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ANALYSIS OF SERVICES TO ADDRESS GENDER-BASED VIOLENCE IN THREE COUNTRIES

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

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AIDS Support and Technical Assistance Resources Project

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ACRONYMS

CEPAM	Centro Ecuatoriano para la Promoción y Acción de las Mujeres
GBV	gender-based violence
HTC	HIV testing and counseling
MOH	Ministry of Health
MSM	men who have sex with men
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
SWAGAA	Swaziland Action Group Against Abuse
USAID	U.S. Agency for International Development
USG	U.S. Government

INTRODUCTION

Gender-based violence (GBV—see Box 1 for definition) affects between 10 and 70 percent of women worldwide (World Health Organization 2005). Men who have sex with men (MSM), people who inject drugs, transgender people, and sex workers are among the most vulnerable to GBV as a result of gender inequalities (Betron and Gonzalez-Figueroa 2009; Burns 2009; Sex Workers’ Rights Advocacy Network 2009). In addition to having implications for almost every aspect of health and development, from economic growth and educational attainment to access to health services, GBV is widely recognized as both a cause and a consequence of HIV infection, which is the leading cause of death among women aged 15 to 44 worldwide (World Health Organization 2005). GBV creates conditions conducive to the transmission of HIV in women because women in violent relationships often experience coercive, violent sex and are unable to negotiate measures to avoid unprotected sex, and fear of violence may prevent women from seeking HIV-related services.

The U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) supports reducing violence and coercion as one of its five high-priority gender strategies (Interagency Gender Working Group of the U.S. Agency for International Development [USAID] 2008). As a result, PEPFAR has greatly increased its investments in strategies and programs to address GBV. For example, in May 2010, PEPFAR announced a U.S.\$30 million, three-year investment to scale up GBV programs in the Democratic Republic of the Congo, Mozambique, and Tanzania. The same year, PEPFAR provided challenge funds to 14 U.S. Government (USG) missions in Latin America and Africa to expand their current gender-related programming. By strengthening local capacity, PEPFAR hopes to enhance the enabling policy environment in each country and support the expansion and sustainability of GBV services and responses.

Box 1. Defining Gender-Based Violence

In the broadest terms, “gender-based violence” is violence that is directed at an individual based on his or her biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

GBV takes on many forms and can occur throughout the lifecycle, from the prenatal phase through childhood and adolescence, the reproductive years, and old age (Moreno 2005). Types of GBV include female infanticide; harmful traditional practices such as early and forced marriage, “honor” killings, and female genital cutting; child sexual abuse and slavery; trafficking in persons; sexual coercion and abuse; neglect; domestic violence; and elder abuse.

Women and girls are the most at risk and most affected by GBV. Consequently, the terms “violence against women” and “gender-based violence” are often used interchangeably. However, boys and men can also experience GBV, as can sexual and gender minorities, such as men who have sex with men and transgender people. Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control.

Source: Khan 2011.

A core principle of the PEPFAR II strategy is to support the long-term sustainability of HIV-related prevention, treatment, care, and support programs and to scale up promising and innovative programs and practices. Breaking the links between HIV infection and GBV requires targeted interventions to foster changes in individual and community norms that perpetuate violence against women and other vulnerable groups (Gardsbane 2010; Interagency Gender Working Group of USAID 2008; Orndorff and Natividad 2009). Achieving this kind of major change, in turn, requires an enabling policy environment at the local, regional, and national levels, as well as sustained advocacy and long-term funding (Rhodes et al. 2005). A number of strategies can be used to keep programs operating: public sector funding; private sector funding through foundations, private business contributions, or reimbursement by service users (i.e., charging for health services); or a mix of public and private funding.

Under the technical guidance of the PEPFAR Gender Technical Working Group, AIDSTAR-One, a global project funded by PEPFAR through USAID that provides support and technical assistance to USG teams across the world, has developed a number of technical resources exploring the connections among gender inequality, GBV, and HIV. These resources focus on identifying and sharing promising programmatic approaches and disseminating key elements of success for replication and scale-up.

In 2010, AIDSTAR-One conducted case studies in three countries where GBV services were available. The goals of the case studies were to:

- Analyze the policy environment related to preventing GBV and providing HIV services to survivors of GBV.
- Describe service delivery components, including crisis intervention, survivor support and advocacy, community education, staff training, monitoring and evaluation, policy advocacy, and counseling.
- Describe how the programs make linkages or referrals to other health and social support programs such as family planning, HIV testing and counseling (HTC), reproductive health services, economic development, and legal support.
- Summarize each program's current and future long-term funding strategies.

