USAID
FROM THE AMERICAN PEOPLE

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

AIDSFree
Strengthening High Impact Interventions for an AIDS-free Generation

GENDER-BASED VIOLENCE INITIATIVE SYNTHESIS REPORT

MAY 2016

GENDER-BASED VIOLENCE INITIATIVE SYNTHESIS REPORT

MAY 2016

This publication is made possible by the generous support of the American people through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with the U.S. Agency for International Development (USAID) under the Cooperative Agreement Strengthening High Impact Interventions for an AIDS-free Generation, number AID-OAA-A-14-00046. The information provided does not necessarily reflect the views of USAID, PEPFAR, or the U.S. Government.

AIDSFree

The Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project is a five-year cooperative agreement funded by the U.S. Agency for International Development (USAID) under Cooperative Agreement AID-OAA-14-000046. AIDSFree is implemented by JSI Research & Training Institute, Inc. with partners Abt Associates, Inc., Elizabeth Glaser Pediatric AIDS Foundation, EnCompass LLC, IMA World Health, the International HIV/AIDS Alliance, Jhpiego Corporation, and PATH. AIDSFree supports and advances implementation of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) by providing capacity development and technical support to USAID missions, host-country governments, and HIV implementers at the local, regional, and national level.

Recommended Citation

Casto, Jennifer, and Lyn A. Messner. 2016. *Gender-based Violence Initiative Synthesis Report*. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project.

JSI Research & Training Institute, Inc.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: aidsfree.usaid.gov

Acknowledgments

Many thanks to the members of the PEPFAR Gender and Adolescent Girls Technical Working Group (GTWG), formerly known as the Gender Technical Working Group, for its leadership in conceptualizing and overseeing this review process. Thanks to the authors of the Gender-based Violence Initiative country reports—Floriza Gennari, Thandie Harris-Sapp, Zuki Mihyo, Jean-Richard Mutombo, Elizabeth Rowley, and Kelsey Simmons. Thanks also to all of the individuals who participated in individual and group interviews, in focus group discussions, and in the culminating workshop: United States government personnel (U.S. Centers for Disease Control and Prevention, USAID, Department of Defense); United Nations organizations; implementing partners; service providers; and representatives of the governments of Tanzania, Mozambique, and DRC, and of nongovernmental and community-based organizations.

CONTENTS

ACRONYMS

AGYW	adolescent girls and young women
AIDSFree	Strengthening High Impact Interventions for an AIDS-free Generation
CDC	U.S. Centers for Disease Control and Prevention
DOD	Department of Defense
DRC	Democratic Republic of the Congo
DREAMS	determined, resilient, empowered, AIDS-free, mentored, safe
FY	fiscal year
GBV	gender-based violence
GBVI	Gender-based Violence Initiative
GTWG	Gender and Adolescent Girls Technical Working Group
HIV	human immunodeficiency virus
MER	monitoring, evaluation, and reporting
MISAU	Ministério da Saúde
MSP	Ministère de la Santé Publique
NBS	National Bureau of Statistics
OCGS	Office of the Chief Government Statistician
PEP	HIV post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
USAID	U.S. Agency for International Development
VAC	violence against children
WHO	World Health Organization

INTRODUCTION

In 2011, the U.S. President's Emergency Plan for AIDS Relief launched the US$55 million, three-year, interagency Gender-based Violence Initiative (GBVI) in the Democratic Republic of Congo, Mozambique, and Tanzania. The GBVI aimed to integrate gender-based violence (GBV) prevention and response into existing HIV prevention, care, and treatment programs at health facility, community, and policy levels. See Box 1 for a definition of GBV.

The GBVI focused on multiplying the effects of PEPFAR investments to integrate GBV prevention and response into existing HIV programs. This included developing national guidelines, strengthening coordination across sectors, and building the capacity of and linkages between clinic- and community-based services in GBV prevention, as well as response, within the context of the existing HIV prevention, care, and treatment.

