventions are scaled up successfully.

Status of Research on Sexual Assault on College Campuses

Chris Krebs, PhD

Dr. Krebs, RTI, presented on the status of research on sexual assault on college campuses, and the importance of campus climate surveys to address the underreporting of assault. Dr. Krebs stated that sexual assault continues to be a widespread national problem on university and college campuses. The number of incidents is vastly underreported. Cases that are reported are often inadequately addressed, with a lack of resolution and a lack of outcomes in favor of the survivor. Dr. Krebs further explained that reporting of rape and sexual assault is low because of the sensitive nature of the misconduct, low confidence in the institution and law enforcement, and the definitional ambiguity of "rape" and "sexual assault" incidents. For these reasons, accurately measuring incidents of sexual assault is challenging.

RTI developed and tested the Campus Climate Survey Validation Study instrument and methodology for collecting valid and reliable data on sexual harassment, sexual assault, and campus climate. The survey was implemented over the span of about 57 days among approximately 23,000 undergraduates across nine schools. Dr. Krebs reported that the prevalence rate for completed sexual assault experienced by undergraduate females during the 2014–2015 academic year, averaged across the nine schools, was 10.3 percent. He added that data indicated that 1 in 4 female seniors experience some form of sexual assault during their college experience. In addition, only 4.2 percent of rape incidents and, even fewer, 1.1 percent of sexual battery incidents were reported to law enforcement. Results solidified the evidence that statistics reported to law enforcement grossly underestimate the magnitude of rape and sexual assault occurring on campus.

Dr. Krebs concluded his presentation with lessons learned and actions for the future in conducting campus sexual assault surveys. Lessons learned included that school-specific results are crucial, as assault rates vary across campuses; a standardized approach enables comparisons; incentives drive response rates, representativeness, and quality; surveys need to be fielded for at least 30 days; and surveys must be functional on mobile devices. Valid information on sexual harassment, sexual assault, and campus climate will assist institutions in identifying factors associated with sexual victimization and in the development and implementation of policies and programs to reduce sexual assault on campus.

We Need to Reduce the Sexual Violence Women Students Experience Now: Challenges of Scaling Up the EAAA Program After a Successful RCT

Charlene Senn, PhD

Dr. Senn, University of Windsor, presented on the need to develop effective interventions to reduce the sexual violence female students experience and the obstacles in facilitating wide-level implementation. Dr. Senn stated that, currently, no proven sexual assault prevention programs or interventions are available on campuses. She added that in some cases, colleges and universities are reluctant to administer such programs for a number of reasons, such as concern about survivor-blaming interventions and the challenge of limited resources. Instead, many colleges and universities prefer bystander interventions. Dr. Senn advocated for a multifaceted approach to fully address the reality of campus sexual assault, in which the goals are to stop perpetration altogether, change the social and broader culture, and provide the information and skills needed for self-defense.

In response to this need, Dr. Senn developed the Enhanced Assess, Acknowledge, Act (EAAA) sexual assault resistance education program for women in their first year of university or college. The program is built on a culmination of over a decade of development and research, and is based on feminist and social psychological theories, including feminist self-defense and activism. The objective of the 12-hour EAAA program is to decrease the likelihood that young women will experience completed sexual assault when they come in contact with coercive men by decreasing the time they need to assess the situation as dangerous; reducing the emotional obstacles to acknowledging the danger; and maximizing the chance they will act by using forceful verbal and physical self-defense tactics, when necessary. The program is further enhanced by addressing relationships and sexuality.

Dr. Senn shared that the program resulted in a 46 percent reduction in completed rapes and 63 percent reduction in attempted rape experienced over 1 year, when compared with the control group. This makes the EAAA program the only intervention to decrease the sexual violence experienced by women while attending university. Dr. Senn further added that at 24-month follow-up, data revealed favorable outcomes in increased perceptions of personal risk of acquaintance rape, increased self-defense self-efficacy, and decreased self-blame.

Dr. Senn concluded her presentation with a discussion of the challenges for implementation and scale-up of the EAAA program, including universities' preference for a fast, easy, one-time, low-cost solution, and pushback from feminists on campus and in government roles arguing that any intervention for women is, by definition, woman-blaming and should not be undertaken. Dr. Senn stated that, going forward, it will be vital to make the EAAA's values more visible, and the program serves as only one piece of a more comprehensive solution.

Breaking the Silence: The National Student Movement to End Campus Sexual Assault

Sofie Karasek, BA

Ms. Karasek, cofounder of End Rape on Campus (EROC), discussed the rise of campus sexual assault from localized student movements to a national-level issue. Ms. Karasek's presentation was guided by nationwide response patterns to sexual assault among universities and colleges, state-by-state strategies, and future goals and policies. Ms. Karasek shared her personal story as a survivor of sexual assault that happened when she was an undergraduate, and her frustrations with the unsupportive administrative system and lack of appropriate action against the serial perpetrator.

Ms. Karasek discussed how colleges' and universities' lack of effective procedures and policies amplify the adverse effects of sexual assault on a survivor's psychological well-being, while compounding additional distress and hostility. Ms. Karasek stated that students across the country connected over social media and discovered new strategies to hold their institutions accountable with the US Department of Education through the use of Title IX. Under Title IX's gender equity law, which prohibits discrimination in gender education—including sexual harassment and violence resulting from a hostile environment—students were able to reshape campus sexual assault as a national issue rather than as a problem isolated on specific campuses. Institutions are held accountable for addressing hostile environments, including sexual assault and harassment, preventing recurrence, and addressing the harmful effects on survivors in the event of an assault.

Ms. Karasek shared that the EROC organization has assisted more than 100 students in filing complaints of sexual assault against 40 institutions since it was founded in 2013. In doing so, the organization discovered nationwide patterns, including institutions refusing to sanction assailants of drugged, incapacitated, or sleeping students; refusing to sanction serial perpetrators; allowing students found responsible for sexual assault to transfer from their university to another university; failing to communicate during the investigation or outcome of the proceeding; stalling the investigation of cases so that the survivor and/or the assailant graduate and move on; failing to move an assailant from a survivor's dormitory or class; and placing the burden on the survivor to move. Ms. Karasek stated that nearly 50 percent of sexual assault survivors experience institutional betrayal or secondary victimization, such as silencing or shaming by the institution. Survivors who experience this secondary victimization are less likely to go forward with their cases.

Ms. Karasek concluded her presentation with a discussion of future goals to address and correct the issues of and associated with campus sexual assault. Goals include providing comprehensive, affirmative education on sexual violence and consent to students much earlier than college; assuring survivors that when sexual assault does occur, they do not have to experience institutional betrayal; an equitable adjudication process against perpetrators and appropriate sanctions; and transparency and accountability by the institution.

Panel 2

Scaling Up Evidence-Based Interventions: Strategies for Advocacy, Policy, and Funding

This panel served as a platform for experts to discuss the importance of scaling up evidence-based interventions that address gender inequality at the nexus of HIV, drug use, and violence. Panelists presented their institutions' experiences in and commitment to advocating for gender-informed policies and the efforts in funding and commitment they are making toward realizing the implementation of proven programs.

CDC's Approach to Scaling Up Evidence-Based Behavioral Interventions to Prevent HIV and Violence in the United States

Jeffrey H. Herbst, PhD

Dr. Herbst opened his talk by acknowledging that HIV, drug use, and violence, alone and in combination, are serious public health problems. The Centers for Disease Control (CDC) uses a public health model for preventing various health conditions, including HIV and violence, and this model includes four key steps: (1) define and monitor the problem; (2) identify risk and protective factors; (3) develop and test prevention strategies; and (4) ensure widespread adoption of proven strategies.[1] CDC's Division of HIV/AIDS Prevention has used a research-to-practice model since 1996. The model includes research synthesis, translation and packaging of intervention materials, provision of training and ongoing technical assistance, program support, monitoring and evaluation, and impact assessment.[2] CDC identifies and nationally disseminates evidence-based and evidence-informed interventions for reducing HIV-related risk behaviors, enhancing linkage and retention in care, and improving antiretroviral medication adherence.[2,3]

CDC's Division of Violence Prevention (DVP) is committed to stopping violence before it begins. The DVP's work includes monitoring violence-related injuries; conducting research on factors that put people at risk or protect them from violence; creating and evaluating the effectiveness of violence prevention programs; helping state and local partners plan, implement, and evaluate prevention programs; and conducting research on effective adoption and dissemination of prevention strategies. DVP employs a four-level social-ecological model to better understand violence and the effect of potential prevention strategies.[4] This model considers the complex interplay among individual, relationship, community, and societal factors; and fosters understanding of the range of factors that place people at risk for violence or protect them from experiencing or perpetrating violence. In March 2016, DVP published online Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots.[5] The strategic vision includes four focus areas: (1) developmental periods of childhood and adolescence to achieve long-term impact; (2) populations and communities at highest risk for experiencing or perpetrating violence; (3) shared risk and protective factors that are most important for reducing multiple forms of violence; and (4) identification, implementation, and scale-up of approaches with cross-cutting impact. While injuries are outcomes that people typically think about as consequences of violence, experiences of violence

are also associated with a range of mental health problems; maternal and child health consequences; negative coping and high-risk behaviors; and lifelong disease outcomes, ill health, and early mortality. Dr. Herbst discussed CDC's approach to preventing violence, including the April 2016 publication of two technical packages highlighting programs, practices, and policies with evidence of impact to help communities and states prevent sexual violence[6] and child abuse and neglect.[7] Also presented were evidence-based and evidence-informed sexual violence prevention strategies identified in the literature and available for widespread implementation by communities, and an overview of CDC-funded research aimed at expanding the portfolio of evidence-based violence prevention programs.

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The Evidence Base and Opportunities for Scaling Up Programming to Address Gender-Based Violence Against Women Within the Context of the Health Sector

Avni Amin, PhD

Dr. Amin's presentation began with the question, "Why should we scale up violence against women interventions?" and responded, "Because women face high burdens of violence." She added that one in three women throughout the world will experience physical violence, sexual violence, or both by a partner, or sexual violence by a nonpartner. Dr. Amin shared that IPV has mental health, sexual health, and reproductive health impacts, and can lead to injury and death. She highlighted that women exposed to IPV are 1.5 times more likely to acquire HIV and 1.5 times more likely to contract syphilis infections, chlamydia, or gonorrhea. Dr. Amin described a study published in the journal Lancet that involved a systematic review of systematic/comprehensive reviews (published January 2000 to April 2013) and of interventions (2012 to date) in reducing victimization/perpetration of violence against women and girls (resulting in 58 reviews and 84 rigorous intervention studies). The objective of this study was to present the most complete synthesis possible on what works to reduce and prevent violence against women and girls. Some of the promising and effective interventions found for impacting HIV outcomes include integrated gender and economic empowerment strategies; integrated sex worker–led community empowerment; promoting gender-equitable attitudes among men and boys; changing unequal norms through community mobilization; edutainment/behavior change communication campaigns; and safety planning/gender power skills negotiation/motivational interviewing in risk-reduction counselling with key populations (e.g., sex workers, drug users). Dr. Amin also described three main limitations in the evidence base: methodological weaknesses, small or nonexistent evidence bases on different types of violence and populations, and limited evidence on cost-effectiveness. In May 2014, the World Health Organization (WHO) Member States adopted a resolution (WHO 67.15) that urges WHO to develop a "global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence in particular against women and girls and against children, building on relevant WHO work."

Dr. Amin acknowledged that implementing the global plan will require scale-up that results in the creation of an enabling legal and health policy environment, provision of comprehensive and quality services, implementation of evidence-informed prevention programs, and improving evidence on violence against women and girls.

Translating Evidence into Policy and Practice: Realizing Rights and Gender Equality Through Evidence-Informed Policy Making

Purna Sen, PhD

Dr. Sen, Director, Policy Division, UN Women, started by highlighting that in September 2015, 193 member states of the UN General Assembly adopted Agenda 2030 for Sustainable Development along with a set of 17 sustainable development goals (SDGs). It is a universal, integrated and transformative vision for a better world. It seeks to establish a new development paradigm in which all development

issues are inextricably linked and in which there is a commitment to understanding that you cannot deliver any one of the goals without understanding or delivering the rest.

Two of the 17 SDGs are particularly relevant. Goal 5 is a commitment to achieve gender equality and empower all women and girls. Goal 3 is a commitment to ensure healthy lives and promote well-being for all at all ages. Dr. Sen added that within goals 3 and 5, there are some incredibly aspirational and bold targets. Agenda 2030 offers us opportunities to advocate; to ensure policies are delivered; to rally activists around; to advance the rights of all women and girls into all dimensions of sustainable development; and to address the intersecting issue of gender inequality, drug use, HIV, and violence in a more integrated way than it has been addressed in the past. Another interesting feature of Agenda 2030 is its universal nature, which means that all countries in the world are held accountable to these targets and goals. Agenda 2030 also has strong references to human rights, nondiscrimination, and leaving nobody behind. It will require prioritizing the hardest-to-reach and the most at-risk groups of women in all their diversity, including women living with HIV, women using drugs, survivors of violence, young women, and adolescent girls.

Disaggregated data are key. The SDGs' indicators call for disaggregation, where relevant, by income, sex, age, race, ethnicity, migratory status, disability, and geographic location. A robust monitoring framework for Agenda 2030 has huge potential for determining whether policy efforts are channeled adequately and goals and targets on gender equality are achieved. Dr. Sen concluded that UN Women's commitment is to ensure that "the voices, the presence, and the lives of women who are caught in these positions, who are always at the end, always the least thought of by us, and always the least heard, will be a priority group for us in our work—and be heard."

BREAKOUT SESSIONS

Breakout Session 1

Engaging Women, Men, and Couples Through Evidence-Based Interventions: Addressing Drug Use, Sex, Gender Roles, and Gender-Based Violence

This session focused on the importance of engaging women, men, and couples through evidence-based interventions to address sex and gender roles at the nexus of HIV, drug use, and violence, and on how to better engage at-risk women, men, and couples through gender-specific and culturally relevant evidence-based interventions to facilitate positive changes in the perception of sex and gender roles.

Engaging Women Through Evidence-Based Interventions: Ten Years of the Women's Health CoOp in Pretoria, South Africa

Jacqueline Ndirangu, Msc-GH

Ms. Ndirangu presented a decade of research and explained the regional context of the Women's Health CoOp (WHC). She noted that South Africa has the highest prevalence of HIV infection globally and that Black African women are disproportionately affected. She added that many South African women depend on male partners for economic survival, and the inequality that exists in sexual relationships is often manifested through sexual coercion and violence. The WHC is an evidence-based intervention based on principles of social cognitive theory, gender theory, and empowerment. The core elements include HIV prevention intervention—peer-led, cue-card–driven sessions; behavioral skills training with roleplay and rehearsal; personalized risk assessment and action plans; and active referrals to local service organizations. The success of the intervention is based in part on having diverse collaborations to reach at-risk women (e.g., community advisory boards, government officials, health professionals) and on the perspective that it is important to address women's essential needs regarding hygiene, food, and children.

Ms. Ndirangu also described the Women's Health CoOp PLUS (WHC+), the next-generation study that added a biomedical intervention (i.e., testing and treatment) and case management (i.e., following women at least once per month) to the WHC intervention. Through funding from the National Institute on Drug Abuse (NIDA), the WHC+ was designed to test whether adding WHC to standard test, treat, and retain practices results in more HIV-positive alcohol and other drug (AOD)-using women getting medical evaluations (e.g., CD4, viral load), starting treatment and staying in treatment, and greater reductions in risk behaviors (e.g., AOD use, unprotected sex, victimization) among all women, whether HIV positive or negative. Preliminary results show increases in the percentage of women initiating antiretroviral therapy (ART) (25% at baseline to 48% among all HIV-positive women in the sample, nearly a twofold increase). The presentation concluded with the woman-focused intervention demonstrating reductions in risk behaviors (drugs, sex, and gender-related violence).

Why Just Women? The Importance of Intervening with Men and Couples

William A. Zule, DrPH

Dr. Zule started his presentation by discussing how the effectiveness of woman-focused interventions among women in couples is often limited by the male partner's resistance to change. Interventions that work with both partners in a couple may be more effective than interventions that work only with women. Dr. Zule presented on a grant from the National Institute on Alcohol Abuse and Alcoholism (NIAAA) that included the Men's Health CoOp and WHC; a couples arm using the Couples Health CoOp; and a third arm that used the WHC with HIV counseling and testing for men in Cape Town, South Africa. Eligibility criteria for the study included being a Black African man 18 to 35 years of age; alcohol use and having spent time in shebeens (taverns) weekly in past 90 days; having unprotected sex with the main partner one or more times in past 90 days; being together in a partnership for 12 or more months and intending to remain together for at least another 12 months; and having no plan to conceive a child. The Men's Health CoOp was designed to parallel the WHC and combines education, skill building, and personalized action planning to help men reduce their sex risk, reduce their alcohol and drug use, and develop more egalitarian gender norms. It is organized into four modules delivered in two sessions. Dr. Zule shared that when examining the distribution of HIV infections among couples, the most common discordant couple type was that the woman was positive and the man was negative. Dr. Zule presented data showing that the couples-based intervention had a significant impact on lowering HIV incidence among women and reducing risk behaviors among men. There was an added benefit of engaging couples together in HIV interventions relative to targeting women and men separately or women alone. Last, Dr. Zule explained the added benefit of working with men individually in addition to working with women individually; working with men decreased drinking, increased condom use, and promoted positive gender norms.

Learning from SASA! in Uganda: Evidence into Section to Strengthen Violence Against Women Prevention

Sophie Namy, MPA, MA

Ms. Namy presented on the SASA! methodology to prevent violence against women (VAW) and HIV. This methodology was developed by Raising Voices and focused on changing social norms that perpetuate VAW and HIV. SASA! is implemented in many countries, although this presentation focused on randomized controlled trials (RCTs) in Kampala, Uganda. The components of SASA! are as follows:

- Start: Building empowerment of community workers (males and females)
- Awareness: Of men's negative use of power over women
- Support: Fostering solidarity
- Action: Prevent VAW and HIV risk

Ms. Namy noted that there are three critical factors in SASA: a structured process; reach and repeated exposure; and content—inclusive and power-based language (their work found language about gender and violence was particularly alienating for men). An example of such language is, "We all have power, how are you using yours?" In Kampala, the reach included over 350 community activists, over 11,000 activities, and more than 260,000 community members. The results showed a significant decrease in intimate partner violence (IPV) and past year concurrent sex partners, and improved community attitudes and responses to IPV. Ms. Namy said the effects were pronounced when both members of a couple were engaged. A lesson learned is that household roles and activities may seem like an aspirational entry point to improve relationship quality, but it could instead create divisiveness and ignore deeper emotional needs (e.g., both want to feel appreciated and respected) between partners. Additionally, men might regard helping around the house as benevolence that could expunge other behaviors, or might feel they should get something in return (e.g., "If I help with dishes, then she should pay half the school fees"). They also found that a shift to what partners wanted from the relationship was more effective. In terms of turning evidence into action, Ms. Namy provided the following guidance.

Programming

- Intense and repeated exposure
- Find an entry point that connects and inspires
- Encourage simultaneous involvement of intimate partners

Research

- Innovate with methods: experiment with "softer" indicators of relationship dynamics
- Nuanced analysis of violence (new vs. ongoing; polyvictimization; severity; frequency; etc.)

Both Programming and Research

- Invest in the partnership
- Plan at the beginning for activism at the end next year

Breakout Session 2

Empowering Adolescents, Young Women, and LGBTQ Youth Through Evidence-Based Interventions

This session focused on early intervention and prevention with adolescents, young women, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth. Young people face situational, structural, and often legal barriers to fully engaging with health services and the continuum of care. These barriers are magnified among the key youth populations discussed in this session.

Empowering Adolescents and Young Women Who Use Drugs in South Africa: Lessons from a Decade of Intervention Studies

Bronwyn Myers, PhD

Dr. Myers presented on why it is necessary to work with young women who use drugs. She provided several reasons: South Africa has high HIV incidence; substance-using women are highly marginalized in South Africa, and addressing alcohol use is important; gender inequality contributes to young women's risk for HIV; drug use and gender-based violence (GBV) intersect to increase sexual risk for HIV; and preventing new infections is necessary. She added that there is a need to address intersecting risk factors and acknowledged that a decade of intervention studies has addressed the nexus (substance use, GBV, sexual risk for HIV), building on the original evidence-based WHC. The WHC is a manualized intervention that facilitates personal empowerment and feminist theory within a resource-scarce environment. The intervention components include a personalized assessment of AOD and sex risks; risk reduction skills; goal setting; communication, negotiation, and conflict resolution skills; and violence prevention and education. Dr. Myers discussed the critical role of adaptations to ensure fit and acceptability with the population being targeted. She noted that women who use drugs are not on the policy agenda. Gender-specific services are lacking, which greatly impacts women's ability to access treatment. Women's needs are not acknowledged at the policy level, and this translates to women being excluded—because of this, many women use drugs and have no hope for a greater future. Dr. Myers is involved in a new study that is reaching young traumatized drug-using women: the Pretreatment CoOp, which is an extension of the WHC. This study targets women 18 to 25 years of age and adopts a trauma-informed approach to AOD use and HIV prevention. It includes self-care modules with strategies for recovery from AOD use and trauma, and peer support networks for retention and sustained change. Dr. Myers is also working on a pilot study for reaching adolescent women who use drugs: the Young Women's Health CoOp, an adaptation for women 16 to 21 years of age. This study targets young women who have dropped out of school. Dr. Myers concluded her presentation by posing the question, "Why is reaching young women important?" She shared that many of these young women have several children already, and they desire change. There is a need to break the intergenerational cycle of drugs and violence. But the short response is "to protect the next generation of young women."

Accessing the Evidence Base for Action in Promoting Adolescent Sexual Health

Alexandra Minnis, PhD

Dr. Minnis shared an epidemiologic profile of adolescent sexual health. She framed the presentation by highlighting that adolescence is a critical developmental period. This population needs attention because adolescence is a key period for developmental transitions that offer intervention opportunities. Dr. Minnis also provided an overview of effective and promising adolescent-focused sexual health intervention approaches, including the importance of expanding the evidence-base for multilevel interventions addressing HIV prevention among LGBTQ youth. Dr. Minnis noted while the HIV epidemic is focused in Africa, 40 percent of new HIV cases occur outside of Sub-Saharan Africa and adolescents and young people constitute a key population at risk for HIV.