These case studies were developed to help program managers design, plan, and implement strategies to integrate GBV within existing HIV, family planning, or reproductive health services and programs. Analysis of the studies—conducted in Vietnam, Ecuador, and Swaziland—yielded five major findings and eight overarching recommendations.

METHODOLOGY

The case studies took place in countries that were chosen purposively through key informant interviews with GBV experts and health care practitioners. Each case study represents a distinct context relating to geographic location, funding, the policy context, and resulting implications for sustainability. Programs did not have to be receiving USG funding for consideration.

In Vietnam, the AIDSTAR-One gender team was also conducting an independent case study on how programs working with highly vulnerable populations are integrating gender into their activities (Spratt and Trang 2011). This allowed for leveraging of resources and reduced costs. The program in Ecuador integrates a multi-sectoral response to GBV within health services which is a model that has been identified by GBV experts as a promising practice. In Ecuador, the government has also recognized this and is working to try to scale up the approach in various sites throughout the country. This civil society-government collaboration is not very common yet important in efforts to scale up GBV and health services in resource-limited settings. The third program in Swaziland was chosen because it is a rare example of a longstanding program that has continued on short-term, project-specific grants and public donations and without long-term, core funding. The following programs were chosen:

- The Hanoi Department of Health GBV programs in Duc Giang General Hospital and Dong Anh General Hospital, Hanoi, Vietnam
- Centro Ecuatoriano para la Promoción y Acción de las Mujeres (Ecuadorian Center for Women's Advocacy and Action, or CEPAM), Guayaquil, Ecuador
- Swaziland Action Group Against Abuse (SWAGAA), Manzini, Swaziland.

AIDSTAR-One staff or a local consultant contacted each program to explain the purpose of the case study and arrange the site visits and interview schedule. Methods used to conduct the case studies included a review of national policies and strategies on GBV, program reports, and evaluations; and interviews with national or local government authorities, collaborating local nongovernment organizations (NGOs), staff and volunteers providing GBV services, GBV service users where feasible, and multilateral agencies providing technical or funding assistance to the programs (e.g., United Nations Development Fund for Women, and United Nations Population Fund).

A standardized site visit protocol and interview guides were developed and used across all three sites. The content of the guides included the following:

- History of the program
- Description of target population, program or service use, outreach, referrals, quality assurance, and training activities
- Description of the services provided
- Challenges faced in maintaining the services

- Innovations incorporated into the services as the program matured
- Lessons learned that other organizations should consider before introducing GBV services
- Strategies for long-term sustainability.

The data was collected over approximately five days in each site. Interviews were conducted in the local language in Ecuador, and in the local language and English with simultaneous translation in Vietnam and Swaziland.

FINDINGS

1. The government structures in the three countries vary greatly, but all have recently enacted policy frameworks for GBV.

The GBV programs described in the case studies operate in societies with relatively weak civil societies and a lack of national operational guidelines, protocols, or dedicated line-item budgets that promote long-term sustainability and scale-up of GBV services.

Vietnam: The Socialist Republic of Vietnam is a single-party country in which all political organizations are under the control of the Vietnamese Communist Party. There is no separation of powers between executive, legislative, and judicial branches. The National Assembly, which is subject to Communist Party direction, is the highest representative body of the people and the only organization with legislative powers (U.S. Department of State 2010). In 1986, the government of Vietnam instituted *doi moi* (renovation), which opened up the economic and political systems, resulting in rapid economic and social change, including the formation of social groups outside the Communist Party (Thayer 2008). In 1992, a new state constitution reaffirmed the central role of the Communist Party of Vietnam in politics and society, and outlined government reorganization and increased economic freedom.

After seven years of negotiation, the Government of Vietnam passed the 2007 Law on Domestic Violence Prevention and Control, which defines domestic violence as “an act intentionally committed by a family member, which causes harm or possibly causes harm in physical, emotional, and economic terms to another family member” (Hoang 2008, 39) regardless of sex, age, or relationship to the victim(s). The Ministry of Culture, Sports and Tourism is responsible for overall implementation of the law and is expected to collaborate with other ministries to develop and disseminate guidance for implementation. The provisions of the law include punishment of perpetrators, shelters for domestic violence survivors, interventions by community-based conciliation committees, expansion of access to family-based counseling, promotion of “trusted addresses” in communities (homes where survivors can seek short-term protection or support), and regular monitoring and supervision of implementation of the law. The law is rather broad, covering any intentional act committed by a family member, including divorced or common law couples (Hoang 2008). The Ministry of Health (MOH) took the first step to implement the law and in 2010 used the model from the Improving Health Care Response to Gender-based Violence project to develop guidance that requires all Vietnamese hospitals to integrate violence screening into health checkups. The MOH requires project training materials and screening tools be used countrywide.