There are important lessons to learn about the potential for synergy created by various models for GBV prevention and response interventions, such as addressing GBV prevention and response simultaneously; taking a selected set of approaches or a multicomponent GBV program model across the PEPFAR platform of services; and building linkages between facility- and community-based GBV interventions. The PEPFAR GTWG asked AIDSFree to conduct a review of the GBVI in all three countries to inform programming, specifically the integration of GBV prevention and response into the context of the HIV cascade of services. These lessons, in turn, can inform PEPFAR and other donor initiatives in designing future investments in GBV prevention and response.

The AIDSFree team conducted a review of the GBVI in the DRC, Mozambique, and Tanzania by examining approximately 475 documents, conducting semi-structured interviews and focus group discussions with 131 GBVI stakeholders[1] (17 global, 19 in the DRC, 43 in Mozambique, 52 in Tanzania), and visiting all three countries (one week in the DRC and two weeks each in Mozambique and Tanzania). GBVI indicator data from fiscal years 2012 to 2014[2] were analyzed to provide perspective on the scope of the GBVI. The purpose of this synthesis report is to provide a global-level overview of the GBVI, highlight successes and lessons from the three country reports,[3] identify GBVI contributions and lessons learned, and identify implications for future PEPFAR programming.

[1] Implementing partners, community-based and nongovernmental organizations, government officials, U.S. Government agencies, United Nations organizations, and service providers.
[2] These data were provided after the country reports were written.
[3] The individual country reports can be found on the AIDSFree website: Democratic Republic of Congo, Mozambique, and Tanzania.

Box 1. U.S. Government Definition of GBV

Violence that is directed at an individual based on biological sex, gender identity, or 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.

Gender-based violence takes on many forms and can occur throughout the life cycle. Types of gender-based violence can include female infanticide; child sexual abuse; sex trafficking and forced labor; sexual coercion and abuse; neglect; domestic violence; elder abuse; and harmful traditional practices such as early and forced marriage, "honor" killings, and female genital mutilation/cutting.

Women and girls are the most at risk and most affected by gender-based violence. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, boys and men can also experience gender-based violence, as can sexual and gender minorities. Regardless of the target, gender-based violence 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.

(U.S. Government 2012)

THE GENDER-BASED VIOLENCE INITIATIVE

The GBVI was the culmination of several years of work on the part of PEPFAR, in particular the PEPFAR Gender Technical Working Group. PEPFAR recognized the links between gender and HIV starting with the original 2003 legislation. As part of the second phase of PEPFAR, under the leadership of Secretary Clinton and then PEPFAR Coordinator, Ambassador Eric Goosby, PEPFAR increased its commitment to addressing gender issues. It was the commitment of that leadership combined with a strong GTWG that led to the development and implementation of the $55 million GBVI.

The first set of PEPFAR central initiatives focused on GBV in 2006, when $8 million was allocated to pilot programs on GBV, male norms, and adolescent girls at the country level.[4] The desire to scale up these types of programs led to the GBVI, with the goal of putting major investments in three target countries to examine the feasibility and impact of such a concentrated effort.

The GBVI's objectives were to demonstrate that GBV prevention and response activities could be integrated into the PEPFAR platform and to understand the best approaches for achieving a successful integrated response through existing HIV prevention, care, and treatment services at both clinical and community facilities.[5]

In 2009, the GTWG sent out a broad solicitation to a preselected number of PEPFAR country teams explaining the new centrally-funded GBVI, and inviting countries to participate. The goal was for the GBVI to augment existing HIV programs in select countries to build upon and expand integration of GBV prevention and response.

Several factors went into the country selection process. GBV prevalence was important, but not the only factor considered due to the challenge associated with collecting accurate data on GBV prevalence. Because of this, the GBVI selection committee also considered HIV prevalence, the level of PEPFAR investment in the country, willingness of U.S. and host-country governments, the work of existing partners and programs, and how the country fit into existing PEPFAR priorities. The selection committee sought to prioritize countries that faced challenges with HIV and GBV prevalence and had the interest and capacity to continue GBVI programming beyond the life of the initiative.