Dr. Minnis asked, "Why focus on adolescence? What is unique about this time period that warrants attention when developing and delivering interventions?" She emphasized the importance of addressing the social and structural environments that shape multiple reproductive health outcomes for youth (HIV, pregnancy, STIs, and youth violence), including the neighborhood, school, and economic and cultural factors that can promote healthy or unhealthy adolescent development. Some newer interventions to reach young men who have sex with men (YMSM), for example, are using technology to address social isolation and promote supportive relationships. Dr. Minnis described the work she has been engaged in since 2001 examining the social-environmental influences on adolescent reproductive health, and several qualitative ancillary studies designed to address questions that emerged through her work—one that focused on gender-based power and protective behaviors within romantic relationships, and another on the reproductive health needs of migrant youth. Dr. Minnis described the Yo Puedo project, or Future Opportunities for Youth. The intervention included delivery to small social networks, educational and job training goals selected by youth, and incentives paid to youth directly. The project featured a 6-month intervention period with life skills groups held weekly during first 2 months. Dr. Minnis noted that Yo Puedo produced positive effects—a reduction in alcohol and marijuana use among youth and a 50 percent reduction in frequent "hanging out" on the streets. This study had strong evidence of feasibility and preliminary evidence of reduced risk behaviors. Next steps include a focus on building a larger study and exploring the effects of biological outcomes.

Breakout Session 3

Addressing Health and Risk Behaviors Using Effective Interventions for Key Populations: Substance-Using Sex Workers, Women Living with HIV, and Trafficked Persons

This session focused on effective interventions that address health disparities and risk behaviors among substance-using sex workers, trafficked persons, and women living with HIV. Speakers discussed the challenges and barriers in reaching these underserved populations in clinical settings, current evidence-based interventions and practices that are working, and the next steps to facilitate wider implementation success and scale-up.

Addressing Health and Risk Behaviors Using Evidence-Based Interventions Among Sex Workers and Women Living with HIV in South Africa

Winnifred Gumula, BA

Ms. Gumula, Kheth'Impilo presented on the Women's Health CoOp (WHC) study in Pretoria, South Africa (funded by NIAAA R01AA14488). Since 2000, the CoOp studies have been adapted in regions across South Africa, Russia, and the United States. The original Women's CoOp (WC) is listed in CDC's *Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention*. The South African WHC is also listed in USAID's *Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa*.

The WHC is an evidence-based, woman-focused HIV intervention adapted to reduce sex risk behavior, AOD use, and victimization among at-risk and underserved women, including female sex workers and women who use drugs. The intervention aimed to help women increase their knowledge about AOD use associated with sex risk and GBV, reduce their substance use, improve their communication skills with their partners, increase their condom use competency, and learn about specific violence prevention strategies.

Findings indicate that HIV prevalence is high among women who also reported drug use in this study. Sex workers reported higher levels of drug use and also have higher levels of HIV; 68 percent of sex workers were HIV positive, compared with 33.6 percent of non–sex workers. Sex workers were less likely to access health services and reported greater abuse. Women who received the WHC intervention reduced their alcohol use, reduced unprotected sex with main partners, and had experienced less physical violence by a main partner in the past 90 days at 12-month follow-up. Sex workers' risky behavior indicates a key population needing a gender-focused intervention addressing personal risk and access to health services.

A further adaption, the Women's Health CoOp PLUS (WHC+) (funded by NIDA R01DA032061), was conducted over the next 5 years and used a biobehavioral (seek, test, treat, and retain) strategy combined with the WHC behavioral intervention to maximize the efficacy of both strategies among

women in Pretoria. Intake data revealed that of the 68 percent of sex workers living with HIV, only 32 percent were currently on antiretroviral drugs (ARVs), and only 29 percent had ever been prescribed ARVs. Drug use was higher among sex workers than in the drug-using women, with 57 percent of sex workers reporting alcohol or other drug use at last sex. The study achieved a 92 percent follow-up rate at 12 months. Current data are being analyzed for outcomes.

Promising Interventions for Responding to the Health Needs of Trafficked Persons

Andrea Bertone, PhD

Dr. Bertone, Family Health International (FHI 360), presented on promising interventions for responding to the health needs of trafficked persons, specifically in the United States. Human trafficking is an umbrella term used to describe acts involved in recruiting, harboring, transporting, providing, or obtaining a person for compelled service or commercial sex acts through the use of force, fraud, or coercion. Trafficking victims may be of any age, race, or gender. Of confirmed global sex trafficking victims, 83 percent are US citizens. Examples of vulnerable groups include children in welfare, foster care, or juvenile justice; Alaskan and American Indian natives; people with limited English proficiency or limited literacy; rural populations; and LGBTQ individuals.

Trafficked individuals face unique health risks and consequences, such as forced or coerced use of alcohol and other drugs, social restrictions, economic exploitation and debt bondage, legal insecurity, and abusive working and living conditions. Unfortunately, it may not always be clear when an individual is being trafficked. Some trafficking cases present themselves as rape or abuse. In fact, most trafficked individuals have been seen by medical professionals, but have not been identified as trafficked.

The identification of human trafficking and recognition of the trafficking process, means, and purpose are key in developing successful interventions. The stages in the human trafficking process include recruitment, travel and transit, destination, detention, deportation, integration, and reintegration. Individuals may fall into this process through threat, force, coercion, abduction, fraud, deception, or other means.

Successful interventions should provide multidisciplinary clinical support, ensuring greater likelihood for accurate identification of a trafficking situation; provide safe, private, empowering spaces; exhibit empathy or understanding of a trafficked person's view of the world; appreciate physical and mental trauma; provide a professional interpreter; and view situations through culturally competent, age-appropriate, gender-sensitive lenses. Ongoing evaluation and safety planning regarding the care and treatment of trafficked persons is necessary. Medical providers must develop trust with trafficked individuals; create long-term, individualized strategic health plans; and use mental health support strategies aimed at successful intervention sustainability.

Breakout Session 4

Using Multilevel Evidence-Based Interventions to Address HIV, Drug Use, and Gender-Based Violence Among Women Involved in the Criminal Justice System

This session sought to identify challenges and barriers in reaching women involved in the criminal justice system; successful elements of current multilevel evidence-based interventions; and ways to strengthen interventions and programs to address the nexus of HIV, drug use, and GBV among this key population.

HIV, Gender-Based Violence, and Drug Use Among Women Affected by the Criminal Justice System: Social Determinants and HIV Prevention Strategies

Nabila El-Bassel, PhD

Dr. El-Bassel discussed the social determinants of HIV among women affected by the criminal justice system and the need for successful evidence-based HIV prevention strategies. The global burden of incarceration for women is increasing faster than the rate of incarceration for males. The United States incarcerates more women than any other country, with 1 million women under some form of community supervision. IPV is a risk factor for HIV infection among women, and women involved with the criminal justice system are particularly at risk of acquiring HIV. Among incarcerated women, 57 percent report ever experiencing severe physical IPV, and 37 percent report having been raped before incarceration. Sexual victimization in prison is also highly prevalent, especially among women who report mental illness. Most women are abused by other inmates and staff. In the WINGS (WOMEN Initiating New Goals of Safety) of Hope in Kyrgyzstan project, funded by the Open Society Foundations, 60 percent of women with a history of incarceration reported sexual abuse by police.

Social and structural factors related to HIV, IPV, and drug use overlap, and therefore, interventions must address all of these elements to be successful. Project WORTH (Women on the ROAD to Health), a randomized controlled trial (RCT funded by NIDA R01DA025878), found a reduction in the number of unprotected sex acts when intervention is combined with multimedia, suggesting that WORTH may be scaled up to redress the concentrated epidemics of HIV/STIs among drug-involved women in the criminal justice system. The study used computerized skills-building intervention to improve women's problem-solving, negotiation of safer sex skills and drug risk reduction, and alternative ways of negotiation to avoid physical and sexual IPV. A systematic review paper shows that only 12 IPV interventions tested in RCTs have been efficacious in reducing physical IPV, and only one of those trials was with women who use drugs. In three systematic reviews, conclusions showed that we need preventive interventions focused on the nexus of HIV, IPV, and drug use in the criminal justice system.

Drug Use, Victimization, and HIV Risk: Implications for Delivery of Evidence-Based Interventions in Rural Jails

Michele Staton-Tindall, PhD, MSW

Dr. Staton-Tindall, University of Kentucky, discussed implications for delivery of evidence-based interventions focusing on drug use, victimization, and HIV risk in rural jails; examined behavioral health service utilization among rural women; and described successes of a risk-reduction evidence-based intervention for rural women in jails. Dr. Staton-Tindall's project (funded by NIDA R01DA033866) randomized participants to either an HIV/HVC education-only session or a motivational interviewing-based, four-session HIV-risk-reduction intervention. Intervention sessions focused on self-perceived risk and readiness to address risk, risk feedback, and action planning. Participants reported high levels of drug use, with 89.2 percent of participants reporting opiate use and 80.9 percent reporting use of downers in the past year. Of those who reported injection drug use, 82 percent used a dirty needle in the past year. Before the Affordable Care Act (ACA), only 36.5 percent had insurance coverage, compared with 79.3 percent after the ACA at 3-month follow-up. The study resulted in improved relationships with county jails. In the intervention group, two-thirds of women completed all sessions. Most women who were not retained were released or moved out of the jail, and follow-up results are currently trending in desired clinical directions.

The criminal justice environment is complicated. The women are willing to engage in interventions, but they need to be reached in creative ways. Not everyone will seek health insurance or formal treatment services. Intervention fidelity can be ensured even in nontherapeutic settings, and risk reduction can be an effective outcome. Clients are the experts and can help to inform the best ways to work with them. Researchers must constantly identify new approaches and strategies to reach the hard-to-reach.

Breakout Session 5

Creating Successful Collaborative Gender Proposals: Combining Resources and Expertise

This session outlined best practices and ways to overcome barriers and challenges in creating successful collaborative gender proposals. Speakers discussed their experiences with these challenges, identified and discussed ways to overcome them, and discussed how to better apply expertise and understand the critical steps associated with launching a collaborative proposal relationship.

New NIH HIV/AIDS Priorities: Implications for Gender-Based Research

Shoshana Kahana, PhD

Dr. Kahana, from the National Institute on Drug Abuse (NIDA), discussed the new National Institutes of Health (NIH) HIV/AIDS funding priorities and their implications for gender-based research. In August 2015, NIH developed an agenda for priority research over the next 3–5 years, including the development and testing of vaccines, development of therapeutics (with fewer complications), and implementation of research through concepts like linkage to care, novel ways to cure, and prevention and treatment of comorbidities that occur in the context of HIV. Future trends point to greater interest in primary HIV prevention strategies (biomedical and behavioral) for vulnerable populations domestically and internationally; in virology and how to embed interventions in nontraditional settings, such as the criminal justice system; in the prevention of mother-to-child transmission; and in using implementation science in low-resource settings.

Key Considerations in Developing Gender-Responsive Proposals for Global Research and Implementation Programs

Peter Vaz, PhD

Dr. Vaz, RTI, discussed key considerations in developing gender-responsive proposals for global research and implementation programs. Gender-responsive programming entails understanding of extant gender roles, norms, inequalities, and inequities in relation to program policies and service delivery activities for the target population; thoughtful and measurable action plans to address these issues during program implementation; and documented assessment of program results over the performance period. Key considerations when developing research proposals and implementing programs should include a gender situation analysis, a review of the legal and regulatory environment, research and data analysis, capacity building, past performance, and staffing.

A common thread to gender responsiveness is recognizing unfavorable differences, measuring them, and taking steps to address those biases. It is important to provide a robust gender situation analysis related to the target population; to be specific and avoid regurgitating cliché statistics; to highlight current gaps in access, use, or knowledge related to the purpose of the proposal; and to provide a summary of challenges and opportunities that the program can

build on. It is also important to consider the legal and regulatory environment the target population faces. When considering past performance, one should include the assessment of ability to perform proposed work and ensure that proposed key staff exceed the funder's required experience. It is important to highlight how success (by key staff and the organization) in past projects relates to the proposed scope of work. One should also identify research partners and collaborators early on by ascertaining what groundwork needs to be completed within the community and setting clear roles and expectations.

Breakout Session 6

Innovations for Capturing Data: Mobile Phones, Tablets, and Social Media

Opportunities to engage hard-to-reach populations globally are increasing as innovations and access to mobile technology continue to expand. Mobile technology allows researchers to remove many barriers to data collection and offers anonymity for participants when receiving interventions that address sensitive health topics, such as HIV and GBV. This session highlighted current examples of interventions and research that use Internet-capable devices, such as cell phones and tablets, and social media.

Personal Health Intervention: Using Mobile Technologies for Behavior Change, Empowerment, and Outcome Assessment

Paul Kizakevich, MS

Mr. Kizakevich, RTI, discussed using the Personal Health Intervention Toolkit (PHIT) to adapt the Young Women's CoOp (YWC), an age-appropriate, woman-focused HIV intervention support tool providing education and skills for risk reduction, empowerment, and substance abuse prevention (funded under NIDA grant R01DA041009). Specifically, the YWC app focuses on reproductive health care, substance use, life skills, and empowerment through the use of educational materials, video vignettes, goal setting, action planning, and monitoring and encouragement.

The PHIT app uses an instrumentation system to collect data, such as self-reported health and behavior, momentary assessment diaries, and brief goal-setting questionnaires. The app then uses a virtual advisor (i.e., protocol intervention logic), to direct the user to the intervention's next steps. The app's activity manager then supplies the knowledge and skills delivery, interactive knowledge reinforcement activities, and tailored reminders that support personal action plans. Data collection is standardized so it does not need to be written each time.

Current challenges to mobile health technology include human studies considerations, such as alignment of the protocol with app design and usage factors, long delays to approve content by virtual stores (i.e., iTunes or Google Play), researcher expectations, and user involvement.

Future areas to explore include app support for integrated health; social and economic action planning; mobile tools to facilitate access to health care, healthy foods, and community resources; ubiquitous sensors for autonomous data collection; voice-activated data collection and assisted intervention; and virtual reality for experimental assessment, learning, and behavior change.

Technologies to Engage YMSM and Transgender Women for Social Network–Based Interventions

Lisa Hightow-Weidman, MD, MPH

Dr. Hightow-Weidman, from the University of North Carolina (UNC), discussed the use of technologies to engage young men who have sex with men (YMSM) and transgender women in social network–based interventions. Social media and social networks are key components in mobile research collection because 90 percent of youth aged 18 to 29 use social media. The proliferation of social media platforms has transformed Internet use and the ability to reach and interact with youth. Dr. Hightow-Weidman is currently conducting a study to encourage HIV home testing among transgender Latinas through mobile messaging. Social media and texting can be used for study recruitment, retention, and engagement. Apps can be designed as a game that creates the feeling that users are engaging in a broader storyline.

Technology changes rapidly, so it is critical to maintain awareness of how your target population is engaging with it. Online social networks can facilitate recruitment, retention, and engagement in HIV prevention and care interventions, particularly for marginalized populations. Interventions delivered via social media can quickly reach large audiences through familiar platforms, building on the trust and influence of social networks. These technologies offer key functions that are particularly relevant within a youth HIV context, including anonymity, social support, provision of real-time assessment and feedback, and highly engaging features. As the field of technology and HIV continues to grow, we will need to be mindful of the rapidly changing technologies being used by adolescents and young adults.

Mobile Technology for Ending Gender Inequalities: Opportunities and Risks

Gordon Cressman, MS

Mr. Cressman, RTI, discussed the use of mobile technologies to end gender inequalities. Of the 7 billion people on Earth, more than 6 billion have access to a working mobile phone. Opportunities to use mobile technology span many fields, including finance, education, health, civil society, governance, and disaster management. However, there is a gender gap: 1.7 billion women do not own mobile phones. Women in Southeast Asia are 38 percent less likely to own a mobile phone than men. Women who own phones may be at increased risk of privacy violations, harassment, violent reprisals, stigmatization, and discrimination.

Applications can be built with mHealth technology; however, projects related to issues that can put women at high risk require careful attention to security. Cressman provided examples of three gender-related projects that use mobile technology. Thuthuzela Care Centers in South Africa provide a one-stop model for combating sexual violence against women and youth. This study created a mobile case management system to manage the legal, medical, and psychosocial care for rape survivors. To avoid putting victims at further risk of violence, the security around this technology must be high. For example, text messages can

be encrypted during transmission, which requires special software. The content of text messages stored on mobile devices may also pose a risk to women. These were important project design considerations. The Sisters with a Voice project in Zimbabwe aims to reduce the risk of HIV acquisition among sex workers and their clients. The project has reached over 20,000 women through 36 sites, providing HIV counseling, testing, contraception, legal advice, and other services built into an offline tablet app that can also collect data that can be synchronized into a database. Nurse counselors manage client data on tablets using the Mutare Coconut Clinic app. The Sistem Informasi Jejaring Rujukan Maternal & Neonatal (SIJARIEMAS) Indonesian project uses a rules-based short message service (SMS) patient referral system. The system primarily focuses on obstetric and newborn care; it has supported more than 12,000 obstetric and newborn referral cases. When a referral is made, the system determines the nearest facility that can most likely provide the care a patient needs and transmits information to the facility. The facility can then confirm whether or not it can accept that patient.

Breakout Session 7

Adapting, Monitoring, and Evaluating Evidence-Based Interventions: Using Mixed-Method Approaches

This session addressed the strength of using mixed methods in maximizing the use of data to target different stakeholders.

Integrating Qualitative Methods into the Evaluation Design of HIV Prevention Trials: A Case Study of NIMH Project Accept (HPTN 043)

Suzanne Maman, PhD, MHS

Dr. Maman, from the University of North Carolina, discussed lessons learned from a mixed-methods evaluation of HPTN 043, a randomized trial in 48 communities in Tanzania, Zimbabwe, South Africa, and Thailand, funded through a National Institutes of Mental Health (NIMH) cooperative agreement. A key finding of the mixed-methods approach is that, although quantitative analysis did not find a change in holding conversations around HIV from baseline to endline, qualitative analysis did find more frequent HIV-related discussions and ones that were grounded in personal experiences.

Using Mixed Methods to Understand the Intersection of Violence and HIV Risk Among Methamphetamine Users in South Africa

Christina Meade, PhD

Dr. Meade, from Duke University, discussed findings from her formative research in South Africa (funded by NIDA R03-DA033828) with people who use methamphetamines, locally referred to as "tik." Her quantitative analysis found that tik users in her sample (N = 345) were a very high-risk group. In the sample, 77 percent reported daily meth use, over 27 percent of the sample reported never having been tested for HIV, and nearly half of all respondents reported participating in sex trading. Qualitative analysis with some participants found that tik and relationship violence were closely entwined. The key implication of this work is that HIV interventions for tik users must address violence alongside HIV prevention, and ideally should be coupled with linking tik users to substance abuse treatment—potentially via respondent-driven sampling techniques, which was a successful recruitment approach in this study population.

Adapting GBV and HIV Interventions for Policy and Scale-up: Lessons from Kenya

Wanjiru Mukoma, PhD

Dr. Mukoma, from Liverpool Voluntary Counseling and Treatment Health, discussed her experiences working in Kenya with efforts to scale up post-rape care services in health clinics. Her talk focused primarily on how mixed-methods research can support scale-up efforts and working with policy makers. Conducting mixed-methods research provides multiple scientific bases and arguments to bring to policy makers, stakeholders, and opposition to help make the argument for scale-up.

Overall, although both methods found fewer barriers to testing and more favorable norms around testing, qualitative data fleshed out why those changes occurred—specifically, the inclusion of personal testing narratives.

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Breakout Session 8

Moving from Research to Practice: Using Implementation Science and Other Considerations for Successful Scale-up and Sustainability

This session focused on the importance of and methods for conducting implementation science studies, in addition to the challenges and barriers in real-world settings. Speakers identified how implementation science will affect policy for evidence-based gender-focused interventions by discussing the lessons learned in implementation of evidence-based interventions in usual care settings internationally, and governmental policies for scale-up at local and national levels for sustainability.

Moving from Bench to Trench: Using Implementation Science and Hybrid Designs to Scale Up and Sustain Effective Gendered Interventions

Richard van Dorn, PhD

Dr. van Dorn, from RTI, discussed real-world consequences of the 17-year implementation gap, such as health disparities among key populations and poor return on research investment. The linear route in which research is currently conducted (first with efficacy, then effectiveness, and finally implementation) prolongs this gap, furthering delays in public health impact solutions. A potential solution to closing this gap, hybrid designs, has been proposed. Hybrid designs combine elements of clinical effectiveness and implementation research to enhance public research. RTI's grant in South Africa to implement the evidence-based Women's Health CoOp (funded by NIAAA R01AA022882) is a hybrid II design that uses a stepped wedge design while conducting process evaluation, using multi-stakeholder-informed implemented strategies in an effort to reach sustainability. Current lessons learned include the following: global implementation science work is challenging; an implementation conceptual framework is necessary; researchers must be flexible with their implementation strategy; and gender-specific implementation designs are necessary—however, barriers exist in clinical care settings, and more research is needed in this area.

Toward a Model Continuum of Care for Women and Families

Deidra Roach, MD

Dr. Roach, from NIAAA, provided examples of recent studies on the impact of alcohol on development throughout the lifespan, and discussed moving toward a model continuum of care for women and families for HIV and drug abuse. NIAAA's mission is to support research on the causes, consequences, prevention, and treatment of alcohol misuse over the lifespan, from its effects on the developing fetus to its impact in adolescence, adulthood, and the senior years. NIAAA seeks to understand how interactions between genes and the environment influence the course of alcohol-related disease at every stage of life.

NIAAA previously launched a major initiative to learn more about the effectiveness of screening and brief interventions among adolescents. Findings

from the randomized trial known as Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Adolescents in a Health System found that (1) few teens received further assessment if screened positive for alcohol and other substance use, (2) mental health professionals and primary care physicians often disagreed on who they believed had substance use disorders, and (3) females had significantly higher rates of risky behavior compared with males.

The results from a similar SBIRT implementation study, Project Alcohol Drinking as a Vital Sign (funded by NIAAA R01AA1866o) involved adult patients at Kaiser Permanente Northern California (KPNC). This study sought to determine if there were gender disparities in the receipt of alcohol SBIRT among adults at KPNC and whether screening, brief intervention, and referral to treatment varied by physician gender. This randomized trial involved 54 primary clinics encompassing more than 500 clinicians and about 640,000 patients. Overall, women were less likely to be screened or to receive a brief intervention than men. Screening and brief interventions have now been systematized at KPNC, bringing the screening rate for primary care patients to 90 percent, and 60 percent of those who screen positive for a substance use disorder receive a brief intervention.

Finally, a recent study by Johns Hopkins University examined the efficacy of a two-session brief intervention for women living with HIV. This study compared clinical outcomes among HIV-positive women receiving a two-session brief intervention versus usual care in a Baltimore clinic between 2006 and 2010. The content was adapted for HIV to address the role of alcohol in antiretroviral therapy adherence and HCV, and its general impact on women's health. There was insufficient power to examine the effects of the intervention on HIV clinical outcomes. Measurement of outcomes depended on self-report; consequently, the results may not generalize to men or to different populations of women. Future directions could include examining the role of depression, anxiety, and posttraumatic stress disorder in risk behavior and shaping response to the intervention; the impact of adding medications to the intervention; the use of biomarkers like phosphatidyl ethanol (PEth); and the feasibility of computerizing this intervention.