Ecuador: For most of the twentieth century, Ecuador experienced economic and political turmoil that resulted in a cycle of short-lived democratic governments that were overthrown by military dictatorships. In 1979, Ecuador returned to democracy, but the country still faces issues of poverty, inequality, and marginalization of ethnic groups. Since 2008, the government’s spending in the social sector has increased significantly. Spending in the area of health has more than doubled, compared to historical levels, and now constitutes 3.5 percent of GDP (around U.S.\$1.8 billion). Free health care coverage and services have been expanded, especially for children and pregnant women (Weisbrot and Sandoval 2009). Ecuador also has a progressive policy record on GBV. However, this

does not mean that the policy has yet been meaningfully implemented. For example, police often take bribes from perpetrators to not process cases, and health providers fear getting involved in lengthy court deliberations, being threatened by perpetrators, and being slandered by lawyers. Ecuador has had a law against violence toward women and the family since 1995, but knowledge of the law is limited, and few women report violence to the authorities or seek judicial redress. In 2007, Presidential Decree No. 620, the National Plan for the Eradication of Gender Violence against Children, Adolescents and Women was enacted. Oversight for the plan is vested with a multi-sectoral committee of ministers. This committee works with a technical assistance team, comprised of various ministries and NGOs with experience in GBV, to formulate and oversee the policies laid out in the plan. The National Plan provides for access to legal protections and services, prevention through mass media campaigns, modules on GBV in school curricula, specialized courts to deal with GBV, support services such as shelters and hotlines, and institutional capacity building for government and NGO staff. Additional protection is promised in Article 66 of Ecuador's new constitution (2008), which guarantees a life free of public or private violence. It also states that the government will adopt measures to prevent and punish violence, particularly against women, children, adolescents, older persons, persons with disabilities, and disadvantaged or vulnerable persons. The same measures will apply against slavery and sexual exploitation (United Nations Entity for Gender Equality and the Empowerment of Women 2011).

Swaziland: The Kingdom of Swaziland is Africa's only remaining absolute monarchy. According to Swazi law and custom, the monarch, King Mswati III, holds supreme executive, legislative, and judicial powers. In general practice, however, the monarch's power is delegated through a dualistic system: modern, statutory bodies, like the cabinet, and less formal traditional government structures. The king must approve legislation passed by parliament before it can become law (U.S. Department of State 2011). A new constitution was adopted in 2006 that provides for equal rights of women and men, but it maintains the dual system of legislation that recognizes both traditional and civil law. Issues of marriage, child custody, property rights, and inheritance laws remain largely covered by traditional law and custom, which reflect strongly patriarchal norms and practices. The deputy prime minister's office houses both the Gender and Family Unit and the National Child Coordination Unit. Gender focal points were appointed in every ministry to mobilize and coordinate anticipated gender-related programs and initiatives. Problems yet to be resolved include the cumbersome infrastructure of the deputy prime minister's office, which slows processes and the ability to get work done, and the practice of appointing low-level individuals as gender focal points, who thus lack authority and decision-making power.

Among the recent positive developments is the 2010 National Gender Policy, a document that has been 13 years in the making. The new policy is expected to guide the attainment of gender equality provided by the constitution. Also, the government acknowledges the need to mainstream gender equality in all key policy documents, because it is included in the National Development Strategy 1997 to 2022. After more than 10 years of work by gender equality advocates, the Sexual Offences and Domestic Violence Bill was approved by parliament in October 2011, and is currently waiting for senate ratification. The original version of the bill was criticized as being too progressive and generated heated discussions about Swazi "culture versus gender equality." The final bill is a compromise, with some contentious issues given attention, although not as strongly as advocates would hope for.

The three case studies illustrate that although these countries have taken important steps toward addressing GBV, the policy environment for institutionalizing and scaling up services beyond a few sites remains limited; comprehensively addressing GBV is not yet a priority.

2. GBV responses vary across countries.

The delivery of GBV services at each case study site reflects three different types of responses—a government-run, health-centered approach in Vietnam; an NGO working with and through government support in Ecuador; and a community-based approach in Swaziland.