The DRC, Mozambique, and Tanzania were ultimately selected because they met these criteria, although each country faced its own unique HIV and GBV challenges. The DRC was a conflict environment where GBV was a high-profile issue on the global stage due to sexual violence in

[4] These included the Male Norms Initiative (in Tanzania, Ethiopia, and Namibia); the Sexual Violence Initiative (in Uganda and Rwanda); and the Go Girls! Initiative (in Botswana, Malawi, and Mozambique).

[5] A clinical health facility is a health delivery site that falls into one of the following categories: tertiary/third-level hospital, second-level referral hospital (provincial hospital), first-level hospital (district-level hospital), hospital-affiliated health center, health center (urban/rural), clinic, or health post/dispensary. A community facility is any nonclinical site where health services are offered, including community support groups, collectives, shelters or safe houses, and food banks.

the eastern part of the country. There was a great deal of investment to combat GBV in eastern DRC, but the HIV sector was not fully engaged in GBV prevention and response outside this region. This presented the opportunity to expand GBV prevention and response to target areas with high levels of GBV in other parts of the country where PEPFAR was already working. Tanzania had strong government commitment to GBV prevention and response and was selected because of the nation's willingness to address and provide leadership in this area. Mozambique was combating high rates of GBV and HIV, and rates were thought to be especially high among adolescent girls, with a high prevalence of school-related GBV. All three countries had distinct challenges but had enough in common for the GBVI to implement similar, yet flexible, programming in each. The GBVI indicators were the same, with the expectation that prevention and response would be implemented in tandem on the HIV platform. The details, structure, and partners were country specific.

> *"We didn't want three drastically different activities. We initially discussed early on that we wanted a lot of alignment and harmonization across the three countries. I don't recall any conclusion that we wanted cookie cutter. We wanted to give the countries some latitude across the three, but before we left, we did want to have common indicators across the three."* (U.S. Government agency)

The GBVI leveraged existing PEPFAR HIV investments and used this momentum to deliver a multiyear intervention with a concentrated focus on GBV and HIV and to identify lessons that could be applied across PEPFAR programs in other countries and regions. This interagency initiative was not only led by different U.S. Government agencies through the GTWG but was planned and implemented by different U.S. Government agencies at the country level.

CONTEXT

The link between HIV and GBV is well documented in the literature and was a key consideration for the development of the GBVI (Ellsberg and Betron 2010; Jewkes et al. 2010). Individuals infected with HIV, especially women and girls, are at increased risk for GBV as a result of their status, and those experiencing GBV face a greater risk of HIV infection (Ellsberg and Betron 2010)—a risk more than 50 percent greater (World Health Organization [WHO] 2013). The intersection between the two creates a dual epidemic. In low- and middle-income countries worldwide, HIV is the leading cause of death and disease in women of reproductive age, and in sub-Saharan Africa, 60 percent of people living with HIV are women (WHO 2013). More than 5,000 young women and girls acquire HIV every week, the vast majority of them in southern Africa. Adolescent girls and young women (AGYW) in southern Africa also acquire HIV five to seven years earlier than their male peers (UNAIDS 2015). However, men and boys are also affected by gender expectations that may encourage risk-taking behavior, that increase their risk of HIV, and that discourage them from accessing health services. Rates of HIV testing and treatment are lower among men compared to women. Men and boys also experience GBV. Key populations and children are at especially high risk, yet often do not have the resources to facilitate their recovery and break the cycle of violence. These disparities are the result of biological, structural, and sociocultural conditions, as well as of stigma and discrimination that affect men and women differently and impede access to resources that can prevent and mitigate HIV. Programs that address both GBV and HIV have the potential to make a greater impact on these epidemics than stand-alone programs that fail to consider this intersection.

COUNTRY PROGRAMS

The GBVI operated in three countries: the DRC, Mozambique, and Tanzania. The initiative was designed to address the needs of each country and to align with existing government and civil society response to GBV and HIV. The overall goal of the GBVI was to reduce barriers to GBV prevention and response services and interventions, thereby reducing GBV.