Community-based adoption and implementation research on multilevel interventions may be the key to building data-driven, integrated systems of care that are flexible and responsive to changing patterns of alcohol and other substance use among girls and women, and changing trends in HIV infection among girls and women at the local level.

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Breakout Session 9

This session focused on the current state of the field with respect to measuring and addressing HIV and key-population stigma, focusing on available measurement and participatory training tools. Participants discussed opportunities, challenges, and barriers in incorporating stigma reduction into ongoing prevention and treatment programs, as well as standalone programs.

Measuring and Reducing HIV and Key-Population Stigma

Laura Nyblade, PhD, and Melissa Stockton, BA

This workshop-style session presented an overview of the current state of the response to HIV and key-population stigma with respect to available measurement and participatory training tools, and the importance of improving all aspects of the HIV response from prevention through each step in the treatment cascade. Session speakers identified opportunities for and challenges and barriers to incorporating stigma reduction into ongoing prevention and treatment programs. Programmatic examples from studies in the Caribbean and Thailand were shared.

Stigma is actionable and measurable through the use of globally validated and tested measures, program models, and practical tools. Stigma is a social process that occurs within the context of power. Reducing stigma and discrimination is a key goal in national strategies and should be incorporated into all HIV programs using intervention and programmatic tools that are widely available. Interventions must address the following: (1) distinguishing and labeling differences, such as people living with HIV and people who use drugs; (2) associating negative attributes, such as being irresponsible or immoral; (3) separating "us" from "them," including physical and social isolation; and (4) status loss and discrimination, including denial of health care and verbal and physical violence.

The different types of stigma include experienced, perceived, anticipated, internalized, compound or layered, and secondary. Immediately actionable drivers, such as fear of transmission of HIV, awareness of stigma, attitudes, and health facility environment, lead to the manifestation of the different types of stigma. This process is critical in understanding stigma's scale, dimensions, and relationship to key health outcomes tracking stigma over time; designing effective programs; evaluation; and advocacy. Key principles for stigma-reduction interventions include addressing immediately actionable drivers by raising awareness, discussing and challenging the shame and blame, and addressing fears and misconceptions; creating partnerships between affected groups and opinion leaders by modeling desirable behaviors and recognizing and awarding role models; and placing affected groups at the center of the response by developing and strengthening networks, empowering and strengthening capacity, and addressing self-stigma.

CONCLUSION

The energy and enthusiasm of the conference was the highlight. The testimonials were powerful and evoked many emotions among participants, as noted in the feedback. The cultural event held the first evening, which encouraged participants to greet strangers and hug, set off a firestorm of discussion about the obvious higher-level need to touch someone if we are to tackle the larger gender inequality issues. As we know and learned even more, the interrelationship of substance use, gender-based violence (GBV), and HIV is exacerbated by gender inequality. Alcohol and drug use compromise women's judgment, power in decision making, and control, which can lead to increased violence, victimization, and rape, as well as risky sexual behavior. These, in turn, lead to an increased risk of HIV and other sexually transmitted infections. Participants at the RTI conference on *Ending Gender Inequalities* learned of programs that work, and ended with an understanding of our shared responsibility to work together, collaborate, and network to identify and develop more interventions and to scale up those that do work so we can have a greater impact. Participants recognized a need, moving forward, to scale up programs and ensure that they specifically address the needs of younger women, adolescents, women with mental health issues, survivors of trafficking, women who are under supervision by the criminal justice system, and LGBTQ populations.

This conference was based on the premise that we convened not only to learn but also to develop collaborations that result in actionable change. Collectively, there was an acknowledgement that the entire process, from the design of interventions to implementation and evaluation, must be influenced to develop a comprehensive, holistic approach that facilitates the behavioral changes required to effectively address gender inequality, the HIV epidemic, and drug use and violence toward women and girls.

To address the nexus of drug use, violence, and HIV, the following overall priority areas were identified:

- Address cultural norms, gender issues, drug use, and GBV among key populations.
- Intervene on co-occurring conditions (e.g., substance use, TB, mental health) with HIV prevention and anti-HIV infection strategies.
- Address structural and environmental barriers to accessing and scaling up evidence-based interventions in the communities where high-risk populations live.
- Develop structural interventions that increase education and economic development and improve access to sexual and reproductive health care.
- Address access and adherence to antiretroviral therapy and overall health care.
- Advance the adoption and sustainability of evidence-based programs through implementation studies.

Recommendations for next steps were as follows:

- Scale up empowering interventions for younger women and girls to reduce risk.
- Develop and implement proven structural interventions that increase education, sexual reproductive health, and protective skills.
- Take interventions where people can be reached.
- Provide access to linkages for services for comorbid conditions.
- Integrate implementation of evidence-based programs in other settings.
- Address the risks refugee women face in migrant camps.

Gender-responsive programming is about changing deeply held beliefs, which takes time and tenacity. Staffing these programs takes people with passion and sincere commitment. Solutions and approaches should be theoretically informed, evidence-based, and contextualized and practical, so they can be sustainable.

Look for the next *Ending Gender Inequalities* conference in 2018.

POSTER ABSTRACTS

Original Research

1. Sexual Violence and Its Impact on Commercial Sex Workers in the Dhaka City of Bangladesh: Guidelines for Providing a Comprehensive HIV/STI Prevention Program

Mohammed Abul Kalam
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Background. Commercial sex workers (CSWs) facing sexual violence are at risk of contracting HIV and other sexually transmitted infections (STIs). Despite the presence of a national HIV/AIDS prevention program to ensure access to HIV prevention services, STI prevalence among CSWs is still high at 18.09 percent, as indicated by serobehavioral surveillance of HIV/AIDS in Bangladesh in 2012.

Method. Information was collected through literature reviews, surveys, focus groups, and in-depth interviews. Focus groups contained 10 to 12 participants, and surveys were collected from 60 CSWs at four different sites in Dhaka City.

Results. Among the 60 CSWs who participated in the study: 85 percent reported ever being a victim of sexual violence by a male counterpart after being on drugs, drinking alcohol, and smoking; 53.3 percent experienced violence in the past 12 months; 95 percent have been assaulted in their lifetime; and 86.6 percent have experienced psychological abuse from a man. Sixty percent have been sexually abused by members of law enforcement agencies. The surveys revealed that the average age at first sexual intercourse was 15.42 years and at first transactional intercourse was 19.5 years. Focus group discussion revealed that men remove condoms during sex. Among the victims of lifetime sexual violence, 41.6 percent had reported unwanted pregnancies, 51.6 percent reported vaginal discharges, and 26.6 percent reported itching around the vagina. Psychological impact like self-pity and unhappiness was very high among the cases of rape.

Conclusion. Sexual violence against CSWs increases their vulnerability to HIV and other STIs because condoms are rarely used in such situations. Therefore, any successful HIV prevention program should put in place strategies to reduce sexual violence. Effort should support grassroots advocacy with community-based organizations, involve CSWs at all levels of intervention, carry out HIV prevention programs with law enforcement agencies, provide postexposure prophylaxis to victims of rape, strengthen partnerships with doctors for emergency checkups and consultations, and regularly monitor sexual violence.

2. The Role of Substance Use Coping in the Relation Between Childhood Sexual Abuse and Depression Among Methamphetamine Users in South Africa

Martha Berg[1], Andréa L. Hobkirk[1], John A. Joska[2], and Christina S. Meade[1]

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Background. Childhood sexual abuse (CSA) is a critical global health issue associated with poor psychosocial outcomes. Individuals with CSA histories are at risk for drug use, which is a growing problem in the Western Cape of South Africa. The present study of methamphetamine users in this region explored how substance use coping, a contextually relevant type of avoidance-based coping, moderates the relation between CSA and depression severity.

Method. Participants included 161 men and 108 women seeking treatment for methamphetamine use. A computer-assisted assessment and a face-to-face interview with clinic staff were conducted to evaluate clinical and behavioral outcomes.

Results. CSA histories were reported by 20 percent of men and 45 percent of women, and the average methamphetamine involvement score exceeded the threshold of high risk. Substance use coping levels were similar in men and women and were positively correlated with depression severity. Substance use coping was a moderator of the association between CSA and depression, with differing interaction effects for men and women. In men, the positive association between CSA and depression was significant at high levels of substance use coping, whereas in women, this association was significant at low levels of substance use coping.

Conclusions. The findings underscore the importance of addressing the psychological sequelae of CSA, including the use of substances to cope with ongoing stressors. Gender-specific coping interventions could provide both men and women with better skills for responding to stressors, and substance use treatment presents an ideal opportunity to identify individuals in need of such interventions.

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3. Hidden and Stigmatised: Vulnerabilities Faced by Young Female Cannabis Users in Lagos, Nigeria

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and Helen Elsey
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Background. Cannabis use is criminalised in Nigeria, and young cannabis users conceal use because of stigma, social ostracism, and punitive law enforcement. The research explored the context of cannabis use among young people aged 16 to 21 years in Lagos, Nigeria. This presentation focuses on vulnerabilities of female cannabis users in their subcultural context and in wider society.

Method. While focus groups and paired interviews were conducted among males, females were difficult to recruit (7 of 39 interviewees) and preferred telephone interviews because they felt too ashamed to speak using conventional face-to-face interviews. All interviews were audio recorded, transcribed verbatim, and analysed using thematic analysis.

Findings. The predominant motivation for cannabis use among females was to cope with strained family relationships and conflicts that, in most instances, forced them to leave home. Leaving home facilitated vulnerability and isolation because without the protection of home, they preferred to be hidden to avoid gender-related sexual molestation and violent situations that frequently occurred in “drug joints.” Those who were arrested during law enforcement raids were at risk of exploitation—if they did not pay bribes to get released, they could be detained for up to 1 year. Women were further stigmatised by male cannabis users who perceived females who used cannabis as sex workers. The triple jeopardy of cultural unacceptability of female cannabis use, socioeconomic disadvantages due to isolation from family, and the criminal identity of a cannabis user combine to increase the women’s vulnerabilities, as some of them were forced to resort to sex work as to a survival strategy.

Conclusion. The multifaceted problems faced by female cannabis users in Nigeria are not visible to health promotion workers, and thus cannot be addressed by conventional programmes. A nonjudgemental participatory approach is needed to contextualise their needs, inform health promotion, and empower female cannabis users to seek help.

4. Constrained Relationship Agency as the Risk Factor for Intimate Partner Violence in Different Models of Transactional Sex

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Background. Women who engage in transactional sex (TS) are more likely to experience intimate partner violence (IPV). Given the normative nature of male financial support and romantic gift giving, it is important to understand the mechanisms through which these factors generate IPV, including how different reasons for engaging in TS—from survival to a desire for fashionable goods—impact IPV risk. The researchers hypothesized that (1) women with less constrained agency within their relationships would experience less IPV, independent of the amount of material goods provided by their male partner, and (2) different motives for TS would be associated with different levels of risk.

Method. We used cultural consensus modeling to generate distinct models of TS motives. We then recruited women from antenatal clinics in Swaziland for an audio computer-assisted self-interview survey measuring experiences with IPV, items received from a partner, and motives for engaging in sex. We used structural equation modeling to examine the separate roles of constrained agency and TS on IPV for different models of TS.

Results. We identified three TS models: one typified by older, rural, married women (nkhosi), one typified by urban women hoping for marriage (aspirational), and one typified by university students (university). Constrained agency, represented by having sex with a partner for reasons of poverty, money, hunger, fear a partner would leave, violence, or being forced by parents, was significantly associated with IPV (standardized coefficient 0.19, $p<0.001$). Engaging in the aspirational and university TS models to greater degrees was protective against IPV (both standardized coefficient -0.12, $p = .05$) while the nkhosi model was insignificantly associated with IPV (standardized coefficient -0.11, $p = .09$). Higher education was associated with increased relationship agency.

Conclusion. If women lack alternative sources of income or the ability to exit relationships, male financial support and gift giving function as a mechanism of control, increasing IPV. In aspirational and university relationships, economic support may signify a loving committed relationship, decreasing IPV risk. More financial support is not protective for married women. Preventing IPV requires recognition of the social and emotional role of male financial support, along with efforts to increase women's economic and social agency within their relationships.

5. Food Insecurity as a Driver of Intimate Partner Violence in Swaziland

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Introduction. Women who experience food insecurity may be more likely to experience intimate partner violence (IPV) and other forms of gender-based violence (GBV). Qualitative work in southern Africa suggests that food insecurity may drive women to risky sexual encounters and partnerships or inhibit their ability to exit an abusive relationship. However, to date, there is very little quantitative evidence exploring the association between food security and IPV or mechanisms that may mediate this relationship.

Method. We interviewed 400 women accessing antenatal care in Swaziland using audio computer-assisted self-interviewing. Women were asked about motives for sexual relations with their most recent partner and experiences with food insecurity. We then used structural equation modeling to measure the association between food security and IPV, with constrained relationship agency as a hypothesized mediator.

Results. Having sex with a partner for reasons of poverty, money, hunger, fear a partner would leave, violence, or being forced by parents represented a single latent construct, which we labeled constrained agency. IPV was independently associated with both constrained agency (standardized coefficient 0.162, $p=.05$), and lower levels of food security (standardized coefficient -.297, $p<.001$). Higher food security was associated with less constrained agency (standardized coefficient -.463, $p<.001$). Rural residence and lower education were both associated with decreased food security.

Conclusion. The effects of food security on relationship agency mediate, but do not completely account for, the link between food security and IPV. Women experiencing food insecurity may be at increased risk of IPV for a number of reasons. Food insecurity may result in less relationship agency, or IPV may precipitate food insecurity. The relationship between food security, agency, and IPV may also be cyclical. More work in the region is needed to fully understand this relationship. However, our findings suggest that efforts to integrate violence prevention into broader development efforts likely have greater potential than efforts that address these targets separately.

6. What Role Can Gender-Transformative Programming for Men Play in Increasing South African Men's HIV Testing and Engagement in HIV Care and Treatment?

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Background. Recent attention has focused on the fact that more men than women die from AIDS in Sub-Saharan Africa, despite women having higher HIV prevalence than men. In this region, men are less likely than women be tested for HIV and engage in HIV care and treatment. Norms of masculinity have been implicated as a key factor for this gender disparity. In this study, we explored masculinity-related barriers to men's testing/care/treatment and how participation in a "gender-transformative" intervention might help change men's ideas about masculinity and help them overcome those barriers.

Method. We conducted in-depth interviews (n = 60) with men who participated in One Man Can (OMC), a rights-based gender equality and health program intervention designed and implemented by Sonke Gender Justice in rural Limpopo and Eastern Cape, South Africa.

Results. We found that men were hesitant to be tested for HIV because of concerns it would make them appear weak or that being HIV-positive would exclude them from activities with male peers. Men who participated in OMC reported an increased capability to overcome masculinity-related barriers to testing/care/treatment. They reported increased ability to express vulnerability and discuss HIV freely with others, which led to greater willingness to be tested for HIV and receive HIV care and treatment for those who were living with HIV.

Conclusion. Interventions that challenge masculine norms and promote gender equality (i.e., gender-transformative interventions) represent a promising new approach to address men's barriers to HIV testing, care, and treatment.

7. Integrating a Brief Gender-Based Violence Prevention Intervention into Harm Reduction Programs for Women Who Use Drugs in Kyrgyzstan: Outcomes of the WINGS Intervention Study

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Background. The widespread problem of gender-based violence (GBV) among women who use drugs (WWUD) in Central Asia constitutes a serious human rights violation, which is also driving the HIV epidemic in this region. There is an urgent need for brief GBV interventions that can be delivered in low-threshold harm reduction settings in Central Asia and other countries with concentrated epidemics.

Aims. This study evaluated the feasibility and preliminary effects of WINGS, a two-session evidence-based GBV screening, brief intervention, and referral to treatment (SBIRT) model with HIV testing and counseling (HTC) in identifying and reducing GBV, completing HTC, and linking women to GBV and HIV services among WWUD in Kyrgyzstan. Using a pre-post design, we employed random effects Poisson and logistic regression analyses for continuous and dichotomous outcomes, respectively.

Method. We screened 109 WWUD from two harm reduction sites in Kyrgyzstan, 73 of whom met the criteria, completed a baseline survey, and enrolled in the study; and 66 women completed a 3-month postintervention.

Results. The study identified extremely high rates of GBV among the sample: 73 percent reported any physical or sexual violence by an intimate partner and 60 percent reported any physical or sexual violence by others (i.e., GBV) in the past year. At the 3-month follow-up, participants reported experiencing 59 percent fewer physical IPV incidents in the prior 90 days than at baseline ($p < .001$) and 27 percent fewer physical GBV incidents ($p < .01$).

Participants were more likely to report receiving GBV services ($p < .001$). The large majority of women (89%) completed HTC. Of these, four (7.7%) tested positive for HIV and three were linked to HIV care.

Conclusions. The high rate of participation, significant reductions in GBV, and completion of HIV testing from baseline to the 3-month follow-up suggest the feasibility and promise of this brief intervention for low-threshold harm-reduction settings.

8. Fathers' Parenting Behavior and Male Youths' Risky Sexual Beliefs in Rural Kenya: An Opportunity for Gender Equity

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Background. Sub-Saharan Africa (SSA) has the highest rates of HIV worldwide. Men are important drivers of this epidemic, as heterosexual sex is the primary mode of HIV transmission. Further, gender inequities in SSA increase men's sexual decision-making power. For young men, masculine norms placing reputational value on sexual activity can contribute to their acceptance of risky sexual beliefs and practices. Yet, positive parenting practices such as involved and warm interactions have been shown to be protective against risky beliefs and behaviors. Further, emerging evidence suggests male engagement in caregiving can positively influence men's beliefs about gender equity. As such, fathers' engagement in caregiving and parenting behaviors may be associated with their sons' degree of acceptance of risky sexual beliefs and behaviors.

Purpose and Hypotheses. The purpose of this study was to identify whether associations exist between (1) fathers' parenting qualities and involvement and sons' acceptance of sexually risky beliefs (e.g., "okay for men to have many sexual partners") and (2) fathers' and sons' acceptance of sexually risky beliefs.

Method. As part of a larger scale trial of a family- and church-based intervention for youth and caregivers in rural Kenya, a survey was administered. For these analyses, participants included 82 father-son dyads. The sons were 10 to 18 years of age. Effects were estimated using ordinary least squares linear regression.

Results. This study demonstrated an inverse relationship between positive, engaged fathering behavior and sons' risky sexual beliefs and a direct relationship between fathers' and sons' sexual beliefs. The implications are that male involvement in caregiving may mitigate male youths' acceptance of risky sexual beliefs and behaviors. Fatherhood may be an avenue toward increasing gender-equitable beliefs in both men and boys through the promotion of positive male caregiving. Also, fathers' sexual beliefs may influence sons' risky sexual beliefs in this context and should be considered in parenting-based HIV prevention efforts.

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9. Trafficking in Persons and Its Consequences for Health: A Systematic Review of TIP Research Methodologies

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Background. Trafficking in persons (TIP) is a human rights violation and social justice issue affecting millions of people globally. Rigorous research is needed to develop practices and policies to address TIP. However, investigating TIP poses challenges due to TIP's clandestine nature, variation in TIP definitions, the need to balance the feasibility of research with rigor, and the need to conduct research with high ethical standards to ensure vulnerable individuals' protection. To address these knowledge gaps and assess the state of TIP research methods, we systematically analyzed literature on TIP and health.

Method. We undertook a systematic review of 70 peer-reviewed papers published since 2000 to identify research methods used to investigate trafficked persons' health, determine what could be learned about TIP from the various methodologies, and identify gaps that exist in TIP and health research.

Results. About half of the papers (n = 39) were quantitative cross-sectional and 23 were qualitative; minorities were mixed methods or longitudinal. Overall, researchers relied on purposive sampling for structured interviews and record reviews at social service organizations. Varying TIP definitions, limited participant recruitment strategies, inconsistent ethical standards in reporting, and a dearth of outcome measures were all shortcomings in the literature. Results indicated a need for representative and nonpurposive recruitment strategies, and research on TIP-related risk and protective factors, intervention effectiveness, and long-term health outcomes. Research is particularly needed on forms of trafficking other than for sex (e.g., labor) and on trafficked men, boys, and transgender persons.

Conclusions/Implications. To our knowledge, this is among the first efforts to analyze all peer-reviewed literature on TIP and health to assess the research methods used in the field. On the basis of the results, we offer strategies to address evidence gaps, particularly for reaching the most vulnerable populations and increasing the use of intervention evaluations.

10. Women and HIV/STD Risk in Five Countries

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In 2014, close to 37 million adults were living with HIV and AIDS globally, with an estimated 2 million new cases of HIV contracted that year. Women constitute slightly more than half of the 37 million, except in Sub-Saharan Africa where women account for almost 60 percent of people living with HIV infection. Concurrently, women are one of the fastest-growing populations being infected with HIV, and the number of AIDS cases among women increases steadily each year. There are multiple physiological and social reasons that women are at higher HIV infection risk than heterosexual men. Women have a power imbalance, so they are less likely to be able to enforce safer sexual practices. They are more likely to need resources and therefore are more likely to trade sex for resources and money. In addition, the vagina has more surfaces where HIV can gain entrance. Populations at highest risk for HIV infection have disproportionately higher rates of other sexually transmitted diseases (STDs). According to the Centers for Disease Control and Prevention, people who get syphilis, gonorrhea, and herpes often also have HIV or are more likely to get HIV in the future. The National Institute of Mental Health Collaborative HIV/STD Prevention Trial was the first multicountry randomized trial of a community-level HIV intervention study with behavioral and biological endpoints. The trial was designed to test the efficacy of a community popular opinion leader intervention to reduce high-risk HIV-related behaviors in five developing countries: China, India, Peru, Russia, and Zimbabwe. Data were collected at baseline, 12 months, and 24 months. This presentation uses the baseline data to describe the risk factor analysis of the associations between the prevalence of viral and bacterial STDs, as well as demographics and patterns of risk behaviors in and across the five sites for the female study participants.

11. HIV+ Diagnosis During Pregnancy Increases Risk of IPV Postpartum Among Women with No History of IPV in Their Relationships

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Introduction. Studies have shown mixed findings on the relationship between HIV and women's risk of intimate partner violence (IPV). Per the dual vulnerability model, it may be that HIV infection matters only for particular relationships. Specifically, when you add an HIV-positive (HIV+) diagnosis into an already stressed relationship (as indicated by IPV history), it may work synergistically to increase IPV risk. In contrast, women with no history of IPV may be more resilient to an HIV+ diagnosis. Therefore, the aim is to test whether the positive association between HIV status and IPV will be exacerbated for women with a history of IPV.