Vietnam: GBV services are extremely limited in Vietnam. The services highlighted in this case study, supported since 2010 by the Hanoi Department of Health, are available in only two hospitals and in a limited number of communes¹ in the vicinity of the hospitals. Several other programs are funded by other donors and implemented through other government partners, but almost all are small in scale, scattered across the country, and focused primarily on physical violence (United Nations Population Fund 2007). In Ecuador and Swaziland, services are available in more sites and extend beyond a medical model of care.

The Improving Health Care Response to Gender-based Violence project was piloted and then integrated into health services at two Hanoi city hospitals. The project, implemented by the Center for Applied Studies in Gender and Adolescence and the Population Council, has three components: screening, referrals, and community outreach and support. All medical and nursing staff in emergency rooms, obstetrics and gynecology, surgery departments, and most outpatient clinics receive basic training about GBV. The training covers the definitions and consequences of violence and teaches participants how to use a short, three-question screening tool,² work with survivors, and collaborate with the community to support GBV survivors. When a GBV case is identified, emergency treatment is provided if necessary and a referral is made to the counseling center in the hospital. Counseling services are free. The project does not support costs for routine HTC or other testing and treatment for sexually transmitted infections, though some women are referred to the hospital HTC site, which is supported by other donors. In terms of community outreach, staff from the hospitals and the two counseling centers visit communities monthly to provide communication sessions to members of mass organizations, like the Farmers' Union and the Students' Union, or interested community members on topics related to gender equality and GBV. These teams also support survivors' clubs but do not work extensively with youth, the schools, or HIV programs in the community.

Ecuador: CEPAM is one of the few organizations in Ecuador that provides comprehensive services for GBV survivors who come to CEPAM's center for assistance. These services, provided in Guayaquil, include complete reproductive health services, legal aid, psychological counseling, access to medical attention, and social support. CEPAM's multi-sectoral team provides these services at no cost, with funding from the Ministry of Economic and Social Investment (MIES). If necessary, the survivor may be referred to a shelter, a specialized health service, or an agency that can provide economic support. Counselors, all women who are GBV survivors, undergo an intensive process of psychological support and training to become community educators and advocates for women's rights, particularly related to GBV. A multi-sectoral approach is one of the defining features of CEPAM's programs. This approach has allowed users of CEPAM's services to avoid the bureaucracy and multiple processes necessary to access the various services they may need.

¹ A commune is an administrative unit below the level of a district; several communes make up a district.

² The three screening questions are 1) domestic violence: "Have you ever been beaten, insulted, or forced to have sexual intercourse by family members (husband, partner, family members) when you did not want to?"; 2) child sexual abuse: "Sometimes, during early ages, women are sexually abused (touched with erotic purpose), did that happen to you?"; 3) rape: "Have you ever been forced to have sexual intercourse by a person you know or a stranger when you did not want to?"

The 2007 National Plan to eradicate GBV is now being implemented through collaboration between ministries in various sectors with technical assistance from a number of local NGOs with expertise in GBV. CEPAM is the leader of these NGOs. CEPAM is currently providing technical assistance to the MIES to integrate its comprehensive model of services into various public institutions throughout Ecuador and to develop norms, protocols, and accompanying operational guidelines for integrated GBV services. Likewise, the National Institute of Family and Children (also part of MIES) has sought CEPAM Guayaquil's technical assistance to develop a service model for GBV. MIES is supporting a pilot project to develop integrated services in the Police for Women and Families of Guayas Province and in the Guayas Province prosecutor's office. CEPAM's collaboration with government has resulted in improved quality of GBV services such as improved understanding within the justice system of the multifaceted needs of women experiencing violence.

Swaziland: SWAGAA was founded in 1990 as a volunteer-operated, grassroots NGO to provide direct services to survivors of family violence and sexual abuse, and it is the only organization in Swaziland whose primary work is to address GBV. Today, services include prevention education (school and community programs), a toll-free hotline providing phone support and counseling, face-to-face counseling for adults and children, case management, legal services, economic self-sufficiency initiatives, a male involvement program, advocacy, community awareness campaigns, and referrals to a network of service providers. The links between HIV and GBV are made explicit throughout SWAGAA's programs, and clients are referred to HTC where appropriate. SWAGAA works in partnership with NGOs as well as governmental agencies such as the deputy prime minister's office, including the Gender Unit, the National Children's Coordination Unit, and the Social Welfare Department; the Swaziland Police Domestic Violence Unit; and Government Correctional Services. A strong referral network is being developed to increase efficiency and resource use and to help SWAGAA focus on its main goal of supporting survivors of GBV.