DRC

In the DRC, the $10 million, two-year GBVI leveraged PEPFAR and other U.S. Government investments to build national capacities to integrate GBV prevention and response into the existing HIV platform of services. The GBVI activities in the DRC were centered on the health sector and engaged the military and media. The GBVI objectives in the DRC are displayed in Box 2. Activities were funded during fiscal years 2011 and 2012, although some continued into fiscal year 2013 and onward. Four partners (listed in Annex 1) implemented activities to achieve these objectives with technical and management support from four U.S. Government agencies: USAID, the U.S. Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), and the Department of State.

Box 2. GBVI DRC Objectives

GBVI DRC National Objectives

- To increase and improve coordination of the GBV and HIV integrated response.
- To increase availability, use, and quality of GBV services.
- To strengthen GBV prevention and response through increased awareness of GBV and its relationship to HIV, GBV laws, policies, and guidelines.

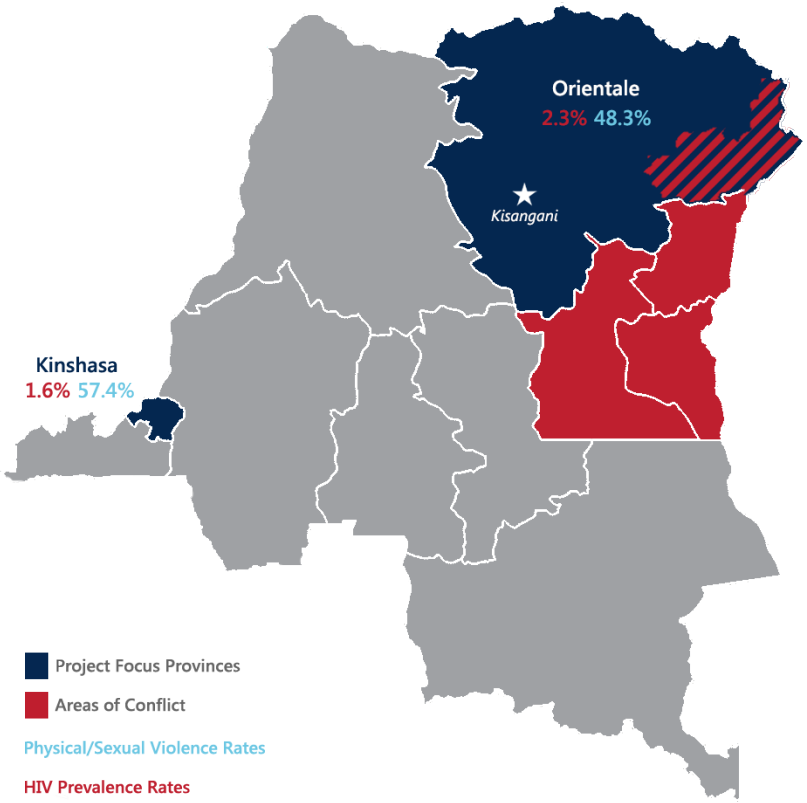
GBVI DRC Provincial Objectives

- To increase GBV service availability, use, and quality.
- To change attitudes and behaviors that perpetuate GBV.
- To increase capacity of social institutions, civil society organizations, and communities to respond to GBV.

The GBVI in the DRC was unique in that it provided a distinct funding mechanism in a country where USAID and other U.S. Government agencies were already making substantial GBV program investments in the conflict areas of eastern DRC. The GBVI activities targeted areas outside the east—specifically, the urban and peri-urban areas around Kinshasa and Orientale provinces (see Figure 1 on the following page)—although some activities were province-wide or national in scope. Although the HIV prevalence in the DRC is not the highest in sub-Saharan Africa, the country's large population (77.8 million) and estimated HIV prevalence among adults aged 15 to 49 (1 percent) means that the DRC has a large number of people living with HIV, including 390,000 adolescents and adults aged 15 and older and 59,000 children from birth to age 14. HIV prevalence in Kinshasa and Orientale provinces is among the highest in the country, at 1.6 percent and 2.3 percent, respectively (Ministère du Plan et Suivi de la Mise en Œuvre de la Révolution de la Modernité [MPSMRM], Ministère de la Santé Publique [MSP], and ICF International 2014).