Method. Data come from 1,064 women who participated in the baseline and 9-month follow-up visit of part of a larger randomized controlled trial (RCT). We conducted logistic regression analysis to examine our hypothesis. Model 1 assessed whether HIV diagnosis at a baseline antenatal visit predicted physical IPV at 9 months postpartum, controlling for demographic covariates. Model 2 included an interaction between HIV+ diagnosis and history of IPV.

Results. As hypothesized, there was a statistically significant interaction between HIV diagnosis and having a history of IPV (AOR: .40; 95% CI: .17, .96). However, the findings were in the opposite direction as expected. HIV was not significantly associated with IPV postpartum among women who had a history of IPV (AOR: .87; 95% CI: .49, 1.55). However, being HIV+ was significantly associated with IPV postpartum among women with no history of IPV (AOR: 2.17; 95% CI: 1.06, 4.42).

Discussion. Receiving an HIV+ diagnosis in pregnancy did not exacerbate postpartum IPV for women with a history of IPV in their relationship. However, the findings have important implications for women with no history of IPV. That is, women who test HIV+ and have no history of IPV should be counseled regarding the future risk of IPV in their relationships.

12. Gender Inequality Within Heterosexual Couples: New Evidence Indicating a Relationship Between Intimate Partner Violence and Nonadherence to Prevention of Mother-to-Child Transmission in Lusaka, Zambia

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Background. Intimate partner violence (IPV) is one of the most compelling manifestations of women's low power within couples. Numerous studies have established a relationship between IPV and poor HIV-related health outcomes. Yet, this study is the first to examine if a quantitative relationship exists between IPV and nonadherence to prevention of mother-to-child transmission (PMTCT).

Method. A cross-sectional survey was administered to 320 HIV-positive postpartum married women attending routine pediatric health care at a large public health center in Lusaka, Zambia, from February through August 2014. Local research assistants verbally administered the survey questionnaire in the local languages. IPV was measured using a version of the Revised Conflict Tactic Scale. PMTCT adherence was assessed through women's self-reporting of antiretroviral therapy (ART) during and after pregnancy (using a visual analog scale), infant feeding practices, and pediatric HIV testing. Drug adherence was defined as taking at least 80 percent of prescribed ART doses. Multivariate logistic regressions established significant relationships between variables.

Findings. Women who experienced IPV had 74 percent reduced odds of ART adherence during pregnancy ($p < 0.05$); 89 percent reduced odds of ART adherence postpartum ($p < 0.01$); 91 percent reduced odds of infant prophylaxis adherence ($p < 0.001$); 2.9 times greater odds of practicing mixed infant feeding rather than exclusive breastfeeding ($p < 0.01$); and 54 percent reduced odds of the child being tested for HIV ($p < 0.05$). Additionally, different forms of violence appear to affect PMTCT differently; physical violence had a less pronounced effect on nonadherence than emotional and sexual violence.

Conclusion. IPV against women is a large concern in its own right. This study indicates, moreover, that IPV may also play a significant role in maternal nonadherence to PMTCT. Many of the risk factors associated with IPV are symptoms of persistent gender inequity, which urgently need to be addressed through multilevel intervention.

13. Experiences of Intimate Partner Violence and Childhood Abuse Linked to Perceived Risk of HIV and Other Sexually Transmitted Diseases: Qualitative Analysis of Interviews with Currently and Formerly Incarcerated Women

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Background. Incarcerated women are commonly exposed to multiple forms of violence (intimate partner violence [IPV], sexual violence, childhood abuse) that can increase their risk for acquiring HIV and other sexually transmitted diseases (STDs) prior to incarceration and postrelease. This study examined how the experience of violence plays a role in perceptions of HIV/STD risk among incarcerated women.

Method. Individual, in-depth interviews were conducted with 25 current and 28 former women prisoners from two North Carolina correctional facilities. Women were asked about persons, places, and situations outside of prison that placed them in harm's way by increasing their risk of acquiring HIV and other STDs. Interviews were independently coded using an iterative process and analyzed using established qualitative methods. NVivo 10 software was used to perform content coding and develop hierarchical nodes/clusters on the basis of a calculated similarity index.

Results. The 53 participants ranged from 18 to 54 years of age (mean 33.7 years); 57 percent were white, and 42 percent were Black/African American. One-third of the sample (33%) reported living with a husband/boyfriend before incarceration. Over three-quarters (77.4%) had a felony conviction; the remainder were incarcerated based on misdemeanor charges. The cluster analysis identified four nodes linking violence experiences to perceived HIV/STD risk: (1) exposure to multiple and cyclical relationships involving IPV and abuse that limited protection (e.g., use of condoms); (2) failure to access needed social and mental health services in their home community to avoid violence and risky behavior (e.g., sex work, substance use and abuse); (3) lifelong struggles to personally cope with abuse that occurred during childhood and that led to consequent risky sexual behaviors and relationships (e.g., affiliation with gangs); and (4) loss of personal control in intimate relationships associated with lowered self-esteem and limited choices except to stay in abusive and unhealthy relationships.

Conclusions/Implications. The findings suggest that experiences of violence prior to women's incarceration are associated with behaviors that can increase perceptions of increased HIV and STD risk. Prevention programs for women with a history of incarceration and exposure to violence should address barriers to accessing needed services to enhance care. In addition to primary prevention of violence, improved identification and early intervention with victims of childhood abuse and IPV could help minimize risk for future incarceration and HIV/STD-related risk behaviors.

14. Legal Knowledge, Needs, and Assistance Seeking Among HIV-Positive and HIV-Negative Women in Umlazi, South Africa

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Background. The rights of women and people living with HIV/AIDS (PLWHA) are protected under South African law, yet a gap exists in the application of these laws. While there are numerous systemic and social barriers to women's and PLWHA's exercise of their legal rights and rights to access social services, little effort has been made to document these barriers along with legal needs and legal knowledge in this context.

Method. HIV-positive and HIV-negative women (N = 1,480) from an antenatal clinic in Umlazi Township completed a questionnaire on legal knowledge, experience of legal issues, assistance seeking for legal issues, and barriers to seeking assistance. We compared the legal knowledge and experience of legal issues of HIV-positive and HIV-negative women and described assistance seeking and barriers to assistance seeking among all women.

Results. Both HIV-positive and HIV-negative women had high levels of knowledge of their legal rights. There were few important differences in legal knowledge and experience of legal issues by HIV status. The most common legal issues the women experienced were difficulty obtaining employment (11%) and identification documents (7%). A minority of women who had ever experienced a legal issue had sought assistance for this issue (38%), and half (50%) of the assistance sought was from informal sources such as family and friends. Women cited lack of time and government bureaucracy as the major barriers to seeking assistance.

Conclusions. These results indicate few differences in legal knowledge and needs between HIV-positive and HIV-negative women in this context, but rather legal needs common among women of reproductive age. Legal knowledge may be a less important barrier to seeking legal assistance than time, convenience, and cost. Expanding the power of customary courts to address routine legal issues, encouragement of pro bono legal assistance, and introduction of legal navigators could help to address these barriers.

15. Integrated HCV-Alcohol Treatment: Development of an Efficacious, Inclusive (Patients with HIV, Women) Program

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Background. People with chronic hepatitis C virus (HCV) can be hard to reach. They have high rates of alcohol consumption, which is associated with progression of fibrosis and lower response rates to HCV treatment.

Method. We examined the feasibility of a 24-week integrated alcohol and medical treatment to HCV-infected patients. We recruited patients from a hepatology clinic if they had an Alcohol Use Disorders Identification Test score of less than 4 for women or greater than 8 for men, suggesting hazardous alcohol consumption.

The integrated model included patients receiving medical care and alcohol treatment within the same clinic. Alcohol treatment consisted of 6 months of group and individual therapy from an addictions specialist and consultation from a study team psychiatrist as needed. Initially, 60 patients were enrolled, and 53 participated in treatment.

Findings. The primary endpoint was the Addiction Severity Index (ASI) alcohol composite score, which significantly decreased by 0.105 (41.7% reduction) between 0 and 3 months ($p < .01$) and by 0.128 (50.6% reduction) between 0 and 6 months ($p < .01$) after adjusting for covariates. Alcohol abstinence was reported by 40 percent of patients at 3 months and 44 percent at 6 months.

Conclusions/Implications. This feasibility study demonstrated that an integrated model of alcohol treatment and medical care could be successfully implemented in a hepatology clinic with significant favorable impact on alcohol reduction among patients with chronic HCV. A randomized controlled trial (RCT) of the pilot program is now being conducted in the Duke University, University of North Carolina at Chapel Hill, and Durham VA Medical Center liver clinics. To date, 20 men and 7 women have enrolled. Top addiction treatment barriers for women are cost, social stigma, and not knowing where to go for help. We screen women using gender-tailored cutoffs; offer free treatment in a familiar environment to women randomized to treatment; provide nonjudgmental support for women to enter treatment; and give personalized, affordable referrals to women randomized to control.

16. Access HIV-Infected MSM to Health Care Facilities in Yaoundé and Bertoua: Difficulties and Suggestions

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Background. The fourth Demographic and Health Survey and Multiple Indicators Cluster Survey of Cameroon shows that the national prevalence of HIV infection was 4.3 percent in 2011, down by more than one point compared with 2004, when it was 5.5 percent. Current Cameroonian law prohibits homosexuality. However, Cameroonians who are gay go to health care facilities to receive treatment like everyone else. After meetings held with leaders of men who have sex with men (MSM) associations, we noticed that several members complained of difficulties in getting access to health care in public health facilities. To better understand the extent of the problem, the Cameroon Network of Associations of People Living with HIV (RéCAP+) conducted a survey on access to reproductive health care of 50 MSM in Yaoundé and Bertoua.

Method. The study was conducted from March to May 2015 with 50 HIV-positive (HIV+) MSM living in Yaoundé and Bertoua who were 16 to 40 years of age. The sample was divided into two groups on the basis of the stature of the association. In associations, interviewees were drawn randomly and the questionnaires were answered by appointment only.

Results. The survey results showed that over half of respondents (almost 75%) have difficulties getting treatment in health care facilities because of their sexual orientation. More than half of interviewees (almost 60%) were afraid to go to hospitals for consultations for fear of being rejected by doctors or nurses.

Conclusions and Recommendations. This study identified the main areas in which the rights of HIV+ MSM are violated: the right to privacy, the right to health, the right to family life, the right to work, and the right to physical safety. Faced with these realities, we can make the following recommendations: make known the results of this survey to associations and other stakeholders involved in the HIV field; promote best practices in the understanding of the care of MSM to health personnel; strengthen collaboration between RéCAP+ and other specialized structures in counseling and legal procedures; ensure that public health staff respect human rights; and encourage public and private institutions to develop public policies and strategies to combat discrimination against HIV+ MSM.

17. Understanding and Addressing Non-Intimate Partner Violence Among Women Who Use Drugs in the United States

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In the United States, research regarding violence against women who use drugs focuses predominantly on intimate partner violence (IPV) and, to a lesser degree, on violence related to sex trading. However, women who use drugs also experience violence at the hands of friends, acquaintances, and strangers. In a recent sample of 631 drug-using women in Oakland, California, a third of women reported being physically assaulted in the past year. Participants reported that 49 percent of perpetrators were friends, acquaintances, or strangers, whereas 44 percent were current or former intimate partners and 13 percent were paying sex partners. Eleven percent of women were sexually assaulted in the past year. In reported sexual assaults, 48 percent of perpetrators were friends, acquaintances, or strangers; 18 percent were current or former intimate partners; and 36 percent were paying sex partners. The risk environment of women who use drugs—many of whom live in impoverished communities with high levels of street crime and lack of safe housing—contributes to their vulnerability to violence. Building on earlier published works, this presentation describes new data examining forms of violence other than IPV (non–intimate partner violence) among women who use drugs in the San Francisco Bay Area. It outlines a potential research agenda for studying and addressing this form of violence among women who use drugs in US cities.

18. Intimate Partner Violence, Alcohol, and Drugs in Uruguay

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Introduction. Intimate partner violence (IPV) is a subject of human rights, public health, and economic development. Drug and alcohol consumption are two of the accepted risk factors.

Objective. Use qualitative data to explore the role of drugs and alcohol in IPV and prevention strategies.

Method. Key informants (medical doctors and social workers) were interviewed using a face-to-face form with 24 codes (16 for current situation, 3 for prevention, 5 for suggestions, and 1 for improvement) and 3 focus groups: (female workers, male workers, and university students). The focus group codes were nested into seven families of 59 codes: 17 for alcohol/drugs causation, 13 for consequences, 11 for reasons, 8 for family description of violence, 7 for who is responsible, 2 for process of violence, and 1 for role of other people.

Results. Most social workers thought drugs and alcohol are not a cause of violence, but they commonly coexist. Medical doctors thought that alcohol and drugs might be a cause. Half of the doctors mentioned IPV related to alcohol/drugs, that aggressiveness can be consubstantial, but violence is culturally learned/facilitated. Focus group participants thought that drugs and alcohol are risk factors for violence, as well as a lack of alcohol (and now marijuana) control and propaganda; violent games for children and a lack of outdoor activities (cycling, soccer); male jealousy; and a lack of communication, also related to devices (cell phones, computers).

Conclusions. Consubstantial or acquired drugs and alcohol are related to IPV and should be prevented starting in childhood with education starting in childhood at home, institutions, and communities on IPV, drugs and alcohol, communication skills, human rights, respect for the "other," and treatment for victims and victimizers. Each judge will need to define and specialize their role (e.g., family, penal, or civil).

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19. A Comprehensive Health Intervention Strategy for HIV-Positive African American Women with Comorbidities: Results of a Formative Evaluation

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Introduction. Chronic diseases such as diabetes and hypertension are now estimated to be among the leading causes of non-HIV-related deaths, especially among low-income African American female substance abusers. Unfortunately, guideline-based recommendations to help them manage their daily needs and medical symptoms within community-based settings are inconsistently followed. The purpose of this study was to conduct a formative evaluation and to identify specific personal, social, and cultural needs that can better inform the development and integration of contextually appropriate self-management strategies within health education programs serving this multiply vulnerable population.

Method. Data were collected using focus groups (N=48) conducted at four harm reduction facilities in Newark and Paterson, New Jersey. The discussions focused on participants' knowledge and level of confidence in their ability to manage the complications associated with having multiple illnesses.

Results. Content analysis of the transcripts revealed several major themes. Not knowing "how to take care of everything I have" or "what to take care of first" was a notable point of stress and frustration for nearly all participants. Many acknowledged feeling "alone," "helpless," or "powerless to change my situation." Having caring and knowledgeable medical staff that "actually listens to me," "not talk down to me like I'm stupid," "talk to me about more than just medicines," and "give me advice that is suited only for me" were described as being essential for "sticking to a program" but reported as being "nonexistent." While they had a general idea on how to stay healthy, most discussed "not knowing what to eat or do for a specific medical condition." Having access to "information that is more suited to who I am as a Black woman with HIV" and "showing me how to be an advocate for myself" were also deemed critical to their ability to have better control over their health.

Conclusions. The findings suggest that culturally sensitive programs are needed to improve overall health outcomes by helping African American female substance abusers faced with the dual diagnosis of HIV and one or more chronic diseases feel empowered to prioritize and self-manage multiple complications.

20. Violence Against Women and Girls in Nigerian Baby Factories: Is It Over?

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Introduction. Baby factories as a new harbinger for human trafficking and places for the violation of women in Nigeria have been recently reported. According to earlier studies, women in baby factories suffer physical, psychological, and sexual violence. At least eight baby factories were discovered by law enforcement officers in 2014. Following these observations, several measures are being taken to stem the tide and reverse the trend. This study extends previous analysis and answers the research question, "Is the practice of baby factories over?"

Method. Data harvested year-round from the media on the discovery of baby factories by law enforcement agents in 2015 were collected and analyzed along with previously available data. These data were used in assessing the trend of the practice. A comparison in the number of baby factories discovered in the past 2 years (2014 and 2015) was made to determine if the practice has been successfully curtailed.

Findings. Seven baby factories were identified and reported by the media in 2015, where women were found pregnant and awaiting delivery, and the babies were subsequently trafficked across Nigeria. This was a 14 percent reduction in the number of baby factories identified in 2015 compared with 2014. These are in addition to 23 illegal orphanages identified and closed for being involved in infant trafficking. Thus, concern on the number of illegal orphanages selling babies shows the practice might be becoming more elusive. Baby factories remain concentrated in the Southeast, harboring 86 percent (6 out of 7) of such discoveries in 2015.

Conclusion. Baby factories are still prevalent in Southeast Nigeria, and the discovery of several illegal orphanages with babies for sale suggests that traffickers are becoming more elusive. More action is needed to reverse the trend, including the engagement of indigent young women.

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21. Diagnosis and Disclosure of HIV Status: Implications for Women's Risk of Physical Partner Violence in the Postpartum Period

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Introduction. This study prospectively examined whether HIV leads to elevated risk in intimate partner violence (IPV) for women and how this risk varies depending on whether a woman disclosed her HIV status to her partner.

Method. We ran a series of logistic regression models using data from 1,092 pregnant and postpartum women enrolled in a randomized controlled trial in Durban, South Africa. Model 1 assessed whether baseline HIV status predicted 14-week postpartum physical IPV, controlling for baseline physical IPV, disclosure to partner, and demographic and study covariates. Model 2 added the interaction between HIV status and disclosure.

Results. HIV was not associated with 14-week physical IPV in the main effects model (AOR: 1.34; 95% CI: .88, 2.05). However, there was a statistically significant positive interaction between HIV and disclosure (AOR 0.22; 95% CI: .05, .96). Among women who disclosed their HIV status, HIV was not significantly associated with 14-week IPV (AOR: 1.12; 95% CI: 0.71, 1.89). However, among women who had not disclosed, the odds of reporting IPV at 14 weeks was 5.15 times higher for HIV-positive women than HIV-negative women (95% CI: 1.25, 21.00).

Discussion. Although we established that HIV does not increase incidence of IPV for all HIV-positive women, we found an elevated risk of IPV among the HIV-positive women who chose not to disclose their status to their partner. Women's choice not to disclose is likely a marker for other problematic aspects of their relationships, and counselors should either find alternative safe options for disclosure or support women's decisions not to disclose.

22. Reproductive Health History and Contraception Use Among Female Exotic Dancers

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Objective. This study aims to describe the reproductive health history and contraception use patterns among a population of female exotic dancers in Baltimore, Maryland.

Method. Female exotic dancers were recruited by study staff from 26 clubs in Baltimore city and county to participate in a prospective study investigating the exotic dance club risk environment and health needs of this population. A cross-sectional anonymous survey was administered at baseline.

Results. Among participants (N=117), sex work was common, with 41 percent (n=48) reporting a past or current history. Many women reported having had one (n=41; 35%) or two (n=15; 13%) prior abortions. Among those with a current contraceptive need (n=96; 82%), 64 percent (n=61) reported contraceptive use. However, most of these women were only using a barrier method (n=58; 60%). Very few reported consistent condom use (n = 3; 3%) or other contraceptive methods such as oral contraceptive pills (n=2; 2%).

Conclusions. Female exotic dancers are a population at high risk for poor reproductive health outcomes, with significant unmet contraceptive and related health needs. A better understanding of these unique needs is warranted to tailor future family planning and other reproductive health interventions.

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23. Child Brides, Forced Marriage, and Intimate Partner Violence in the United States: Tip of an Iceberg Revealed

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Background. Forced marriage is a violation of human rights and thwarts personal safety and well-being. Child brides are at higher risk of intimate partner violence (IPV) and are often unable to effectively negotiate safer sex, leaving them vulnerable to sexually transmitted infections, including HIV, and early pregnancy. The prevalence of forced and child marriage in the United States is unknown. The intersection of forced and child marriage and IPV is equally unknown.

Method. Mothers (N = 277) who reported IPV to shelter or justice services were asked about forced marriage attempts, frequency and severity of IPV, mental health status, and behavioral functioning of their child.

Results. Among participants, 47 (17%) reported a forced marriage attempt, with 45 percent of the women younger than 18 years of age at the time of the attempt. Among the 47 women, 11 (23%) reported death threats, 20 (43%) reported marriage to the person, and 28 (60%) reported a pregnancy. Women younger than 18 years of age reported more threats of isolation and economic deprivation associated with the attempt and pressure from parents to marry. Regardless of age, women experiencing a forced marriage attempt reported more intimate partner sexual abuse, somatization, and behavior problems for their children. Forced marriage attempts happened to one in six women (17%) reporting IPV and are associated with worse functioning for mother and child.

Conclusion. The frequent occurrence and associated impact of forced marriage attempts to maternal child functioning indicates that routine assessment for forced marriage attempt is needed as part of comprehensive care for women reporting IPV.

24. Structural Violence in Papua, Indonesia: Reflections on the Emergence of Home-Brewed Alcohol and Gender-Based Violence

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Background. In Papua, Indonesia, there is almost no indigenous tradition of drinking alcoholic beverages. Yet today, home-brewed alcohol is transforming gendered and political violence in the highlands. This presentation draws on discussions of alcohol, gender, and violence undertaken with indigenous men and women in Wamena, situated in the highlands of Papua.

Method. Discussion groups were conducted with indigenous Dani men and women aged 18 to 60 years as part of an evaluation of a nongovernmental organization (NGO) program to combat violence against women.

Findings. Male and female participants were candid about the devastating consequences of increased alcohol consumption, with many predicting that binge drinking, coupled with epidemic levels of HIV, will result in the demise of the indigenous population. Participants said that alcohol influenced men to sexually assault women, which contributed to feelings of trauma and insecurity among women, transmitted infections, and unwanted pregnancies. Drunken behaviour also attracted violent responses from the police or military. Young male informants pointed to economic marginalisation in the city as a motivation to produce homebrew and to binge drink. Being stigmatised as drunks further inhibited their economic activities.

Conclusions. The production and consumption of homebrew in the highlands is adding a dangerous ingredient to already volatile conditions. So far, policy actions related to alcohol simply ban the production of home-brewed alcohol and the importation of alcohol to the highlands. The consumption of home-brewed alcohol in Papua alerts us to issues of poverty, social and economic exclusion, indigenous stress, stigmatisation, and political oppression that reflect, in part, a structural violence resulting from an unwanted colonial regime.