SWAGAA provides broad-based community education about GBV in 24 communities, as well as awareness raising and advocacy on GBV at the national level. SWAGAA began mainstreaming HIV into all its programs well before donors and other agencies turned their attention to this issue, and many survivors who use SWAGAA's services report experiences with both GBV and HIV services. The NGO's organizational strategies have evolved with an increasing emphasis on engaging men and boys, increasing GBV prevention activities, developing a referral network to increase the capacity to meet survivors' needs, and taking a more strategic response to GBV. SWAGAA's ongoing programs include school sensitizations, education and outreach, girls' empowerment clubs, the *Liblombe Lekukhalela* ("A Shoulder to Cry On") initiative (a child protection project created by the Government of Swaziland and the United Nations Children's Fund), and a male involvement initiative.

There is no "one size fits all" in terms of initiating GBV services. But what all sites demonstrate is that the sustainability and scale-up of GBV services requires collaboration between the government and civil society. In Vietnam, the effort started in the health sector; in both Ecuador and Swaziland, initial efforts began at the community level. The transfer of skills needed to achieve scale-up—from civil society experts to government, and in the case of Vietnam, from government to community organizations—is not an overnight process. There must be long-term commitment, funding, and partnerships to make it happen.

3. HTC services are not routinely provided across all sites.

Swaziland has the highest HIV prevalence in the world, so HIV prevention is foremost in all interventions in the country. The connection between HIV and GBV has not been addressed

sufficiently in either the Vietnam or Ecuador case study sites. Both are low-prevalence countries where HIV is concentrated within most-at-risk populations: sex workers, MSM, and people who inject drugs in Vietnam, and MSM, transgender people, and sex workers in Ecuador. These populations may not use public health services, where stigma and discrimination can be high, nor feel welcome at services targeting women. In low-prevalence countries, most health care providers are not familiar with HIV or may assume that female GBV survivors who are not from high-risk populations cannot be at risk for HIV (see Box 2 on why women face greater risks from HIV).

Vietnam: Until the second phase of the project, the service delivery model did not include a referral to sexually transmitted infection testing and HTC for GBV clients. Missed opportunities to provide HTC were due in part to the nature of project funding: the project was a GBV project, not a GBV *and* HIV project, and so HTC was not integrated into the training or the services even though free HTC services were available at both hospitals.

Ecuador: CEPAM has learned that an effective strategy to improve a policy response to GBV is to frame it as a social problem that requires action and mitigation efforts by all institutions and community members. While CEPAM clearly promotes GBV as a health problem that affects development, and project staff are trained to understand the link between GBV and HIV, funding and policy constraints limit the ability of CEPAM staff to provide HTC or post-exposure prophylaxis. Women who need these services are referred to other providers.

Swaziland: SWAGAA has been addressing the linkages between the HIV epidemic and GBV for almost a decade, and it mainstreams education and counseling on HIV throughout its programs and services. The intake process for clients who receive face-to-face counseling includes asking if they know their HIV status, although clients are not pressured to disclose. Clients who do not know their status are encouraged to go to an HTC site. All clients receive some counseling on HIV, including referral to partner support groups for those who are HIV-positive and counseling on prevention strategies for those who are HIV-negative or do not know their status. Following initial counseling, SWAGAA refers survivors of sexual assault (if they have reported the assault within 72 hours of the incident) to the Family Life Association of Swaziland for emergency contraception and post-exposure prophylaxis.

Box 2. Women’s Bodies and HIV Risk

Hormonal changes, vaginal microbial ecology and physiology, and a higher prevalence of sexually transmitted infections make women—especially young women—inherently more susceptible to HIV infection than men. Women are twice as likely as men to acquire HIV from men during sexual intercourse. Forced or violent intercourse can cause abrasions and cuts, which facilitate HIV infection for women (American Foundation for AIDS Research 2005). The combination of biological vulnerability and social, economic, and structural inequalities has fueled the feminization of the epidemic (Quinn and Overbaugh 2005).