Although sexual violence is a brutal hallmark of conflict-affected areas in eastern DRC, GBV affects the population countrywide and significantly impacts individuals, families, and communities. According to the 2014 Demographic and Health Survey Report, more than half of all Congolese women surveyed had experienced physical violence since the age of 15, most often at the hands of their husbands or partners (MPSMRM, MSP, and ICF International 2014). To address the country's significant GBV-related challenges and underlying gender inequities, the DRC government developed a series of national laws, policies, and guidelines. These include the 2005 national constitution that calls for elimination of discrimination and violence against women as well as 2006 amendments to the penal code that outlaw rape and all forms of sexual assault, although spousal rape and violence between domestic partners is not clearly addressed by the country's penal codes in general (Canada 2012).

Figure 1. GBVI Provinces of DRC with HIV Rates



In 2009, the Ministry of Gender, Family, and Children issued the National Strategy Against Gender-based Violence (*Stratégie Nationale de Lutte Contre les Violences Basées sur le Genre*), which outlines enforcement of laws and actions against impunity; prevention and protection; support for reforms within the army, police, security forces and the legal system; response to the multisectoral needs of GBV survivors; data and information management; sensitization on GBV among government actors and political, traditional and religious leaders; institutional capacity strengthening; and support for women's rights (République Démocratique du Congo, Ministère du Genre, de la Famille et de l'Enfant 2009). The Ministry of Gender, Family, and Children is the mandated focal point for national and international actors addressing gender inequality, including GBV. The Ministry of Health National Reproductive Health Program (*Programme National de Santé Reproductive*), the National Program for the Fight against AIDS (*Programme Nationale de Lutte contre le VIH/SIDA*), the Ministry of Justice, the Ministry of Education, and the Ministry of Youth, Sports and Recreation also address GBV prevention and response through their work. At the provincial level, gender focal points are tasked with supporting implementation of a separate National Gender Policy, while the Ministry of Gender, Family, and Children is the mandated focal point for national and international actors addressing gender inequality, including GBV. Gender focal points also exist within other ministries; however, they have been characterized as underused and with insufficient capacity to address gender equality

and GBV. The Ministry of Gender, Family, and Children conducted an organizational self-assessment that showed that the ministry had limited capacity to implement its mandate and promote its agenda with other ministries (Davis and Alphonse 2014).

The GBVI in the DRC used multiple programmatic approaches to achieve its objectives at the national and provincial levels. To achieve strong coordination at the national level, the GBVI aimed to align PEPFAR GBV activities and indicators with the DRC government's GBV and HIV strategies, to increase PEPFAR partner engagement in relevant national coordinating groups, and to support national GBV health standards and protocols. Activities at the provincial level complemented efforts to address GBV at the national level by working with provincial leadership and provincial coordination mechanisms and by supporting the implementation of specific facility- and community-based activities in Kinshasa and Orientale Provinces.

Mozambique

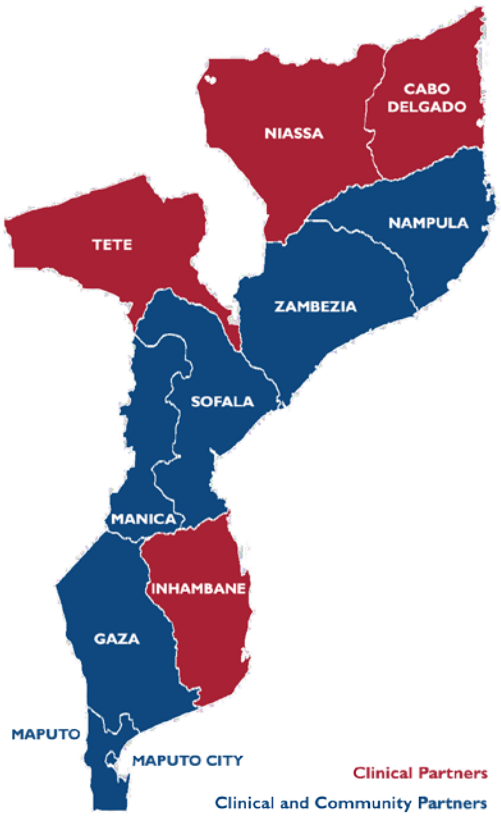
In Mozambique, the $21 million, three-year GBVI was designed to prevent GBV by addressing the sociocultural norms that condone it and offering comprehensive post-GBV services for survivors. GBVI activities focused on three primary objectives (see Box 3). Twenty-five (25) partners (see Annex 1) implemented activities to achieve these objectives, with technical support from three U.S. Government agencies: USAID, CDC, and the DOD.