25. Using Community Asset Mapping to Support Recruitment and Retention for a Community-Based Sexual Violence Prevention Program

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Background. As a potentially impactful health strategy, global health organizations highlight engaging men and boys in preventing violence against women. "Manhood 2.0" is a prevention program for high-school–aged young men that combines healthy sexuality skills, gender norms change, and bystander skills to interrupt peers' disrespectful and harmful behaviors to reduce sexual violence and relationship abuse perpetration among adolescent males. The program is implemented in community-based settings such as the YMCA, Urban League, youth-serving agencies, and churches. We are using a community asset mapping approach to ensure that multiple community partners are involved at each site to help build trust, assist with recruitment and retention of youths, and nurture positive youth development in each of these sites.

Method. Sixteen socially disadvantaged neighborhoods in an urban community were randomly allocated to intervention or control conditions. Asset maps were constructed via an iterative process to identify key community champions to both facilitate the program and recruit youths to participate, as well as to develop partnerships with agencies willing to host the program or assist with recruitment into the program.

Results. We described the range of asset maps created across sites, identifying key components needed for implementation. We defined successful program implementation as having community-based facilitators, community partners assisting with recruitment, consistent attendance at the program by youths, and the ability to retain youths throughout the program.

Conclusions. Non-school-based prevention program implementation can be challenging because of less infrastructure for recruiting and retaining youths as compared with school-based programs. Community asset mapping approaches can facilitate increased community partner involvement for successful implementation.

26. Migrant Labor, Street Life and Sex Work: Experiences of Violence, HIV Vulnerability and Drug Use for Girls and Young Women in Côte d'Ivoire

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Background. Studies have found an overrepresentation of rural adolescent girls migrating to large urban areas for domestic work.

Objective. To investigate the intersectionality of experiences related to violence, self-medication related to pregnancy prevention, and HIV vulnerability of the adolescent girls who migrated to urban areas for domestic work.

Method. The study used a purposive mixed-methods design to examine factors that could lead to extreme vulnerabilities for girls in Côte d'Ivoire. Participants included 334 girls using validated measures on similar populations. Thirty of these children were selected for in-depth interviews. Street children accounted for at least 50 percent of the in-depth interviews. Quantitative and qualitative findings of girls living on the street are featured in this presentation.

Results. The average age of the girls in the study was about 15.03 years (SD = 2.53). Most of the girls experienced early sexual debut and were sent to work at earlier ages than boys and young men. About 50 percent of the exploited child sex workers were formerly domestic workers. Nine percent of the girls had children, and some reported street abortions. About 70 percent of girls younger than 14 reported being forced to have sex. In-depth interviews revealed the girls were using street drugs to keep them from getting pregnant. This study suggests a link between sex work and HIV vulnerability, as well as unintended pregnancy.

Conclusions. Girl children living on the street continue to be a "hard to reach" key population in the prevention and intervention of HIV and violence and pregnancy prevention. There are complexities of migration and the vulnerabilities experienced by girls and young women because of their gender. Understanding these complexities will contribute to ending gender inequalities and implementing culturally appropriate interventions.

27. Comparing Perceptions with Actual Reports of Close Friend's HIV Testing Behavior Among Urban Tanzanian Men

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Background. Men have lower rates of HIV testing and higher rates of AIDS-related mortality than women in Sub-Saharan Africa. One promising approach to increasing men's HIV testing may be to leverage peer testing norms. Peers likely influence HIV testing through social norms, which provide important information on perceived or actual prevalence and appropriateness of behaviors. Perceptions of social norms may be inaccurate and systematically biased as individuals may overestimate or underestimate actual peer behaviors. Interventions using a social norms approach can be implemented to rectify misperceptions with the aim of increasing health-promoting behaviors, such as HIV testing, by revealing actual healthier norms.

Method. To assess whether there is an opportunity to increase men's uptake of HIV testing by correcting misperceptions about testing norms, we compared men's perceptions of their closest friend's HIV testing behaviors with the friend's actual testing self-report using a unique dataset of men sampled within their social networks (n = 59) in Dar es Salaam, Tanzania. Data came from an ongoing cluster-randomized HIV prevention trial funded by the National Institute of Mental Health (NIMH R01MH098690). We examined the accuracy and bias of perceptions among men who have tested for HIV (n = 391) and compared them to the perceptions among men who never tested (n = 432).

Results. We found that testers and nontesters did not differ in the accuracy of their perceptions, although nontesters were strongly biased toward assuming that their closest friends had not tested. Specifically, even when controlling for demographic characteristics, nontesters had 3.27 times greater odds of incorrectly rejecting versus correctly identifying HIV testing in their closest friends (95% CI: 2.00, 5.33) compared with men who had previously tested.

Conclusion. Our results lend support to social norms approaches designed to correct the biased misperceptions of nontesters to promote men's HIV testing.

28. Evidence of Social Network Influence on Multiple HIV Risk Behaviors and Normative Beliefs Among Young Tanzanian Men

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Background. Research on network-level influences on HIV risk behaviors among young men in Sub-Saharan Africa is severely lacking. One significant gap in the literature that may provide direction for future research with this population is understanding the degree to which various HIV risk behaviors and normative beliefs cluster within men's social networks. Such research may help us understand which HIV-related norms and behaviors have the greatest potential to be changed through social influence. Additionally, few network-based studies have described the structure of social networks of young men in Sub-Saharan Africa. Understanding the structure of men's peer networks may motivate future research to examine the ways in which network structures shape the spread of information, adoption of norms, and diffusion of behaviors.

Method. We contributed to filling these gaps by using social network analysis and multilevel modeling to describe a unique dataset of mostly young men (N = 1249 men and 242 women) nested within 59 urban social networks in Dar es Salaam, Tanzania. We examine the means, ranges, and clustering of men's HIV-related normative beliefs and behaviors. Networks in this urban setting varied substantially in both composition and structure, and a large proportion of men engaged in risky behaviors, including inconsistent condom use, sexual partner concurrency, and intimate partner violence perpetration.

Results. We found significant clustering of normative beliefs and risk behaviors within these men's social networks. Specifically, network membership explained between 5.78 and 7.17 percent of variance in men's normative beliefs and between 1.93 and 15.79 percent of variance in risk behaviors.

Conclusion. The results suggest that social networks are important socialization sites for young men and may influence the adoption of norms and behaviors. We conclude by calling for more research on men's social networks in Sub-Saharan Africa and map out several areas of future inquiry.

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29. What Is Needed to Break the Cycle of Drug Use and Violence for Poor Young Women from Cape Town, South Africa

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Background. A large proportion of poor young women who use alcohol and other drugs (AODs) in Cape Town, South Africa, have been exposed to physical and sexual trauma. Efforts to help these women heal are hampered by limited understanding of their services needs and the availability and appropriateness of health services to meet these needs. To address this gap, we explored the service needs of young AOD-using women with histories of trauma.

Method. We conducted four focus groups with women aged 18 to 25 who used AODs and had histories of victimization from two township communities in Cape Town. We also conducted 16 in-depth interviews with health and social welfare service providers.

Results. The findings revealed that these young women had never received any assistance for their traumatic experiences. As a result, AOD use was a way of coping with traumatic memories and negative emotions, and they were reexposed to violence. Many young women wanted to stop AOD use but did not know how to manage their trauma-related triggers. Providers noted the importance of self-care strategies (e.g., exercise, nutrition, mindfulness techniques) to help women manage their triggers for AOD use. Although providers understood that these vulnerable young women needed trauma-informed services that address AOD use, trauma and other health risks in an integrated manner, current AOD and trauma services operate in silos. Because of gender inequality and stigma, young AOD-using women are unable to access trauma services. If they do access AOD treatment services, the services do not provide trauma-informed care. Consequently, these young women slip through the cracks and continue to be reexposed to AOD use and violence.

Conclusion. Young women who use AODs and have histories of trauma need comprehensive trauma-informed services that enable them to break the cycle of AOD use and violence.

30. Gender Relations and HIV Transmission in Married Women in North-Central Nigeria

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Background. Nigeria's most recent National HIV/AIDS and Reproductive Health Survey in 2012 shows a decline in the national prevalence rate from 3.6 percent in 2007 to 3.4 percent in 2012. Despite this moderate decrease, the rate for the north-central geopolitical zone—5.7 percent in 2007 and 3.6 percent in 2012—remained higher than the national average for both years. Besides, virtually all of the HIV and AIDS surveys conducted in Nigeria from 1999 to date have consistently shown higher rates among females than males. For instance, the rate was 4.0 percent and 3.5 percent among females and 3.5 percent and 3.3 percent among males in 2007 and 2012, respectively. Higher vulnerability among married females implies higher risk of parent-to-child transmission. In 2014, the United Nations Programme on HIV/AIDS reported that studies on the mode of transmission in 2008 found the bulk of new infections were among cohabiting and married sexual partners who are not engaged in high-risk sex (42%) compared with casual heterosexual sex (9.1%) and sex workers (3.4%).

Method. Against this backdrop, this qualitative study examined some of the sociocultural factors that influence the spread of HIV/AIDS among married women in two ethnic groups in north-central Nigeria. We conducted 24 in-depth interviews and 30 focus group discussions in six communities.

Results. The results indicate that forced marriage, sex partner double standards in breastfeeding norms, women's poor access to sexual negotiation, gender-based violence, and other forms of gender inequality influence the spread of HIV infection in married heterosexual couples.

Conclusions. This study suggests that marriage does not necessarily reduce HIV vulnerability in women. Consequently, addressing the challenges of gender inequality and other social and cultural factors could be an effective strategy for intervention programmes focused on HIV/AIDS reduction in Nigeria.

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31. Early Initiation of Sex Work: Associations with Early-Risk Environment, Recent Violence, and Gender Norms in Adulthood

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Background. Initiation of sex work during childhood or adolescence (i.e., prior to age 18) is common among female sex workers (FSWs). Greater understanding of the long-term influence of early sex work initiation can inform the development of effective interventions to improve the health of adolescent and adult FSWs. This research investigates if early sex work initiation among adult FSWs in Mombasa, Kenya, is associated with (1) early-risk environment, (2) recent violence, or (3) violence-related gender norms.

Method. Data were collected as part of a randomized controlled alcohol harm-reduction intervention study. The sample comprised FSWs in Mombasa who were 18 years of age or older, visited HIV prevention drop-in centers, and were moderate-risk drinkers. Early initiation of sex work was defined as beginning sex work at 17 years of age or younger. Logistic regression modeled violence and gender norms as a function of early sex work initiation, adjusting for drop-in center, current age, education, HIV status, supporting others, and childhood abuse.

Results. Early initiators were significantly more likely to report childhood physical and sexual abuse, and reported first sex and drinking alcohol at significantly younger ages compared with those who started sex work in adulthood. Early initiation was significantly associated with recent verbal abuse from paying sex partners and having been robbed or not paid as agreed to by a client. FSWs who initiated sex work early endorsed greater acceptance of intimate partner violence and were less likely to seek help for violence from paying partners compared with those who did not initiate sex work early.

Conclusions. The findings speak to the need for early intervention for high-risk youths and adolescent FSWs, particularly in relation to violence risk reduction. Structural interventions that address underlying risk factors for adolescent sex work are warranted. Interventions should incorporate components designed to increase self-efficacy and help-seeking among FSWs experiencing violence.

32. Evaluation of CHOICE-8 Effect on Girls and Boys Who Took Part in the Substance Abuse Prevention Program

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Background. To understand gender implications in measuring CHOICE-8 effectiveness, a study was conducted involving 887 eighth-graders from 15 schools in Ukraine. A presurvey conducted in October 2013 indicated that 42 percent of boys and 36 percent of girls were truant for at least one lesson within the past 30 days. Twenty-three percent of boys and 15 percent of girls showed social acceptance of tobacco; 27 percent of boys and 17 percent of girls showed social acceptance of alcohol; and 81 percent of boys and 76 percent of girls showed lack of tolerance to people living with HIV. Given these findings, CHOICE-8 was conducted for 15 classes; another 15 classes constituted a control group.

Method. The survey questions were: (1) "How many lessons have you been truant for in the past 30 days?" (responses "1" and "More than 1" were considered); (2) "Is it bad when somebody smokes tobacco?" (options were "Yes," "No," "Maybe"); (3) "Is it bad when somebody drinks alcohol?" (options were "Yes," "No," "Maybe"—for attitudes to tobacco and alcohol, responses "No" and "Maybe" were considered); and (4) "Are you ready to make friends with an HIV-positive person?" (options were: "Yes," "No," "Maybe"; responses "No" and "Maybe" were considered).

Results. At the postassessment, 31 percent of boys and 22 percent of girls reported having committed truancy (11% less for boys and 14% less for girls compared with baseline), 20 percent of boys and 8 percent of girls showed acceptance of tobacco (3% less for boys and 8% less for girls), 20 percent of boys and 8 percent for girls showed acceptance of alcohol (7% less for boys and 9% less for girls), and 59 percent of boys and 46 percent of girls demonstrated lack of tolerance to people living with HIV (22% less for boys and 30% less for girls).

Conclusion. The findings demonstrate some gender differences on all four survey questions. Girls tended to report more positive changes in attitudes. The research will be extended.

33. Intimate Partner Violence and Substance Use Among Young Women in Rural South Africa

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Background. Adolescent South African women are at risk for intimate partner violence (IPV), particularly in settings where they rely financially on male partners. Drug and alcohol use may increase this risk.

Method. HPTN 068 was a randomized controlled trial conducted to assess the impact of a conditional cash transfer (school attendance required) on HIV incidence among young, South African women; 2,533 women in school, aged 13 to 20 (median 15 years), enrolled in the trial. IPV was evaluated using eight questions from the World Health Organization (six questions about physical abuse and two about sexual abuse). We examined the association between IPV and substance use at the baseline visit.

Results. Prevalence for any IPV (physical or sexual) was 19.54 percent (95% CI: 18.03, 21.18), for sexual IPV was 4.54 percent (95% CI: 3.79, 5.43), for physical IPV was 17.42 percent (95% CI: 15.99, 18.98), and for both physical and sexual IPV was 2.53 percent (95% CI: 1.98, 3.23). The rate of ever drug use was 4.75 percent (95% CI: 3.99, 5.65). Current alcohol consumption was 8.91 percent (95% CI: 7.86, 10.09). Among ever drug users, 35.83 percent (95% CI: 28.20, 45.53) experienced any type of IPV ever, and among never drug users, only 18.68 percent (CI: 17.16, 20.33) experienced any type of IPV ever (prevalence ratio: 1.92; 95% CI: 1.49, 2.47). Among alcohol consumers, 44.39 percent (95% CI: 38.33, 51.42) experienced any type of IPV ever, and among non-alcohol consumers, 17.03 percent (95% CI: 15.54, 18.67) experienced any type of IPV ever (prevalence ratio: 2.61; 95% CI: 2.19, 3.10).

Conclusions. In this young, female, school-going population, nearly one-fifth of young women reported ever experiencing any IPV. Although less than 10 percent of young women reported consuming alcohol or ever using drugs, those who did were more likely to experience IPV compared with those who did not. Further exploration of the relationships between IPV and alcohol and drugs can help elucidate these findings.

34. Association Between Intimate Partner Violence and STI/HIV-Related Risk Behaviors: Findings from the Nepal Demographic Health Survey

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Background. Intimate partner violence (IPV) is a significant global health issue and has been associated with increased sexually transmitted infection (STIs) and HIV-related risk behaviors and vulnerability to STIs and HIV infection. While IPV exists across all strata of Nepali society, its link to STI and HIV-related risk behaviors has not been studied in this region. This study was designed to examine the potential relationship between physical and sexual IPV and STIs and HIV-related risk behaviors among women in Nepal.

Method. We used data from the nationally representative Nepal Demographic Health Survey 2011, which employed a two-stage complex design to collect data. We limited our analyses to 3,084 currently married women, aged 15 to 49 years, who completed questionnaires on demographic characteristics, domestic violence (including physical and sexual IPV), and sexual behaviors in the past year. We used multivariate logistic models, adjusted for age, educational and employment status, cohabitation duration, and husband's drinking behavior, to assess the association between IPV and STI and HIV-related risk behaviors.

Results. Over one-fourth (28%) of women reported having experienced some type of IPV during their lifetime, including physical IPV (23%) and sexual IPV (14%). Low or no educational attainment, educational disparity between a woman and her partner, higher economic status, and problematic alcohol use were significantly associated with an increased physical and sexual IPV risk among women. After adjusting for potential confounders, women who reported physical IPV were significantly more likely to report a history of STIs (AOR: 1.74; 95% CI: 1.37, 2.22), multiple sex partners (AOR: 2.31; 95% CI: 1.56, 3.43), inconsistent condom use (AOR: 1.88; 95% CI: 1.03, 2.85), husband with known HIV-related risk behaviors (AOR: 1.75; 95% CI: 1.04, 2.94), and inability to negotiate safer sex (AOR: 1.44; 95% CI: 1.17, 1.78). Women experiencing sexual IPV were significantly more likely to report a history of STIs (AOR: 1.52; 95% CI: 1.15, 2.00), being unable to refuse sex (AOR: 2.56; 95% CI: 1.69, 3.84), and inability to negotiate safer sex (AOR: 1.63; 95% CI: 1.28, 2.12).

Conclusions. The findings reinforce the globally growing evidence that women who experience violence from their intimate male partners are more likely to exhibit STI and HIV-related risk behaviors. This highlights a need to develop effective interventions aimed at eliminating IPV to decrease the disproportionate burden of adverse health outcomes, including STIs and HIV, among women.

35. Discrimination and Exclusion of the LGBTQ Community in South India: A Critique

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The genesis of the problems of the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) community in India lies in the stigma and discrimination they face in the society, resulting in their exclusion from the socioeconomic and political spectrum. They are considered an outlier group of the society. Based on international activities, organizations in India started working for the protection of the basic dignity of LGBTQ people and work against discrimination in education, labor market, health, housing, domestic violence, denial of family rights, and recognition in the larger society. In the case of India, it can be said that it goes "one step forward and two steps backward" in dealing with gender issues, particularly related to the LGBTQ community. Decriminalizing homosexuality was considered a positive step in that direction by a landmark ruling in 2009, but that ruling was set aside in 2013, again making homosexuality illegal. Organizations that work for LGBTQ community rights, particularly in five south Indian states, have started organizing several events through dance, theatre, speeches, and glitter and glamour to sensitize Indians about the struggles of the LGBTQ community, which generated awareness about the problems they face in day-to-day life. These groups advocate for laws and policies that should protect everyone's dignity and a world where all people can enjoy their rights fully, without any gender or sexuality discrimination. LGBTQ people in India experience multiple forms of social and legal discrimination. The social and cultural practice of discrimination, coupled with poverty, illiteracy, and limited employment opportunities have led to increased vulnerability of these communities, driving them to resort to drug peddling and sex work. This presentation provides a critique of health conditions (particularly HIV/AIDS), violence against these groups, discrimination in education and employment, measures of affirmative action taken up by governments (such as setting up Transgender Justice Boards), actions and developments on the legal status of the LGBTQ community, and focuses on discrimination on the basis of gender or sexuality status in India.

36. Transfer of Learning After an Online Training for Caregivers and Professionals Who Work with Youths Identifying as LGBTQ in North Carolina's Substitute Care System

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The US child welfare system sometimes fails to ensure the safety of youths who identify as lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ). Because of limited foster home placements for these youths, many are placed into group homes where they are at risk for verbal and physical abuse. To increase support for youths who identify as LGBTQ in North Carolina's substitute care system, we developed an online training for caregivers and social workers. This study evaluates the effectiveness of the training in increasing (1) participants' knowledge about youths who identify as LGBTQ and (2) participants' application of that knowledge. The training covers experiences of youths in substitute care who identify as LGBTQ, best practices in supporting these youths, and a video-recorded panel discussion with caregivers and professionals. We designed a 25-item online survey to gather data on participant demographics, measure increase in knowledge about the training topics, and assess whether and how participants transferred knowledge to their work or parenting. The survey also asks about facilitators and barriers to applying knowledge. Because some participants completed the training anonymously, a pre-post comparison is not possible. We elected to measure outcomes on the basis of participants' perceptions and to implement the survey as a 1- to 5-month follow-up. In a fall 2015 pilot launch, 13 foster and adoptive parents and child- and family-serving agency professionals completed the training, and the winter 2016 launch is imminent. Participants will receive the follow-up survey in early 2016. Although focusing only on initial launches, this study will use participants' reports to provide a base in knowledge about how effectively the training increased knowledge and changed practice or parenting for the social workers and caregivers involved. The findings will support further development of the training and its widespread use throughout North Carolina, which, in turn, will yield more general knowledge about the training's effectiveness.

37. Intimate Partner Violence Among Men and Women Who Use Methamphetamine: A Mixed-Methods Study in South Africa

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Introduction. The prevalence of methamphetamine use has risen dramatically in parts of South Africa. Globally, methamphetamine has been linked to intimate partner violence (IPV) and other forms of aggression. The aim of this mixed-methods study was to examine the experiences of physical IPV and its contextual factors among methamphetamine users in an urban community in Cape Town, South Africa.

Methods. Active methamphetamine users were recruited using respondent-driven sampling. All participants (N=360) completed structured surveys, and a subset (n = 30) also completed in-depth interviews that included discussions of personal IPV experiences. Quantitative data were examined separately by gender. Multivariate logistic regression models were used to identify predictors of IPV victimization and perpetration. Qualitative data were analyzed to provide contextual understanding.

Results. In the past 3 months, 17 percent of women and 18 percent of men reported being a victim of IPV, and 12 percent of women and 12 percent of men reported being a perpetrator of IPV. Victimization and perpetration were highly correlated. In the multivariate models, histories of childhood and adult abuse were strong predictors for both IPV victimization and perpetration. Most notable was the strong predictive value of adult sexual assault on women's history of IPV victimization (OR=5.54) and IPV perpetration (OR=6.34). Although the quantitative data suggest gender equivalence in the proportion of women and men experiencing IPV, the qualitative data provide a more nuanced context, with female victimization by male partners being particularly frequent and intense. In narratives, IPV was a product of male aggression while using methamphetamine, norms around sex trading, and gender-based attitudes endorsing violence against women.

Conclusion. Addiction to methamphetamine creates a heightened risk of IPV, especially among those with previous traumas. The bidirectional violence noted in the survey may reflect gender differences, whereby men use violence to demonstrate dominance and power, and women use violence as a form of self-protection.

38. Impact of Sexual Trauma on HIV Care Engagement: Perspectives of Female Patients with Trauma Histories in Cape Town, South Africa

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Background. South African women are disproportionately infected with HIV and report experiencing sexual traumas at high rates. HIV-infected individuals with sexual trauma histories have worse HIV-related clinical outcomes, but insight into the effect of traumatic history on HIV care engagement in South Africa is lacking.

Method. We conducted in-depth qualitative interviews with 15 women who were receiving HIV care at a public clinic and had histories of sexual trauma. Interviews conducted between December 2014 and March 2015 explored participants' HIV and sexual trauma histories, coping behaviors, HIV care engagement, and related contextual issues. The interview transcripts were analyzed for themes related to how sexual trauma directly or indirectly impacted HIV care engagement.