4. Funding for GBV programs is insufficient and precarious.

Vietnam: Economic restructuring has reduced central funding to public sector health services, which are increasingly under pressure to charge fees to cover salaries, operating expenses, and services. GBV services are currently not included in hospital operating budgets or by MOH subsidies to hospitals. The 2010 MOH guidance requires GBV screening in all hospitals but does not specify how GBV screening will be funded or how to cover costs for counseling, referrals, and community outreach. Hospital administrations may or may not decide to use their own budget to

reimburse staff for GBV screening and counseling. As a result, the quality and level of GBV services may vary widely across Vietnam, dependent on the extent to which hospital administrators prioritize GBV. The administrators at the two hospitals profiled in the case study indicate that they are committed to continuing GBV services, but maintaining the current level depends on a funding mechanism from the MOH. Moreover, the Hanoi Department of Health, which administers hospital and clinic funding, has been unable to fully fund the level of services and staff positions previously supported by donor funding. As of July 2010, one hospital from the case study retained one of the two full-time counselors and remained committed to paying the counselor's salary for at least the next year, but does not have funding for community outreach activities or for long-term recurrent costs for the counseling center. At the second hospital, GBV services were combined with the HTC site to compensate for a lost position in the GBV clinic; outreach activities were curtailed. Fortunately, a few community-based activities initiated through the project may continue with local Women's Union or Farmer's Union budgets.

Ecuador: CEPAM has been able to position itself as a leading expert on GBV and obtain funding from the government to help implement the National Plan for the Eradication of Violence. CEPAM in Guayaquil has received government funding and is providing technical assistance to develop norms, protocols, and guidelines for integrated GBV service provision for several provincial offices in Guayas, including the Police for Women and Families. However, sustainability remains an ongoing challenge: CEPAM receives insufficient funding from government and piecemeal funding from various international donors which results in start-and-stop activities. In the case of the community-based rights counselors, for example, when the donor-funded project that built their capacity and initiated activities came to an end, the counselors stopped meeting with multi-sectoral GBV networks to coordinate their detection and referral efforts.

Experiences collaborating with the public sector show that it is possible for government and civil society to partner successfully to implement services. However, CEPAM and its partners have found that too much participation and leadership by civil society can lead to government over-reliance on civil society to assume responsibility in the GBV response.

Swaziland: SWAGAA is funded by a variety of sources, although not by the Swazi Government, even though SWAGAA works with GBV survivors who are referred by government institutions. In addition to PEPFAR, donors include private, individual, and corporate sources; local and international foundations; Canadian Crossroads International; the European Union; Irish Aid; and United Nations agencies. However, SWAGAA has never had a single large donor that provides sustained core support. Hence, at any one time, SWAGAA's sustainability can appear precarious. While government, civil society, and ordinary citizens place a high value on SWAGAA's contribution to the country, funding is a constant challenge. Interviews indicate that SWAGAA is taken for granted by many partners—with an assumption that the organization will always be “bailed out” financially. Most Swazis, including those working for other NGOs, government agencies, and donors, say that SWAGAA is part of the “fabric of Swaziland” and assert the organization will never be allowed to “go under” for lack of finances. For SWAGAA staff, however, the constant worry about being able to make ends meet affects staff morale, as well as the availability of resources for needed infrastructure and programmatic expenses.

5. Programs need to work with men and boys.

In all three countries, violence against women is seen by many as a “natural” part of life, and this perspective is a major barrier to efforts to address GBV. From the community to the police to the justice system, there is a lack of sensitivity to the human rights of women, children, and youth with

respect to violence. The level at which programs engage men and boys to change gender norms and reduce GBV varies greatly.

Vietnam: A male involvement component was missing from the project examined for the case study; this reduced the project's potential long-term impact.

Ecuador: CEPAM does not have a specific focus on working with men. The program begins training with reflections on gender norms and rights, seeking to have participants address myths about men's and women's roles in relationships and views of sexuality. Through its Integrated Center for Adolescents and Youth, CEPAM works with male youth to transform harmful notions of masculinity and increase respect for women and girls. Currently, the center is training three male youth as facilitators on the topic of positive masculinity.

Swaziland: Partnering with men to seek a more gender-equitable society has been a critical aspect of SWAGAA's work in recent years. The "Men for Change" project was launched in 2006 as a response to a community assessment and feedback that men and boys must be engaged if SWAGAA is to achieve its goals. The project is introduced to communities by engaging the chief, the chief's inner council, and other influential males who are part of the traditional community power structure. Facilitators have been trained in all 24 SWAGAA target communities. They organize male dialogues as opportunities for men to come together to discuss a wide range of topics relating to gender norms. The focus of the project is to engage men as positive partners in ending GBV, rather than simply as perpetrators. While engaging men as partners to eliminate GBV has been a good practice, serving men as clients is raising questions about how to properly screen male reports of abuse. Adult males comprised 22 percent of clients in fiscal year 2001-2002, 25 percent in fiscal year 2008-2009 (SWAGAA 2009), and 28 percent in fiscal year 2009-2010 (SWAGAA 2010). Staff report that counseling is provided both to men who say they are victims of abuse and to perpetrators. Perpetrators receive one-on-one anger management counseling; when the client is repentant and the couple wants to remain together, couples counseling and communication skills building is provided.