Results. Participants reported experiencing multiple and complex sexual trauma experiences across their lifetimes, as well as ongoing trauma symptomology and challenges with interpersonal relationships. Sexual trauma had directly affected some participants' HIV care engagement behaviors, particularly in the early period after diagnosis. For others, sexual trauma had the potential to adversely affect HIV care engagement in the future, via traumatic stress symptoms, including avoidance. Disclosure of sexual trauma history was limited, and none of the women had spoken with an HIV care provider about their trauma histories.

Conclusion. The findings suggest that, given the coexisting burdens of HIV infection and sexual trauma among South African women and the repercussions that trauma has on engagement in care, efficacious trauma interventions that can be delivered in an HIV care setting are urgently needed in South Africa.

Policy Analysis

39. Gender in Context: From Conflict to Truth Commissions Bettering the Future for Post-Conflict Women

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This research explores the gendered dimension of conflict in transitional societies. Particularly, it argues that truth commissions must be representative of women to address their marginalization, which precedes, flourishes in, and often survives periods of conflict and mass atrocity. Truth commissions have been largely gender neutral to date. To understand, redress, and transform the inequality experienced by women, their positions must be contextualized throughout the entire transitional justice process. This paper explains that women experience sexual, reproductive, and other abuse, but also recognizes that many indirect causes and effects are entrenched in historical, cultural, and social constructs. Three case studies are included to illustrate attempts to incorporate gender into truth commissions. Scholars have conducted extensive research on truth commissions in Peru, South Africa, and Timor-Leste, which provides a blueprint of expertise on the multifaceted components truth commissions face in addressing gender. The case studies provide examples of successes and failures of their approaches, and evidence of the importance of contextualizing women's positions in confronting post-conflict scenarios. As acknowledgment of gender issues becomes increasingly prevalent, it is important to recognize the far-reaching grasp of what gender inequality has enveloped and to use the opportunity to better the future of women through respect, acknowledgement, and sensitivity in transitional societies.

40. Integrating and Mainstreaming Gender into Social and Behavior Change Programs: What Does It Take?

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According to the United Nations, gender mainstreaming entails greater attention to gender perspectives as an integral part of all activities across all programs. This involves making gender perspectives—what women and men do and the resources and decision-making processes they have access to—more central to all policy development; research; advocacy; development; implementation and monitoring of norms and standards; and planning, implementation, and monitoring of projects. Within social and behavior change (SBC) programs, gender integration and mainstreaming is important as many social norms and practices are gender related. Through a user-centered informal inquiry among international and local nongovernmental organizations (NGOs), we found that groups are struggling with how to integrate and mainstream gender into SBC programs, starting with their internal staff. The first objective of the inquiry was to share a brief overview of documents, resources, and Web sites in gender across health and non-health sectors, and find other materials that were available. The second objective was to identify needs regarding how to effectively integrate and mainstream gender into projects and programs. The results showed that while technical areas considered gender and aspects of integration and mainstreaming in programs, a comprehensive approach could not be replicated in other projects. Many organizations also equated the term "gender" to include women, versus balancing men's and women's participation in a transformational way. On the basis of the findings from this inquiry, we are conducting participatory and user-centered research to identify and address policy and programmatic needs of stakeholders from various development areas. A literature review will produce an annotated bibliography that synthesizes gender integration and mainstream best practices and related outcomes. This resource will contribute to the development of practical, user-friendly, and evidence-based guidance on the application and evaluation of gender integration and mainstreaming in health and non-health programs, policy, and advocacy efforts.

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41. An Evaluation of World Bank Group Engagement on Gender Issues in Low-Income Fragile and Conflict States (2001–2012)

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Gender issues merit special attention in fragile and conflict states (FCS) because of different needs, coping strategies, and challenges for women and men. Women and girls in several conflict-affected countries suffer disproportionately because of displacement, poor access to services, and targeted sexual violence as a tactic of war designed to disrupt the social fabric. Unequal legislation and coexistence of dual legal frameworks (constitutional and patriarchal customary law) hinder access to justice for women. This presentation evaluated gender dimensions of World Bank Group performance in 33 low-income FCS with an emphasis on nine case study countries during 2001–2012. The main evaluation question was whether the World Bank Group emphasized gender disparities in country-level policy engagement and development projects in FCS during this timeframe. Further, this work assessed whether gender mainstreaming or gender-targeted approaches would be appropriate to address gender disparities in FCS, at both the policy and project levels. The evaluation relied on primary and secondary data sources. Primary data included qualitative data collection in case study countries through key-informant interviews with project staff and government officials and focus groups with project beneficiaries. Secondary data included information from the United Nations Entity for Gender Equality and the Empowerment of Women and datasets and project documents from the World Bank. The World Bank has been relatively effective in mainstreaming gender in health, education, and community-driven development projects, but has paid insufficient attention to women's economic empowerment and conflict-related VAW in FCS. Assessing the nature and impact of conflict on women should be integrated into framing country strategies, gender-disaggregated data should be collected for monitoring program indicators and measuring results, and the World Bank Group should design targeted employment and psychosocial health support programs for female-headed households affected by gender-based violence in FCS.

Program Description

42. Community-Led Development Initiatives: Doing Gender the "Clever" Way

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Issue. This presentation describes community "clever" approaches that help organizations address gender inequalities and gender-based violence (GBV) within community development programs.

Description. Following the global initiatives such as 16 Days of Activism Against GBV and Equal Rights, Equal Participation, Diyalo Pariwar (DP) in Nepal has worked with communities in central Nepal to integrate gender equality (GE) and gender-based violence prevention (GBVP) within community-based programs. Ample evidence suggests that integrating gender into strengthening the small farmers program and poverty alleviation activities leads to significant behavior change to transform traditional gender roles and reduce GBV, whereby communities are created that offer both men and women equal rights and participation. However, even when programs are aware of the importance of integrating GE and GBVP, they may not know how to do it. In response, DP developed community-oriented tools at the local level and training so organizations understand the degree of GE in their programs. This ranges from reinforcing gender stereotypes (gender negative) to achieving greater equity and equality (gender equity promotion). The model has helped more than 35 user groups design and facilitate or guide local bodies (LBs) to integrate gender and rights and to address the links between GBV and community development crossing local challenges. DP is working with these user groups and other partners and LBs to reduce violence through empowering girls and women and involving boys and men to redefine gender roles.

Lessons Learned. The integrated model has helped the understanding of different approaches to GE, and has increased consistency in integrating gender not only into GBVP but also in major components of the development process.

Recommendations. Compiling best practices on GE promotion for program planners, implementers, and LBs will help build organizations' and local bodies' capacity to deal with GBV programs that will empower women and help men to change harmful behaviors that perpetuate violence in communities.

43. The Intersection of Violence Against Women and HIV/AIDS: A Cross-Training Guide for Service Providers

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Background. The intertwined nature of intimate partner violence (IPV) and HIV/AIDS results in a complex relationship, with each serving as a risk factor for the other. The intersection of risk is particularly prevalent among women and lesbian, gay, bisexual, and transgender (LGBT) individuals. We aimed to improve skills, messaging, and services among professionals providing care for IPV victims and survivors and individuals at risk for HIV/AIDS by cross-training HIV and IPV professionals on strategies to address the intersection between HIV and violence.

Method. RTI adapted materials developed by the Office on Women's Health (OWH) and conducted trainings at HIV/AIDS and IPV service organizations spanning four geographic regions in the United States. Trainings included an introductory webinar, individual trainings at each organization to educate service providers on the counter issue, and joint trainings intended to allow HIV/AIDS and IPV service providers to build a collaborative relationship. Upon completing the series, sites provided feedback on the materials and information presented and discussed plans for future collaboration.

Results. Despite geographic proximity, the majority of training sites did not have strong working relationships. The training series allowed sites to share more information about their services and think about ways to better serve their target populations in light of the intersection of HIV/AIDS and IPV. The majority of training sites plan to incorporate the knowledge gained from the training series into screening procedures and client services.

Conclusion. Training on the intersection of risk reinforced the benefits of a working partnership to address the needs of clients at HIV/AIDS and IPV service organizations. Sites anticipated using the relationship that was built during the training to support referrals for at-risk clients, onsite mobile rapid testing at IPV service organizations, and formalizing working relationships for future collaboration and pursuit of funding opportunities. OWH also plans for broader dissemination of the training for service providers.

44. Females Who Use Drugs and Female Sex Workers in Nepal: Vulnerable to Various Abuses

Binod Gurung,
Sujin Maharjan, and
Prabesh K.C.
SATHI SAMUHA, Nepal

Issue. In Nepal, women have been marginalized by traditional and societal norms and values for centuries. They have been forced to suffer psychologically and physically in their families and society. The exclusion and discrimination further increase their vulnerability to HIV transmission, especially when they are engaged in unsafe behaviors and explicit environments such as drug use and sex work. The aims of this project are to strengthen national advocacy efforts and create an enabling environment for female injection drug users (FIDUs) to access HIV services.

Settings. There are approximately 92,000 people who use drugs in Nepal. Among them, female users account for 8 percent (approximately 6,000). There is no distinctive drug use and HIV service facility for FIDUs, and existing services are not reaching the overwhelming majority of FIDUs in the country.

Project. SATHI SAMUHA, a community-led organization of drug users and people living with HIV in Nepal, implemented the Advocacy for Strengthening an Enabling Environment to Access HIV Services for FIDUs project in support of the United Nations Office on Drugs and Crime in five regions of the country.

Outcomes. During this project, SATHI conducted five regional-level consultations with FIDUs and service providers to identify and collect information on key issues affecting FIDUs; organized regional-level advocacy workshops with concerned agencies in five regions; developed and distributed information, education, and communication materials on FIDU issues; and produced radio dramas and public service announcements related to personal stories of FIDU and HIV/AIDS challenges. Most FIDUs face triple discrimination for being female, being sex workers, and being drug users. Low negotiation power for condom use keeps FIDUs at risk of HIV and sexually transmitted infections. Additionally, self-stigma and a preference to stay hidden makes them hard to reach. Because of family and societal exclusion, they are constantly vulnerable to physical, mental, and sexual abuse from family and friends.

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45. Risk for Lethality Among Abused Stimulant-Using Women: Expanding the Danger Assessment

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Background. Drug-using women are three to five times more likely to experience physical or sexual intimate partner violence (IPV), which increases their risk of intimate partner homicide, the most severe outcome of IPV. We used the Danger Assessment (DA) tool to assess lethality risk among general female populations. We explored contextual factors surrounding DA items and provided suggestions for the inclusion of additional items that are specific to drug-using women.

Method. From January to June 2014, we conducted a mixed-methods study among 30 adult women residing in San Diego, California, reporting current stimulant use (i.e., methamphetamine, cocaine, or crack) and recent physical or sexual violence by a male intimate partner. Interviewer-administered surveys incorporated the DA, which categorizes women on the basis of weighted scores: variable danger (<8), increased danger (8–13), severe danger (14–17) or extreme danger (18+), while semistructured qualitative interviews explored lethality risk.

Results. The sample consisted of 30 ethnically diverse women with an average age of 46 years (SD=9.2). Commonly reported stimulants included methamphetamine (90%) and crack (27%), with 80 percent reporting polydrug use. The average DA score was 27 (SD=10.7), with women falling into the extreme danger (76.7%), severe danger (16.6%), and increased danger (6.7%) categories. In addition to quantitatively endorsing a number of lethality risk factors (e.g., unemployment, death threats, prior domestic violence), women qualitatively described being held hostage, being driven to secluded areas where they were then threatened, and being forced to engage in prolonged sexual activity as additional potential lethality risk factors.

Conclusions/Significance. The findings indicate common risk factors for potential lethality identified by the DA and additional risk factors specific to drug-using women. This supports the expansion of the DA when applied to active drug-using women. Ultimately, this will promote interventions that target multiple points to reduce lethality risk among this underserved population.

46. Integrating Gender Into a National HIV/AIDS Monitoring and Evaluation System: Lessons From Zambia

Samantha Herrera[1], Debra Prosnitz[1], John Mwale[2], Katongo Silwizya[2], and Ellen Mubanga[2]

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[2] Zambia National HIV/AIDS/TB/STI Council, Zambia

Gender inequity continues to be a major driver of the HIV epidemic in Sub-Saharan Africa. Women constitute 58 percent of people living with HIV, while young women, MSM, commercial sex workers, and injection drug users face an increased risk for HIV. These high-risk populations encounter gender-specific challenges that intersect with or compound their risk. Many Sub-Saharan African countries have recently responded by shifting their strategies to address gender-related drivers and inequities in their HIV programs. However, data to inform and track their progress is often lacking or nonexistent. Integrating gender into monitoring and evaluation (M&E) systems is thus an essential next step to ensure that evidence is available to inform the design of and assess the progress and effectiveness of programs. The US Agency for International Development's (USAID) MEASURE Evaluation Project has developed guidelines for incorporating gender into a national M&E system and an accompanying M&E capacity assessment tool that is based on the United Nations Programme on HIV/AIDS Organizing Framework. The project aimed to create a functional and national HIV M&E system for use by national HIV/AIDS agencies to assess and improve their M&E systems to capture, report, and use gender data. A pilot test of the guidelines and assessment tool was conducted in Zambia with the National HIV/AIDS/TB/STI Council in November 2015. The assessment revealed a number of gender-related gaps in the M&E system, including limited gender M&E skills among staff, lack of data collection tools and capacity for collecting data among key vulnerable populations, and inadequate gender-specific indicators for HIV/AIDS. A key lesson learned from the pilot was the importance of ensuring a common understanding of gender, what gender M&E entails, the difference between gender programming and gender M&E, and the importance of gender data in the HIV response among M&E and program staff prior to the start of the assessment.

47. Gender Integration: The Key to Sustained Improvements in HIV Programs

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WI-HER, LLC, Washington, DC, USA

The US Agency for International Development's (USAID) Applying Science to Strengthen and Improve Systems (ASSIST) project's mandate integrates gender as part of the work to strengthen health systems and build improvement capacity. This gender integration rests on the understanding that achieving sustained and equitable improvement in health requires a gender-sensitive approach that takes the different needs, constraints, and opportunities that women, men, girls, and boys face into account and responds to those issues strategically in the design, implementation, and evaluation of projects. ASSIST partner Women Influencing Health, Education, and Rule of Law (WI-HER, LLC), developed an innovative six-step approach to integrate gender throughout a program to improve health outcomes. The approach has been tested in a variety of HIV/AIDS programs—including antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), and voluntary medical male circumcision (VMMC)—and has achieved improved service use and retention in care, as well as a decrease in adverse events. For example, ART programs identified and addressed barriers preventing men from initiating and remaining in treatment; PMTCT programs engaged male partners to improve outcomes and retention rates for mothers and babies; and VMMC programs engaged female partners to improve follow-up and decrease adverse events. Our gender integration approach also helps to identify unintended negative consequences from changes introduced. For example, prioritizing couples in PMTCT or VMMC services in an effort to encourage partner involvement leaves single clients at a disadvantage; pressuring women to disclose their HIV status to their partners may increase their risk of violence; and economic strengthening programs designed to improve health, economic, and education outcomes of those living with and affected by HIV may increase participants' risk of intimate partner violence. Examples from country programs, including program descriptions, effective strategies to overcome barriers and close gender-related gaps, scale-up within countries and regionally, and gender-sensitive evaluation methods are shared.

48. Vijana Vijiweni II: A Cluster-Randomized Trial to Evaluate the Efficacy of a Microfinance and Peer Health Leadership Intervention for HIV and Intimate Partner Violence Prevention Among Social Networks of Young Men in Dar es Salaam

Suzanne Maman[1], Peter Balvanz[1], Mrema Noel Kilonzo[2], Gema Mwikoko[2], Thespina Yamanis[3], Marta Mulawa[1], Deus Kajuna[2], Lauren Hill[1], Donaldson Conserve[1], Heathe Luz McNaughton Reye[1], Sheila Leatherman[1], and Lusajo Kajula[2]

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[2] Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania

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Background. Intimate partner violence (IPV) and sexually transmitted infections (STIs), including HIV, remain important public health problems with devastating health effects for men and women in Sub-Saharan Africa. There have been calls to engage men in prevention efforts; however, effective approaches to reach and engage them are lacking. Social network approaches have demonstrated effective and sustained outcomes on changing risk behaviors in the United States. Our team has identified and engaged naturally occurring social networks mostly comprising young men in Dar es Salaam, Tanzania, in an intervention designed to jointly reduce STI incidence and the perpetration of IPV. These stable networks are locally referred to as "camps." In a pilot study, we demonstrated the feasibility and acceptability of a combined microfinance and peer health leadership intervention within these camp-based peer networks.

Method. We are implementing a cluster-randomized trial to evaluate the efficacy of an intervention combining microfinance with health leadership training in 60 camps in Dar es Salaam. Half of the camps have been randomized to the intervention arm, and half to a control arm. The camps in the intervention arm will receive a combined microfinance and health leadership intervention for a period of 2 years. The camps in the control arm will receive a delayed intervention. We have enrolled 1,258 men across the 60 study camps. Behavioral surveys will be conducted at baseline, and at 12 and 30 months after intervention launch; and biological samples will be drawn to test for *Neisseria gonorrhea*, *Chlamydia trachomatis*, and *Trichomonas vaginalis* at baseline and endline. The primary endpoints for assessing intervention impact are IPV perpetration and STI incidence.

Discussion. This is the first cluster-randomized trial targeting social networks of men in Sub-Saharan Africa that jointly addresses HIV and IPV perpetration and has both biological and behavioral endpoints. Effective approaches to engage men in HIV and IPV prevention are needed in low-resource, high-prevalence settings like Tanzania. If we determine that this approach is effective, we will examine how to adapt and scale up this approach to other urban, Sub-Saharan African settings.

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49. Solving Barriers to Prevent HIV Among Women in Lombok Island Through Increasing Knowledge on Sexual Rights

Satyawanti Mashudi
Indonesian Planned Parenthood Association/IPPA, Indonesia

Cases in West Nusa Tenggara Province, Indonesia, especially Lombok Island, showed that targeting persons who access voluntary counselling and testing (VCT) is aligned with the target established by the government. However, until December 2015, the number of AIDS cases was still higher than HIV cases and the number of housewives infected by the virus increased over time. These women were infected by their husbands and often they had no knowledge of HIV. This project used small group discussion among women from July 2014 to June 2016 in four districts in Lombok Island. The discussion is intended to increase women's knowledge of HIV and to help them understand their sexual rights, and to help them negotiate safer sex with their husbands to protect themselves from HIV. As of June 2015, this project has reached 778 women. After the small group discussions, there were some cadres (women) in the community who asked for dissemination of information about HIV and VCT and wanted to know their HIV status. Some of them also asked their husbands to do the same thing. This is not easy for these women, because in Lombok women usually cannot make their own decisions related to reproductive health. The most dominant reason is because reproductive health is financially supported by the partner/husband or the partner/husband's family. In a patriarchal culture that has strong religious perceptions, it is important to ensure that women's rights in this regard are not contrary to religion and to foster the perception that the sexual relationship is a shared responsibility in which decisions are made with the rights of men and women in equal proportions.

50. Youth Participation in Preventing Violence Against Women

Aprajita Mishra
Maitri, India

Violence against women and girls is a serious global issue that affects women, their families, and societies as a whole. A recent increase in reported cases of violence against young women and girls in India requires a multifaceted approach. Institutional campaigns on violence against women (VAW) mobilizing youths and young girls on college campuses and institutions are one such initiative that will not only empower the youths and young women, but will also help reach families and communities and encourage them to stand against VAW. Maitri India, a nongovernmental organization, is working in Ranchi, Jharkhand, to prevent and reduce VAW by mobilizing youths and young women through a college campus campaign to encourage students to stand up against the existing violence against women. The intervention consists of a broad array of activities and strategies such as active engagement of youths; preventive strategies to reduce VAW; workshops for recognizing signs of violence in a relationship; existing legal frameworks to understand rights; coping mechanisms; support groups; active engagements with men and boys; and creating safer and healthier workplaces by conducting training sessions on sexual harassment and facilitation and forming sexual harassment committees in the workplace to adequately, appropriately, and sensitively intervene in cases of sexual harassment. The initial findings of the intervention and focus group discussions with youths and young girls show that these campaigns have been successful and helped youths, particularly young girls, to be sensitive toward these issues, which helped them to talk about and report cases of violence openly within the family and at the institutional level. Youths also reported that now they are more aware of different facets and forms of violence.

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51. Capacity Building Assistance for Health Care Organizations: A Collaborative Effort to Support Organizations in Achieving Their HIV Prevention and Care Goals

Deena Murphy

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High-impact HIV prevention (HIP) programs (biomedical interventions, public health strategies, behavioral interventions) and the accompanying approaches that support and increase effectiveness and efficiency (e.g., integration of services) can assist with public health problems by addressing disparities and improving outcomes along each step of the HIV prevention and care continuum. Despite this, many health care organizations (HCOs) lack the capacity to successfully implement HIP programs. As HCOs struggle with the complexities in operationalizing the Affordable Care Act and juggle multiple priorities (e.g., cancers, diabetes, smoking-related illnesses, obesity), the task of implementing systems-level changes in the HIV arena—such as universal HIV screening, culturally competent care for trans-women and men who have sex with men, integrating services in electronic medical records, and HIV linkage, retention, and reengagement programs—can be both difficult and daunting without assistance. For decades, the Centers for Disease Control and Prevention's (CDC's) Division of HIV/AIDS Prevention has funded a variety of organizations to provide capacity-building assistance (CBA) services to community-based organizations (CBOs) and health departments to support them in their HIV prevention efforts. To better align the provision of CBA services and to support the public health priorities of increasing diagnosis of, and reducing transmission from, persons living with HIV, as well as reducing HIV transmission to persons at high-risk of infection, the Capacity Building Assistance Provider Network extends free assistance—in the form of training, consultation, facilitation of peer-to-peer mentoring, and information dissemination—to HCOs, health departments, and CBOs. The 21 national programs funded by CDC to provide CBA services are collaborating to collectively and effectively leverage resources at the crossroads of clinical, behavioral, and CBA services and use expertise in partnering with HCOs, health departments, and CBOs across the country, to deliver an innovative, time-phased spectrum of CBA services to support the National HIV/AIDS Strategy.

52. Mobile Society and Drug Use Associated With Transmission of HIV/AIDS Among Women and Girls in Myanmar

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Dr. Linn Aung Swe[2]

[1] Myanmar Anti-Narcotic Association, Myanmar

[2] Community Based Self-help Group, Myanmar

Background. The HIV epidemic in Myanmar is concentrated in nature. HIV Sentinel Surveillance (HSS) showed 18.7 percent (5.4% to 35.5%) seropositivity in people who injected drugs in 2013. Myanmar is the world's second largest producer of opium, accounting for 23 percent of the land used for illicit poppy cultivation. Methamphetamine pills are predominantly used in Myanmar. Poverty and lack of economic opportunities encourage women and girls to leave home in search of employment and income. Women and girls from rural and geographically isolated areas often become sex trafficking victims.

Objective. To explore the sociodemographic status of female drug users and gain knowledge on contextual factors that are important for evidence-informed programming and to understand the more detailed context of risk behaviors among them.

Method. This study was conducted with individual interviews, and the data were recorded in specially designed, precoded, structured questionnaires to gather data concerning sociodemography, drug use background and behavior, sexual behavior, and knowledge on HIV/AIDS, hepatitis B virus and hepatitis C virus. We randomly selected 108 female substance users aged 15 to 53 years with an average age of 28 in Northern Shan State, Myanmar.

Results. More than 60 percent of participants (n=73) engaged in sex work, and 33 percent (n=35) were unemployed. Approximately 85 percent (n=90) of the participants had a history of travelling more than 1 month during the previous year, and 35 percent of the participants were trafficked. Most participants used drugs as an outlet for stress. More than half of participants stated that they had sexual experience under the influence of amphetamine-type stimulants. It is difficult to determine how many sex partners each participant had.

Conclusions. This study showed that preventing the multiple effects of HIV and hepatitis B and C transmission in women and girls, which is catalyzed by sex trafficking, involves conducting health awareness, increasing social skills, and providing entrepreneurial training as well as postdischarge economic empowerment among vulnerable women and girls.

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53. Gender-Based Violence, HIV, and Schools

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AIDS Information Center, Uganda

Background. The Safe Schools program, conducted by AIDS Information Center–Uganda, is a 2-year African Development Bank–funded pilot. To date, the program is working in 71 schools, targeting students 10 to 14 years of age in primary and secondary school. The aim is to reduce school-related gender-based violence (SRGBV) and increase gender-equitable behaviors, which are keys to HIV prevention. Interventions include week-long training programs to enable teachers, students, and community volunteer counselors to prevent gender violence and transform harmful gender norms that contribute to inequality; revise national teacher codes of conduct; and mobilize local communities to address SRGBV. Challenges include resistance by some parents to changing entrenched cultural practices, such as child marriage. Individuals who want to report GBV still face barriers such as fear of reprisal, stigma, and not understanding reporting procedures.

Intervention Response. Quarterly project reviews and monthly monitoring meetings are held to handle problems and find solutions. Challenges have been addressed through the innovative use of student-selected community members to serve as counselors, and a platform to sensitize parents and community members about GBV and the need to delay marriage and keep girls in school.

Results and Lessons Learned. The program uses a quasi-experimental design with pretest and posttest comparisons between intervention schools and control schools. Anecdotal evidence shows promising trends in intervention schools. Corporal punishment has been reduced, and counseling services are being used by victims and perpetrators of GBV. School officials have noted that absenteeism and dropouts have decreased. Sexual relations between teachers and students have been reduced or stopped altogether in most schools. Incidents of early marriages are resolved with the concerned parties. The results on the changes in students' and teachers' knowledge, attitudes, and practices relating to SRGBV have been assessed.

Recommendations. Safe Schools is designed to protect adolescents from GBV and transform the gender norms that make them more at risk of HIV infection. Natural linkages for the Safe Schools approaches include school-based and informal HIV prevention programs for the general school populations in addition to specific groups such as orphans and vulnerable children. Other recommendations include examining ways to weave the Safe Schools curriculum into existing national school-based life skills programs and into preservice teacher training courses.

54. "Group Prenatal Care"—Providing Obstetric Care in a Community-Based Substance Abuse Treatment Center

Elizabeth Zadzielski,
Stephanie Rogers,
Stefanie Gargano, and
Yukiko Washio

Christiana Care Health Services, Newark, DE, USA

Pregnant women on methadone maintenance are challenged to receive prenatal care in an environment that meets their needs. Obstetrical providers from Christiana Care Health System, the largest provider for obstetric care in the State of Delaware, offer prenatal care within a community-based methadone treatment center in Wilmington. Evaluation of a group prenatal care model designed for this patient population will be conducted in collaboration with the methadone treatment center and the pediatrics department to assess child development. The evaluation format will be in a mixed-methods approach that includes medical chart reviews and qualitative patient and provider satisfaction surveys. Initiation of prenatal care in the first trimester, attendance at prenatal visits, adherence to antenatal testing recommendations, breastfeeding initiation and duration, attendance at postpartum visits, and uptake of postpartum contraception with an emphasis on long-acting reversible contraception. Neonatal outcomes to evaluate will be duration of stay in the continued care nursery or neonatal intensive-care unit among infants; diagnosis and severity of neonatal abstinence syndrome; and early identification of delays in child development.

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55. Impact of Human Trafficking and Exploitation

Kiricka Yarbough Smith

North Carolina Council for Women, Raleigh, NC, USA

This workshop educates service providers, community members, faith-based groups, law enforcement, mental health groups, colleges and universities, and school systems on human trafficking and the increasing problem it presents globally, nationally, and locally. This training defines what human trafficking is and identifies signs of human trafficking activity. It also covers key factors that contribute to the problem, preventive measures, and best practices for recognizing and providing services to victims of human trafficking, as well as identifying populations at risk for trafficking.

APPENDICES

Appendix A. Biographical Sketches for Speakers

Ambassador Eric Goosby, MD

University of California, San Francisco

Ambassador Eric Goosby is a Professor of Medicine and Director of Global Health Delivery and Diplomacy, Global Health Sciences, at the University of California, San Francisco. From 2009 to 2013, he served in the Obama Administration as Ambassador-at-Large and US Global AIDS Coordinator, overseeing the implementation of the President's Emergency Plan for AIDS Relief (PEPFAR); he also led the State Department's Office of Global Health Diplomacy. As Chief Executive Officer and Chief Medical Officer of Pangaea Global AIDS Foundation from 2001 to 2009, he played a key role in the development and implementation of HIV/AIDS national treatment scale-up plans in South Africa, Rwanda, China, and Ukraine. During the Clinton Administration, Ambassador Goosby was Director of the Ryan White Care Act at the US Department of Health and Human Services (HHS). He later served as Deputy Director of the White House National AIDS Policy Office and Director of the Office of HIV/AIDS Policy at HHS. In January 2015, Dr. Goosby was appointed by UN Secretary-General Ban Ki-moon to be the UN Special Envoy on Tuberculosis. As Special Envoy, he works to promote awareness of tuberculosis, both to encourage people to get tested and to send a message to world leaders that more resources are needed to make the world free from tuberculosis.

Susan Markham, MA

United States Agency for International Development

Susan Markham is the United States Agency for International Development Senior Coordinator for Gender Equality and Women's Empowerment. In this role, she is working to improve the lives of citizens around the world by advancing equality between females and males and empowering women and girls to participate fully in, and benefit from, the development of their societies. Ms. Markham has an extensive background in both domestic and international women's political empowerment. She most recently served as Director of Women's Political Participation at the National Democratic Institute. She started her career as a political fundraiser, serving as the Finance Director for the Ohio Democratic Party and Executive Director of Participation 2000 (a multicandidate political action committee). Ms. Markham has a BA degree in political science and international studies from the Ohio State University. She received her master's degree in public policy and women's studies from George Washington University.

Myron Cohen, MD

University of North Carolina

Dr. Myron Cohen is the Yeargan-Bate Eminent Professor of Medicine, Microbiology, Immunology, and Epidemiology at the University of North Carolina, Chapel Hill. Dr. Cohen is the Director of the UNC Institute for Global Health and Infectious Disease, and serves as co-Principal Investigator of the NIH HIV Prevention Trials Network (HPTN). He is a member of the Institute of Medicine, the American Society of Clinical Investigation, and the American Association of Physicians. Dr. Cohen's awards include the Distinguished Career Award for lifetime achievement in STD/HIV research from the American Sexually Transmitted Diseases Association, the Smadel Award from the Infectious Disease Society, the O. Max Gardner Award from UNC, and the Award for Science from the State of North Carolina, the highest honor in the state. Dr. Cohen led the HPTN 052 trial that demonstrated that antiretroviral treatment for people with HIV infection prevents sexual transmission of the virus, recognized by the magazine *Science* as the 2011 Breakthrough of the Year. Dr. Cohen is the author of more than 500 publications and two books. His three decades of research have focused on prevention of the sexual transmission of HIV, with extensive work in Malawi and the People's Republic of China.

Rachel Jewkes, MD, MSc

South African Medical Research Council

Professor Rachel Jewkes is a medical doctor and physical health specialist and the Director of the South African Medical Research Council's Gender and Health Research Unit. She is a former Vice President of the Medical Research Council and is leading the Department for International Development (DFID)-funded What Works to Prevent Violence? Global Programme, which is funding research and innovation in prevention of gender-based violence (GBV) in 14 countries in Asia, the Middle East, and Africa. She is also Secretary of the Sexual Violence Research Initiative. Professor Jewkes has spent the past 20 years researching intersections of GBV, gender inequity, and health using methods drawn from epidemiology, anthropology, and health systems research. She has authored over two 250 publications in peer-reviewed journals, book chapters, and reports. Professor Jewkes has been working to ensure that these research findings are translated into interventions within society to improve the lives of women.

Wendee M. Wechsberg, PhD

RTI International

Dr. Wendee Wechsberg is the Director and Principal Researcher of the Substance Use, Gender, and Applied Research Program at RTI International. Dr. Wechsberg is also the Director of the RTI Global Gender Center, an initiative across the Institute that started in 2013 with close to 300 affiliates domestically and internationally. She is also Adjunct Professor at the Gillings School of Global Public Health, University of North Carolina at Chapel Hill, Adjunct Professor of Psychology at North Carolina State University, and Adjunct Professor in Psychiatry and Behavioral Sciences at the Duke University School of Medicine. Dr. Wechsberg started her career in 1977 as an addiction clinician and treatment director. She is the creator of the woman-focused HIV prevention program, the Women's CoOp, one of the Centers for Disease Control and Prevention's best-evidence HIV behavioral prevention interventions. It has been adapted specifically for underserved and vulnerable adult and adolescent women in the United States, and in multiple regions in South Africa, Republic of Georgia, and Russia. Dr. Wechsberg conducts policy forums when projects are completed to ensure dissemination and to develop plans for "real world" implementation and sustainability. She is currently funded by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism.

Nabila El-Bassel, PhD

Columbia University

Dr. Nabila El-Bassel is a Professor at the Columbia University School of Social Work and Director of the Social Intervention Group, which was established in 1990 as a multidisciplinary center focusing on developing and testing HIV, drug use, and gender-based violence effective prevention and intervention approaches and disseminating them to local, national, and global communities. Dr. El-Bassel is also the Director of the Columbia University Global Health Research Center of Central Asia, a team of faculty, scientists, researchers, and students in both New York and Central Asia committed to advancing solutions to health and social issues in Central Asia through research, education, training, policy, and dissemination. Dr. El-Bassel has designed and tested a number of multilevel HIV, drug use intervention, and prevention models for women, men, and couples in drug treatment and harm reduction programs, primary care, and criminal justice settings. She has been studying the intersecting epidemics of HIV and violence against women and has designed HIV interventions that address these co-occurring problems with significant scientific contributions in gender-based HIV prevention for women.

David Wilson, PhD

World Bank

Dr. David Wilson is the World Bank's Global AIDS Program Director and the World Bank's Global Lead for Decision and Delivery Science. He has worked as a scientist and program manager in over 50 countries and has published approximately 100 scientific papers. His interests lie in HIV epidemiology, HIV prevention science, and program evaluation. He has developed prevention programs

that have been recognized as best practice by the World Bank, the World Health Organization (WHO), and the Department for International Development (DFID), and has been influential in international HIV prevention science. Additionally, he has served as technical consultant and advisor to many international agencies, including the United States Agency for International Development, DFID, the European Union, the Australian Agency for International Development, the Swedish International Development Cooperation Agency, the North American Aerospace Defense Command, the Joint United Nations Programme on HIV/AIDS, UNICEF, and WHO.

SPECIAL GUEST

Thema Bryant-Davis, PhD

Pepperdine University

Dr. Thema Bryant-Davis is an Associate Professor of Psychology at Pepperdine University. She is the 2015 awardee of the California Psychological Association's Distinguished Scientist Award for her research addressing trauma and oppression. She is also a past president of the Society for the Psychology of Women and a former American Psychological Association representative to the United Nations. She received the Early Career Distinguished Contributions to Psychology in the Public Service award. Dr. Bryant-Davis is director of the Culture and Trauma Research Lab at Pepperdine University, which focuses on the cultural context of recovery from interpersonal traumas such as child abuse, sexual assault, intimate partner abuse, racism, and human trafficking. She is published in numerous peer-reviewed journals. She is author of the book *Thriving in the Wake of Trauma: A Multicultural Guide* and coeditor of the books *Surviving Sexual Violence: A Handbook of Recovery and Empowerment* and *Foundations of Resilience: Religion and Spirituality in Diverse Women's Lives*.

SPEAKERS

Avni Amin, PhD

World Health Organization

Dr. Avni Amin works on gender equality and violence against women (VAW) at the World Health Organization, Department of Reproductive Health and Research. Her work involves compiling and translating evidence into policies and programs to address VAW and gender inequality in the context of sexual and reproductive health and HIV programs and policies. Specifically, she has authored publications on effective interventions to address VAW in the context of HIV programs, prevent intimate partner violence and sexual violence against adolescents, and address violence against sex workers. She authored the development of WHO's global plan of action on strengthening health systems response to violence against women and girls, which will be the basis for Ministries of Health to design, plan, and implement/scale up responses to violence against women and girls. Dr. Amin has worked on issues of gender equality and VAW and their relationship to sexual and reproductive health and HIV for the past 20 years.

Monica Anderson

S.H.A.D.E. Project

Monica Anderson is a survivor advocate who, for the past 6 years, has been working with young men and women who have experienced or are at risk for sexual exploitation. Monica previously worked at MISSSEY (Motivating, Inspiring, Supporting & Serving Sexually Exploited Youth) as their case manager and resource specialist and Youth Radio as their development and program assistant. In 2014, Ms. Anderson was voted into the Alameda County Women's Hall of Fame for serving as a mentor and role model for young women seeking an exit from the devastating spiral of sex trafficking. She participated in an award-winning Youth Radio series about youth exploited through the commercial sex trade, which raised national awareness about this issue and the ravages it brings to our community. She has also spoken to Congress about domestic human trafficking along with Jada Pinkett-Smith and other survivor

leaders in the movement. She is currently attending school to become a public defender to fight for young people's rights in Alameda County, California.

Nukshinaro Ao (Naro)

ANPUD

Ms. Nukshinaro Ao (Naro), from Nagaland, India, represents women living with HIV and drug users. She started her journey in the field of drugs and HIV in 2005 by engaging in outreach activities and providing counseling to both people who use drugs and the community of people living with HIV (PLHIV) in her hometown. Thereafter, she worked with the Nagaland State AIDS Control Society, Government of Nagaland, from 2008 to 2012 as Greater Involvement of People Living with HIV/AIDS (GIPA) coordinator. Later, she joined the Asia Pacific Network of People Living with HIV/AIDS in the capacity of Women Coordinator. As a drug user activist, she has represented women who use drugs from Asia in various national and regional platforms highlighting the specific issues faced by women who use drugs in the region, and she has advocated on issues that affect their lives. Currently, she is an executive board member of the Asian Network of People Who Use Drugs (ANPUD).

Andrea M. Bertone, PhD

FHI 360

Dr. Andrea M. Bertone has 20 years of international development and related research experience on human trafficking, gender-based violence, gender integration and mainstreaming, gender equality in education, and girls' and women's empowerment. She has managed projects, developed tools on girls' education, and conducted research about women and gender. She coauthored two girls' mentoring guides and authored several peer-reviewed articles on human trafficking. Dr. Bertone is the Director of FHI 360's Gender Department, where she provides strategic programmatic and technical leadership, coordinates gender integration across technical sectors and geographic locations, and consults on technical program implementation issues. Concurrently, she serves as Adjunct Professor at George Washington University, where she teaches graduate courses on human trafficking and gender and development. Dr. Bertone holds a PhD in Government and Politics from the University of Maryland, College Park.

Gordon Cressman, MS

RTI International

Mr. Gordon Cressman is Senior Director of the International Information and Communication Technologies (ICT) program for RTI's Research Computing Division. He leads an experienced team of international ICT experts working in health, education, and governance. His team is engaged in strengthening national health information systems in Tanzania and Zimbabwe and in helping countries develop and deploy innovative ICT solutions to development challenges. Examples include improving early-grade reading and math performance, rapidly detecting and reacting to new cases of malaria to help eliminate the disease, and monitoring mass drug distributions to combat neglected tropical diseases. With more than two decades of experience, he has been a pioneer in using ICT for international development. Mr. Cressman's experience includes assessment, strategic planning, operational planning, system design, integration, and implementation, procurement, capacity building, operations, sustainability, and scale-up strategies. His ICT applications experience spans health, education, and governance. He has helped organizations in more than 28 countries use ICT effectively through sustainable strategies sensitive to local context.

Tim Gabel, MBA

RTI International

Mr. Tim Gabel, a long-term RTI employee with technical training in both statistics and computer science, has served in a variety of leadership roles during his career, including the head of the Research Computing Division and the Vice President for Survey and Computing Sciences. Mr. Gabel helped pioneer RTI's efforts to conceptualize and develop Internet applications for research activities and has extensive experience directing data collection and data processing activities for scientific research studies. He currently leads RTI's Social, Statistical,

and Environmental Sciences (SSES) business group, comprising approximately 1,800 researchers working to solve some of the world's most challenging problems.

Winnie Gumula, BA

Khethimpilo

Ms. Winnifred Gumula holds a bachelor's degree in development studies and has extensive experience working with women from disadvantaged communities. She has over 10 years of experience implementing and training others on the Women's Health CoOp package, an evidence-based intervention for substance-using women that has been adapted for use with populations including substance-using couples, commercial sex workers, pregnant women who use substances, and other high-risk groups. She has extensive experience working with women who use alcohol and other drugs, particularly those in underserved populations, such as women living in townships in South Africa. Her work as an educator integrates client empowerment and relationship building.

Stephanie Hawkins Anderson, PhD

RTI International

Dr. Stephanie Hawkins Anderson is a clinician and researcher at RTI International with more than 20 years of experience working with youth who reside in resource-poor urban communities. She has extensive research experience working in the areas of girls and delinquency prevention, boys and men of color, youth violence prevention, teen dating violence prevention, youth substance abuse prevention, youth mentoring, the provision of evaluation technical assistance, and program- and systems-level evaluations. Dr. Hawkins has led and worked on a number of projects for the Office of Juvenile Justice and Delinquency Prevention, National Institute of Justice National Institute of Mental Health, Centers for Disease Control and Prevention, and Substance Abuse and Mental Health Services Administration. She currently leads a demonstration evaluation funded by the National Institute of Justice focused on male survivors of violence. She is the author of numerous articles, chapters, and technical reports on a range of topics, including gender and delinquency, youth violence prevention, intimate partner violence prevention, and youth substance abuse prevention.

Jeffrey H. Herbst, PhD

Research & Evaluation Branch, Division of Violence Prevention, NCIPC, CDC

Dr. Jeffrey H. Herbst is the Chief of the Research and Evaluation Branch at the Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), Atlanta, Georgia. He has nearly 30 years of research and public health experience. In 2002, Dr. Herbst accepted a position in the Prevention Research Branch, Division of HIV/AIDS Prevention, at CDC. He led numerous systematic reviews and meta-analyses of HIV behavioral interventions for high-risk populations, including men who have sex with men (MSM), Hispanic/Latino persons, persons living with HIV/AIDS, and transgender persons. He served as leader of the Operational Research Team and Science Officer on several research studies testing the efficacy of HIV prevention interventions for high-risk populations, including Black/African American MSM, Black women and adolescents, male adolescents in juvenile detention, substance-using MSM, and incarcerated women. In 2014, Dr. Herbst accepted the Branch Chief position in CDC's Division of Violence Prevention. He oversees a portfolio of intramural and extramural initiatives to prevent multiple forms of violence in the United States. Dr. Herbst has coauthored over 70 articles in psychology and public health journals and textbooks.

Lisa B. Hightow-Weidman, MD, MPH

UNC Chapel Hill

Dr. Lisa B. Hightow-Weidman is an Associate Professor of Medicine in the Department of Infectious Diseases, University of North Carolina at Chapel Hill. She has been directly involved with the management of HIV-infected and at-risk adolescents and adults at UNC–Chapel Hill since 2001. Dr. Hightow-Weidman is an expert on mHealth, social media, and utilization and evaluation of technology-based interventions to address the HIV Care Continuum for youth and young adults, particularly

among young men who have sex with men (YMSM). She has published over 50 peer-reviewed articles on these topics. Her research interests include HIV prevention for YMSM using both the Internet and other mobile technologies, interventions that use game-based elements, and social networking to change behavior. She has developed technology-based interventions to address uptake and adherence to biomedical HIV prevention technologies, as well as intervening to increase HIV diagnosis, linkage, and retention in care for YMSM. She has a proven track record of successful funding from the National Institutes of Health, HIV/AIDS Bureau, and the Centers for Disease Control and Prevention. She is currently an Associate Editor of the journal *Sexually Transmitted Diseases*.

Shoshana Kahana, PhD

NIDA

Dr. Shoshana Kahana joined the Services Research Branch at the National Institute on Drug Abuse (NIDA) in 2011. At NIDA, Dr. Kahana manages a portfolio of grants that focuses on HIV testing as well as access and adherence to HIV care for substance-abusing and other high-risk, vulnerable populations; mobile technologies; and the delivery of treatment services that target drug abuse and psychiatric comorbidities. She helps to coordinate the "Seek, Test, Treat, and Retain" for Criminal Justice and Vulnerable Populations Data Harmonization initiatives, and has authored and led multiple initiatives on the use of mobile technologies to promote engagement in care and treatment adherence for substance-abusing populations with HIV. Dr. Kahana also serves as a scientific consultant to various NIH-funded HIV networks. She earned her doctorate in clinical psychology from Case Western Reserve University in 2005. Dr. Kahana continues to publish peer-reviewed articles on HIV adherence interventions and the intersection of substance use and HIV care.