RECOMMENDATIONS

1. Expand GBV beyond a health focus and integrate the issue into all development work through PEPFAR and other programs.

GBV is a social epidemic, and all institutions and community members should act to prevent and mitigate it. More specifically, GBV is a public health problem with impacts on physical, sexual, reproductive, maternal, and mental health. Linking GBV to wider human rights, health, and development concerns helps place the issue at a higher priority level, garnering greater attention to and support for ending GBV. In countries with low-prevalence or concentrated epidemics, the link between HIV and GBV is less compelling to donors and governments than in higher-prevalence countries like Swaziland. However, if left unattended, GBV will help to fuel the epidemics in low-prevalence countries.

Vietnam has made enviable progress on Millennium Development Goal 3 (promoting gender equality and empowering women) by reducing poverty and increasing educational levels for girls, but it will fall short on increasing gender equality if its efforts to address GBV remain limited (United Nations Entity for Gender Equality and the Empowerment of Women 2011). In Ecuador, where citizen safety is a priority issue, framing GBV as a security issue has been strategic in advancing CEPAM's agenda. In Swaziland, SWAGAA's focus on eradicating GBV and promoting human rights through a wide range of activities has greatly increased awareness of GBV at all levels with a strategic focus on the intersections between GBV and HIV.

2. Ensure that GBV survivors and people living with HIV (PLHIV) are credibly engaged in policy discussions and program planning and implementation.

GBV survivors, their families, and those affected by HIV are disturbingly absent from the national dialogue and decision making on policies and planning with relevance to GBV in Vietnam and, as other research has shown, in countries around the world. Yet program experience in Ecuador and Swaziland shows that survivors can be effective advocates and spokespersons. GBV programs should commit, as a guiding principle, to the meaningful inclusion of GBV survivors, their families, and PLHIV throughout the development of GBV policies and services, both in the private and public sectors.

3. Advocate for a national budget for GBV.

None of the funding strategies described in the three case studies offered sustainable models for GBV service delivery. Policies and programs cannot be adequately and sustainably implemented without long-term financial support. In all three countries, the mechanism through which GBV services are provided is poorly defined. In Vietnam, national government guidance mandates screening of all hospital clients but does not clarify how that screening (and subsequent response) will be paid for. In Ecuador, the National Plan outlines procedures for the institutionalization of the response to GBV—including assigning budgets, coordinating work across sections, and conducting monitoring and evaluation—but more efforts need to be conducted for the implementation or funding of these procedures so far. In Swaziland, the absence of a reasonable national budget for the Gender Unit, the National Children's Coordinating Unit, and other government agencies tasked

with addressing gender inequity limits the ability of these entities to do the work even with committed staff. All three countries need to ensure a sufficient, designated national budget specifically for GBV. Some funds allocated for HIV programs should also be allotted to cover GBV interventions, and this will require a stronger awareness of the links between GBV and HIV.

4. Clarify that GBV is a human rights and development issue as well as a public health problem.

More work is needed to create awareness of the links between gender equality and social and political development. Poverty and gender inequality often go hand in hand. Gender equality can enhance productivity, improve health and education outcomes for children, and ensure that a range of voices make institutions more representative (World Bank 2011). Working to increase gender equality is critical for social change, including effective GBV and HIV services. In societies where GBV is considered normal, much more needs to be done at the community level to increase awareness of the rights of girls, women, and other marginalized populations to be free from violence and coercion. Changing norms around GBV will increase the likelihood that communities will demand an adequate response to preventing and addressing GBV from the local government. Donors and governments should invest in approaches based on human rights and empowerment as effective strategies for creating social change. Ultimately, community ownership of efforts to reduce GBV will depend on the leverage that informed and energized communities can use to ensure long-term resources from government or the private sector.

5. Develop GBV advocates within civil society, including GBV survivors and PLHIV.

Involve community members: An important lesson from CEPAM's experience in Ecuador is that civil society can monitor government actions and hold government accountable for promises to address GBV. To ensure that governments and other stakeholders deliver on their commitments and implement the policies and services they promise, civil societies must have the capacity to both support and monitor this implementation, and to comment on the quality of the services delivered. This requires that civil society groups, including survivors of GBV and PLHIV, be included in the planning, implementation, monitoring, and evaluation of policies and programs. Civil society representatives can ensure that initiatives are appropriate, responsive to community needs, and effective in producing meaningful social change. Survivors of violence and PLHIV can be effective advocates, particularly by sensitizing others to the reality of living with violence or HIV.