Sofie Karasek, BA

End Rape on Campus

Sofie Karasek is an anti–sexual violence advocate and Director of Education and cofounder of End Rape on Campus, a national survivor advocacy organization. Prior to her graduation from the University of California, Berkeley, in 2015, she spearheaded several federal complaints against Berkeley and has assisted students nationwide in holding universities accountable to Title IX. Ms. Karasek has been a leading advocate for California's groundbreaking affirmative consent law, and her work has been featured in national and international media, including the *Wall Street Journal*, the *Guardian*, CNN, and the *Washington Post*. She is also a subject in the documentary film "The Hunting Ground" and was featured in Lady Gaga's 2016 performance of "Til It Happens to You" at the Academy Awards.

Paul N. Kizakevich, MS

RTI International

Paul Kizakevich conducts research and development in personal, mobile health (mHealth) monitoring and intervention, health communications and training, and physiological simulation and modeling. As Director of RTI's Personal Health Intervention Tool Framework for health app development, he leads RTI's mobile health data collection and intervention research. He has extensive experience in physiological monitoring, signal analysis, medical data processing, and medical instrument development. During his 35-year career, he has gained broad R&D experience and has published on a variety of topics.

Chris Krebs, PhD

RTI International

Dr. Chris Krebs is a Chief Scientist within RTI International's Center for Justice, Safety, and Resilience. Dr. Krebs received his PhD degree in criminology from Florida State University in 2000 and started working at RTI soon thereafter. In his 15+ years at RTI, he has worked on and led projects in a variety of areas, including substance abuse epidemiology and treatment, intimate partner violence and sexual violence, and the behavior of prison and jail inmates. He is best known for his research on the prevalence and nature of sexual assault among college students, the subject of his presentation today. He has visited US Senate and House offices on Capitol Hill numerous times to discuss RTI's research in this area, and he was the

Project Director for the recently completed Campus Climate Survey Validation Study, a large methods-focused effort to assess how to best collect data on sexual assault from college students. In connection with this study, Dr. Krebs has visited the White House on two occasions and has presented to the House and the Senate about the results, the need for future research in this area, and different aspects of pending federal legislation that call for additional survey efforts of this kind.

Kyla Sawyer-Kurian, PhD

North Carolina Central University

Dr. Kyla Sawyer-Kurian focused her dissertation research on understanding the effects of oppression on the identity development of Black and Coloured South African women. After completing her doctorate, she spent 3 years as a National Institute on Drug Abuse postdoctoral scholar under the leadership of Dr. Wendee M. Wechsberg, where she received advanced training in the research areas of substance abuse and HIV interventions. During her postdoctoral experience, she had the opportunity to work with substance-abusing African American and South African women who are at risk for contracting HIV. Since this experience, she has had a passion to create interventions and programs that not only teach women how to reduce risk, but also encourage women how to live a victorious life by fulfilling their unique destiny and purpose. Dr. Kurian continues to explore ways to reduce substance abuse and HIV risk among African American women. Dr. Kurian adapted an evidence-based HIV intervention, the Aziza CoOp, for African American college women. The Aziza CoOp was designed to address the specific needs of African American women at historically African American colleges and universities.

Pam Lattimore, PhD

RTI International

Dr. Pamela K. Lattimore is Director of RTI's Center for Justice, Safety, and Resilience, which focuses on improving understanding of crime and related problems, criminal justice systems, safety threats and responses, and prevention and intervention activities designed to ameliorate societal problems and increase community and individual resilience. Her research focuses on evaluating interventions; investigating the causes and correlates of criminal behavior, including substance use and mental health; and developing approaches to improve criminal justice operations. She is currently principal investigator for several large multisite evaluations and a Department of Defense–funded project examining the factors related to military workplace violence. Dr. Lattimore is an internationally recognized expert on prisoner reentry and multisite, multimodal, multiyear experimental and quasi-experimental evaluations of programs and initiatives. She has published extensively, has served on the editorial boards of multiple academic journals, and is coeditor of the annual series *Handbook on Corrections and Sentencing*, sponsored by the American Society of Criminology's Division of Corrections and Sentencing and published by Routledge Press.

Suzanne Maman, PhD, MHS

UNC Chapel Hill

Dr. Suzanne Maman, University of North Carolina, is a social scientist trained in public health with over 15 years of research experience related to HIV/AIDS and gender-based violence (GBV) prevention in Sub-Saharan Africa. Dr. Maman's work focuses on two aspects of the association between HIV and violence: (1) violence as a barrier to women implementing HIV risk reduction strategies and (2) violence as an outcome of women's experience with HIV testing and HIV status disclosure to their sexual partners. She uses a combination of qualitative and quantitative research methods to develop and evaluate interventions that address the nexus between HIV and violence. She has conducted National Institutes of Health–funded intervention trials in South Africa and Tanzania that address HIV and GBV. She is currently leading a trial with social networks of young men in Tanzania that is designed to reduce HIV risk and violence perpetration through a combination of microfinance and health leadership training.

Lynn McIntyre, MD

University of Calgary

Dr. Lynn McIntyre serves in the Department of Community Health Sciences, Cumming School of Medicine, University of Calgary, Alberta, Canada. Dr. McIntyre retired from her active faculty position in November 2015. Prior to retirement, she served as Associate Scientific Director of the O'Brien Institute for Public Health at the University of Calgary, and from 2008–2013 she held a Canadian Institutes of Health Research Chair in Gender, Globalization, and Health. She has spent 20 years studying household food insecurity in Canada and globally. Despite her retirement, she continues to be involved in gender-based research and population health advancement.

Christina Meade, PhD

Duke University

Dr. Christina Meade is Associate Professor of Psychiatry and Behavioral Sciences at Duke University School of Medicine, with secondary appointments in Global Health and Psychology & Neuroscience. Dr. Meade's domestic research program focuses on predictors of HIV risk in adults with substance use disorders, and the relationship between neuropsychiatric conditions and continued risk behavior in HIV-positive adults. Many of her current projects incorporate MRI to isolate the effects of addiction and HIV on both brain function and structure. Dr. Meade is also interested in the development of evidence-based treatments to improve cognitive functioning and reduce risk behaviors among drug users. Dr. Meade's international research program is based in South Africa, where there is concern that recent increases in methamphetamine use may further fuel the HIV epidemic in this country. Current projects focus on characterizing drug addiction and HIV risk behaviors in this understudied group, both in community and treatment settings, and ultimately increasing uptake of HIV services to improve health outcomes and reduce the continued spread of HIV.

Alexandra Minnis, PhD

RTI International

Dr. Alexandra Minnis is a social epidemiologist with the Women's Global Health Imperative, within RTI International's Center for Global Health. Dr. Minnis's research addresses the prevention of HIV, STIs, and unintended pregnancy in the United States and internationally. Her research has investigated methodological issues in conducting HIV prevention research; end-user perspectives on the design of biomedical HIV prevention products; and social environment and structural factors, including community violence and migration, which lead to reproductive health disparities among adolescents. Her research approach integrates quantitative and qualitative methods and uses community-based participatory action research principles in design and implementation. She has research experience in Zimbabwe, South Africa, Kenya, Mexico, India, and the United States. Dr. Minnis is Assistant Professor in the School of Public Health at the University of California, Berkeley (UCB), where she also holds a core faculty member position in the University of California, San Francisco–UCB Joint Medical Program.

Wanjiru Mukoma, PhD

LVCT Health

Dr. Wanjiru Mukoma is the Executive Director of LVCT Health, where she provides management and oversight for research, national and international policy engagements, and institutional monitoring and evaluation. She has successfully led and managed public-private partnership initiatives between LVCT, the private sector, and tertiary institutions, and she is currently focused on strengthening collaborative research. As a member of various national technical working groups in Kenya, she has ensured utilization of LVCT's programs and research evidence in the development of national policies and programs. She has more than 15 years of experience in HIV and sexual reproductive health research, programming, management, and policy advocacy in Kenya and South Africa. Dr. Mukoma has published more than 15 articles in peer-reviewed journals as first author or coauthor, published four book chapters,

and presented at many national and international conferences. She regularly reviews manuscripts for various journals, including Health Education Research, and for national reports, documents, and policies on HIV in Kenya.

Bronwyn Myers, PhD

South African Medical Research Council

Professor Bronwyn Myers is a Chief Specialist Scientist in the Alcohol, Tobacco and Other Drug Research Unit of the South African Medical Research Council, where she leads the Intervention Research substream. Over the past 15 years, her work has focused on improving access to and the quality of care for vulnerable populations through delivering behavioural interventions to reduce substance use and HIV risk among vulnerable populations and integrating evidence-based practices into current health systems. She has an honorary appointment with the University of Cape Town's Department of Psychiatry and Mental Health, where she is Cochair of the Division of Addiction Psychiatry. Her expertise in substance abuse treatment and HIV has been acknowledged via invitations to serve on an International Reference Group to the United Nations on HIV and Drug Use and World Health Organization working groups on the development and assessment of global substance abuse treatment services. She is a member of the Scientific Advisory Board for Harm Reduction International and an affiliate of RTI's Global Gender Center. She serves on the editorial or advisory boards of three international journals and is an associate editor for a local journal. Professor Myers has published extensively on the topics of substance use disorders, vulnerable populations, HIV, access to treatment, and provision of evidence-based practices for substance use disorders in South Africa. She is a founding member of the South African Young Academy of Science and a recipient of the International Society of Psychology's Psychology for Change fellowship award.

Sophie Namy, MPA, MA

Raising Voices

Ms. Sophie Namy is an applied researcher with a focus on evaluating community-based interventions to promote women's rights and prevent violence against women and girls. From 2008–2009, she worked with the Kumaon Agriculture and Greenery Advancement Society in rural India, providing formative research for an HIV prevention intervention targeting female sex workers. Subsequently, she worked with the International Center for Research on Women (ICRW) for 5 years, where she designed and carried out several evaluative studies focused on violence against women (VAW), engaging men and boys, and social norm change. During that time, she served as the Principal Investigator (PI) for ICRW's multiphased evaluation of CARE International's Young Men Initiative program in the Western Balkans, and as the technical lead on an evaluation of an intervention to decrease alcohol-related HIV risk in Namibia. She also designed and implemented a qualitative evaluation of a program to delay marriage in Ethiopia. Since 2014, Ms. Namy has been working with Raising Voices as the Learning Coordinator, where she is responsible for implementing the organization's learning strategy across a range of programming to prevent VAW and violence against children (VAC). She is currently the co-PI on a mixed-methods study to explore the intersection of VAW and VAC in Kampala, Uganda, as well as the technical lead on an implementation science grant to assess program replication and adaptability in three diverse contexts.

Jacqueline Ndirangu, MSc-GH

RTI International

Ms. Jacqueline Ndirangu is a public health research analyst at RTI International. She is the project manager for the Combination Prevention for Vulnerable Women in South Africa Study in Pretoria and Implementation Science for Vulnerable Women in South Africa Study in Cape Town, both under the direction of Dr. Wendee Wechsberg. Ms. Ndirangu earned her Master of Science in Global Health from Duke University, Durham, NC, and a Bachelor of Science in Biological Sciences from the University of

Maryland, College Park. She has 8 years of experience working in the field of public health. Prior to joining RTI, she worked as a research coordinator for a cervical cancer screening and prevention program in Haiti where more than 10,000 women were screened for the human papillomavirus, the virus that causes cervical cancer. Ms. Ndirangu's passion is disease prevention with a special focus on women.

Laura Nyblade, PhD

RTI International

Dr. Laura Nyblade is Senior Technical Advisor on stigma and discrimination at RTI International and for the Health Policy Plus (HP+) project. With doctoral preparation in demography, her career focus has been on international public health and HIV and AIDS in particular, with extensive research and application of findings to improve programming and policy. She has two decades of experience working on stigma and discrimination, spanning 15 countries in Sub-Saharan Africa, South and Southeast Asia, and the Caribbean. This work has included close collaboration with civil society, researchers, governments, multilateral organizations, and a range of donors to conduct research, develop and validate measures, design and implement stigma reduction programs, create innovative participatory training tools for diverse audiences, strengthen capacity for measurement and stigma-reduction programming, and support improvements in policies. Her work has been disseminated at seminars and international conferences, and she has an extensive record of publication.

Sheila V. Patel, BS

RTI International

Sheila Patel received a Bachelor of Science in Public Health from the Gillings School of Global Public Health, University of North Carolina at Chapel Hill. As a public health analyst in RTI's Center for the Health of At-Risk Populations, she supports projects evaluating health care transformation and projects that inform evidence-based health care decision making. She has implementation and research experience related to sexual and reproductive health issues concerning adolescents, LGBTQ individuals, and low-income populations. This work has been conducted in the United States and internationally in partnership with the World Health Organization, Every Woman Southeast, the Harvard T.H. Chan School of Public Health, The University of North Carolina at Chapel Hill LGBTQ Center, and Student Health Action Coalition. Ms. Patel is an active affiliate of the RTI Global Gender Center and part of the key planning staff for this conference.

Deidra Roach, MD

NIAAA

Dr. Deidra Roach currently serves as a Medical Project Officer for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). She manages research portfolios addressing the treatment of co-occurring mental health and alcohol use disorders and alcohol-related HIV/AIDS. She also serves on the Interagency Coordinating Committee on Fetal Alcohol Syndrome, the NIH Coordinating Committee for Research on Women's Health, and the Office of AIDS Research Committee for Research on Racial and Ethnic Minorities.

Doris Rouse, PhD

RTI International

Dr. Doris Rouse is Vice President of RTI International's Center for Global Health. She manages the coordination of diverse disciplines to address major global health needs. Dr. Rouse has been the Project Director for three Bill & Melinda Gates Foundation grants to advance public- and private-sector collaborations to develop improved technologies for global health needs. She has extensive experience in forming public and private consortia. Dr. Rouse served as a member of the Business Advisory Committee for HealthSpot, a health franchise for diagnosis and treatment of HIV and tuberculosis in Sub-Saharan Africa.

Caroline Rushby, MBA

RTI International

Ms. Caroline Rushby is a Global Senior Financial Analyst, Operations and Project Manager at RTI. Ms. Rushby has worked in clinical research since 2009, first as an operations manager at a biotechnology research company based in Rockville, Maryland, where she managed the delivery of clinical trials for viruslike particle influenza vaccines in healthy adults and the elderly. Before coming to the United States, Ms. Rushby was with Ernst & Young in the United Kingdom for 11 years. Ms. Rushby grew up in Lima, Peru, where she had the opportunity to work in the private sector, developed a thorough understanding of the culture, and first became aware of gender-based issues.

Purna Sen, PhD

UN Women

Dr. Purna Sen is Director of Policy at UN Women, where she is responsible for direction, leadership, and management of the Policy Division as well as the UN Women Training Centre. She has over 30 years of experience in capacity building, service delivery and evaluation review, teaching, advocacy, and research publishing. Her work has included research, publications, and activism on violence against women, culture and human rights, trafficking, sexuality and sexual control, human rights, developments, civil society organizing against violence, and social development issues and race equality in the United Kingdom. She has consulted with organizations such as Article 19 and the British Council, and she has been on the management and advisory groups of nongovernmental organizations, including the Refugee Women's Resource Project and Southall Black Sisters. Dr. Sen was previously a board member of the Kaleidoscope Trust (an LGBTQ rights charity), RISE (a domestic abuse charity), and the Commonwealth Human Rights Initiative. Prior to UN Women, Dr. Sen was Deputy Director of the Institute of Public Affairs at the London School of Economics and Political Science, where she also taught gender and development.

Charlene Senn, PhD

University of Windsor

Dr. Charlene Senn is a social psychologist and Professor of Psychology and Women's and Gender Studies at the University of Windsor, Ontario, Canada. She is an expert on effective sexual violence interventions, particularly those developing women's capacity to resist sexual assault. She developed the Enhanced Assess, Acknowledge, Act (EAAA) sexual assault resistance education program for women in their first year of university. The findings from the randomized controlled trial evaluation were published recently in the New England Journal of Medicine. This 12-hour program resulted in a 46 percent reduction in completed rapes and 63 percent reduction in attempted rapes experienced across 1 year, when compared with the control group. EAAA accomplishes this while reducing woman-blaming and self-blame. With her coinvestigators, she has planned an effectiveness study at nine Canadian universities over the next 4 years. She recently created a nonprofit (SARE Centre) to facilitate scale-up. With her colleague, Dr. Anne Forrest, she has worked since 2010 on another important aspect of campus sexual assault prevention to institutionalize effective bystander education for men and women on campus and to study its impact in the short and longer term. The institutionalization involves integration of both peer facilitator training and a 3-hour workshop (an adaption of Bringing in the Bystander®) into the academic curriculum so that it is sustainable.

Ashley Simons-Rudolph, PhD

North Carolina State University

Dr. Ashley Simons-Rudolph promotes gender equity and social justice in her home state of North Carolina. She is a graduate of North Carolina State University (NCSU) and earned her PhD in Gender and Social Policy from the George Washington University, Washington, DC. In her research in higher education, Dr. Simons-Rudolph has worked in diverse communities, ranging from Native American reservations and Sub-Saharan Africa to Washington, DC, and Cairo, Egypt. As a faculty member in Women's and Gender Studies at NCSU, she works to create gender equity–focused theory to

practice opportunities for the university community. She is also the Editor in Chief for *Gender Issues*, a multidisciplinary, international journal covering gender and health.

Ilene Speizer, PhD

UNC Department of Maternal and Child Health

Dr. Ilene S. Speizer is a Research Professor in the Department of Maternal and Child Health, Gillings School of Global Public Health, University of North Carolina at Chapel Hill. She is also a Faculty Fellow at the Carolina Population Center. Dr. Speizer has led research and evaluation studies on family planning, HIV prevention, and adolescent reproductive health programs. Her primary research interests focus on barriers to family planning use, adolescent sexual behaviors, the meaning and measurement of unintended pregnancy, and intrahousehold decision making in US and global settings. She has also studied the role of intimate partner violence on reproductive health outcomes. Dr. Speizer and colleagues have designed comprehensive impact evaluations of urban family programs in Uttar Pradesh, India, Nigeria, Kenya, and Senegal while at the same time building local capacity to undertake monitoring and evaluation and disseminating findings nationally, regionally, and globally.

Michele Staton-Tindall, PhD, MSW

University of Kentucky

Dr. Michele Staton-Tindall is an Associate Professor in the College of Social Work and a Faculty Associate of the Center on Drug and Alcohol Research, University of Kentucky. Dr. Staton-Tindall has a primary research interest in the delivery of screening and brief intervention for substance use in nontraditional venues. Dr. Staton-Tindall is the principal investigator for an ongoing study funded by the National Institute on Drug Abuse (NIDA) to study drug abuse, risky sexual behavior, and HIV/HCV among rural women in the Appalachian area of eastern Kentucky. Dr. Staton-Tindall also recently completed a trial funded by the National Institute on Alcohol Abuse and Alcoholism utilizing brief intervention via telemedicine with rural offenders on community supervision. She also serves as coinvestigator on a cooperative agreement funded by NIDA entitled Juvenile Justice Translational Research on Interventions for Adolescents in the Legal System (JJTRIALS), which focuses on the design, implementation, and testing of interventions for juveniles focused on substance use and HIV. Dr. Staton-Tindall has published in the areas of women and substance abuse, prison-based treatment, health service use among incarcerated women, and employment among drug offenders.

Melissa Stockton, BA

RTI International

Melissa Stockton is a health analyst in RTI's International Development Group. Ms. Stockton performs qualitative and quantitative data analysis for multiple projects aimed at monitoring and evaluation. She also provides technical support in the areas of stigma and discrimination, reproductive health and family planning, HIV, and health governance under the US Agency for International Development's Health Policy Plus Project (HP+), previously Health Policy Project. Under this project, she supported several projects exploring the role of stigma and discrimination in access to reproductive health and HIV services and information among vulnerable populations in Africa and Southeast Asia. Ms. Stockton is also the acting Research and Project Associate for the Bill and Melinda Gates Foundation's REACH project under the Gates Sick Child Initiative.

Richard van Dorn, PhD

RTI International

Dr. Richard Van Dorn is a senior mental health services researcher in the Behavioral Health Epidemiology Program within RTI International's Center for Justice, Safety, and Resilience. Prior to joining RTI in February 2012, he was an assistant professor with joint appointments in the University of South Florida's (USF's) College of Public Health, Department of Community and Family Health and USF's College of Behavioral and Community Sciences, Louis de la Parte Mental Health Institute, Department of Mental Health Law and Policy. He serves as principal investigator and coinvestigator on a number of grant-, foundation-, state-, and

pharmaceutical-funded studies. His experience and interests include mental illness and substance use epidemiology broadly, and treatment outcomes, including criminal justice involvement, for these conditions. Dr. Van Dorn has authored more than 70 peer-reviewed journal articles on substance use, mental illness, criminal justice, and violence and victimization. Dr. Van Dorn also has mentored clinical researchers, postdoctoral research fellows, and public health students, and developed graduate and undergraduate courses in behavioral health law, research methodology, and data analytic principles.

Peter Vaz, PhD

RTI International

Dr. Peter Vaz is a senior governance and public finance specialist in the RTI's International Development Group at RTI. He has more than 20 years of experience in municipal finance and local government transformation and, more recently, in gender-based violence, HIV/AIDS, and anticorruption. He is currently a Program Director for Urban Management and Markets in the Governance and Economic Development Division and an Associate Director of RTI's Global Gender Center. Prior to this, Dr. Vaz held USAID-funded Chief of Party positions, including on the Women's Justice and Empowerment Initiative in South Africa. In these capacities, he worked with the South African government on decentralization and extending and upgrading one-stop rape care management centers and with municipalities on capacity building and strengthening systems for performance improvement, revenue enhancement, and HIV/AIDS in the workplace. Dr. Vaz has also worked as a consultant at the World Bank, researching issues on local resource mobilization and poverty alleviation strategies in West African countries and on the gender impact of structural adjustment. His country experience includes Côte d'Ivoire, DRC, El Salvador, Indonesia, Nigeria, South Africa, Uganda, and Zimbabwe. Dr. Vaz has a bachelor's degree in economics, master's degrees in finance and urban policy, and a PhD in international economic development from the Massachusetts Institute of Technology.

William A. Zule, DrPH

RTI International

Dr. William Zule is an RTI Fellow in Health Policy and a Senior Research Health Analyst at RTI; he has been involved in community-based HIV prevention studies since 1989. He has been a principal investigator, coinvestigator, project director, associate project director, and ethnographer on several large HIV prevention epidemiologic research projects that targeted drug users and men who have sex with men (MSM). In addition to his research activities, he is experienced in program evaluation. Dr. Zule has done extensive work addressing the effects of childhood trauma on substance use behavior and risk. He has a strong background in studying sex risk among stimulant users, women, MSM, and people who inject drugs. As an affiliate of the RTI Global Gender Center, he has collaborated on numerous studies addressing substance use and sexual risk among women and couples who use alcohol and other drugs.

Appendix B. Directory of Conference Participants

A, B

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