Train and deploy survivors as counselors: Both SWAGAA and CEPAM learned important lessons by working with GBV survivors. Survivors became community-based counselors or organized self-help groups that provided immediate advocacy and referrals. Given that most survivors do not initially seek services from the formal sector, this is a critical strategy that empowers GBV survivors as community resources and provides accessible help to other community members who may not seek services out of fear, shame, or lack of knowledge. Survivor-advocates can provide the long-term follow-up needed to navigate the legal system and other follow-up care. Empowered GBV survivors also break the silence around GBV, challenging the concept that GBV is normal or that it is a private family issue. Training GBV survivors and PLHIV for the central role of survivor-advocates could be a relatively small investment, and could increase the uptake and impact of comprehensive services.

6. Develop GBV advocates within all levels of government.

Levels of support for policies vary among national, provincial, and local policymakers. To advance the implementation of GBV policies, advocates must help implementers 1) understand the policy as a priority for their own organizations or agencies; 2) believe that the policy lays out an acceptable solution to the problem; 3) conclude that taking action now is in implementers' own best interest; and 4) develop the capacity needed to implement the interventions (Spratt 2009). For policy implementation to go forward, advocates are needed at all levels of government. These advocates need to have the capacity to persuade their peers that implementation of national policies on GBV is in their own interest; much more work must be done to build the capacity of internal advocates to ensure attention to a policy as it is disseminated to the local governments for implementation. This is especially important in Vietnam and Swaziland (and other countries like China or Russia) where civil society is weak or suppressed by the government, and within which there is little political will to address GBV. Ecuador provides the best example of advocacy among the three countries in the case studies, but there is still much to do to generate commitment to addressing GBV and providing services at local government levels.

7. Engage men and boys.

Of the three organizations examined, only SWAGAA had a program that engages men and boys to begin to address gender norms and the harmful inequities that these norms support. In all the case studies, GBV continues to be viewed predominantly as a woman's issue, tied to internal family conflict. Yet a growing number of impact evaluations from Asia, Latin America, and Africa show that well-designed and -implemented interventions can change men's attitudes and practices as they relate to gender roles and relations and HIV. Many program tools and models are now widely available and should be used to design locally relevant interventions to enlist men and boys in preventing GBV and reducing the spread and impact of HIV. GBV programs should strive to synchronize their efforts with programs for men and boys to change gender norms that perpetrate gender inequity and GBV (Greene and Levack 2010).

Some case study participants recognized that men and boys also experience physical, sexual, and psychosocial violence, but only SWAGAA provided services to men or boys or addressed how gender norms influence violence by and against men and boys.

Overall, the response to GBV needs to include strategies that involve both public and private agencies as well as NGOs to scale up programs that work with men and boys and to maintain a focus on ensuring that laws and policies about GBV are enforced and that services for survivors of GBV are sustainable over the long-term. It is critical to move beyond small-scale group education sessions for men and boys to larger and more lasting social change.

8. Support a comprehensive response to GBV and HIV.

A comprehensive response to GBV and HIV includes multi-sectoral approaches; addresses impact at multiple levels, including the individual, family, community, and national levels; and includes multiple strategies for addressing GBV and HIV. The literature documents a wide range of interventions, including:

- A human rights framework with supporting laws and policies
- A strategy to challenge gender norms, roles, and behaviors
- Interventions to increase women's economic security

- Projects to promote women's empowerment and life skills
- Comprehensive services for survivors
- Appropriate training for professionals
- Community awareness, outreach, and mobilization
- Face-to-face counseling and education (Gardsbane 2010).

Each of the programs highlighted in the case studies represent only part of a comprehensive response to GBV and HIV. A comprehensive response requires effective coordination among multiple players as well as effective referral and case management systems.

CONCLUSION

Promising programs in very different circumstances share similar challenges and successes in their efforts to address and prevent GBV. Organizations that focus on ending violence engage in long-term struggles to ensure that policies to address and reduce GBV are enacted and enforced. The three organizations described in the GBV case studies met the needs of GBV survivors, helped many reclaim their lives and dignity, and increased attention to the issue of GBV. However, no funding strategy—private sector, public sector, or public/private—has proven sufficiently dependable to sustain a comprehensive response to GBV or to ensure strong links between efforts to prevent HIV and those to prevent GBV. In the short and long run, demand from the community and support by the public and private sectors will be critical to the long-term sustainability and scale-up of these and other GBV services.

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