GBVI activities were implemented nationally. As shown in Figure 2, provinces in red had clinical partners, and provinces in blue had both clinical and community partners. Priority geographic areas within provinces were those with high HIV and GBV prevalence among women and girls, target groups (including special populations and military populations), U.S. Government presence, and current PEPFAR activities that could be expanded to include GBV prevention and response. The GBVI in Mozambique attempted to address GBV prevention and response using a multisectoral, multilevel approach that involved health and social services and legal and law enforcement at national, institutional/facility, and community levels. In Mozambique, the initiative did not set out to address specific types of GBV, but rather responded organically to the country's needs. Every level at which the GBVI operated was closely

Box 3. GBVI Mozambique Objectives

1. To expand and improve coordination and effectiveness of GBV-prevention efforts.
2. To improve policy implementation in response to GBV.
3. To improve the availability and quality of GBV services.

Figure 2. Map of GBVI Mozambique Activities by Province



connected to and influenced by the levels above and below it. Each activity required engagement of different sectors and staff at each level. Annex 2 displays this sociological model.

With an estimated HIV prevalence of 11.5 percent, Mozambique is one of the most HIV-burdened countries in sub-Saharan Africa; and women are disproportionately affected (Instituto Nacional de Saúde [INS], Instituto Nacional de Estatística [INE], and ICF Macro 2009). Women's vulnerability to HIV is also reflected in the magnitude of GBV prevalence: 37 percent of women ages 15 to 49 reported having experienced any form of GBV in their lives, including emotional, physical, or sexual violence (Ministério da Saúde [MISAU], Instituto Nacional de Estatística [INE], and ICF International [ICFI] 2011). Mozambique has the tenth highest rate of early marriage in the world, with 48 percent of women ages 20 to 24 reporting that they married before the age of 18 (Hodges 2015). Although countrywide survey data are lacking, emerging data suggest that sexual violence affects a significant proportion of orphans and other vulnerable children, including boys. Although there is a paucity of data on key populations, such as men who have sex with men and people who inject drugs, it is well known that these groups often face additional barriers in accessing HIV and GBV prevention and response services due to stigma and discrimination, which places them at greater risk for both epidemics (Dunkle and Decker 2013).

Prior to the GBVI, the Government of Mozambique demonstrated increasing commitment to preventing and responding to GBV. Along with other donors and partners, the GBVI helped the country build on existing GBV commitments and prioritize GBV in policies and plans. Over the last five years, the government integrated gender and GBV in several plans, policies, and laws, including the Government's Quinquennial Plan (2010–2014), which guides high-level priorities for the country; the National Plan for the Advancement of Women (2010–2014); and the National Plan of Action for Children II (PNAC 2013–2019).

In 2009, the Mozambican Parliament passed the Law on Domestic Violence against Women, which civil society organizations and international partners, including those within the GBVI, disseminated through all levels of society and government. The 2014 revised penal code also increased the penalty for sexually assaulting children. In 2012, the government released the Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence. This document outlines the roles and responsibilities of four ministries: the Ministry of Health, the Ministry of Justice, the Ministry of the Interior (the police), and the Ministry of Gender, Children, and Social Action. The first-ever national multisectoral meeting was held in May 2015, with more than 250 participants from the four ministries and all government levels. Additionally, in 2015, the Ministry of Health, with support from GBVI partners, developed a five-year national GBV strategy that is expected to be approved in 2016.

The government has made several advances within the four Multisectoral Mechanism sectors, although significant challenges remain. Within the Ministry of the Interior, the government established the *Gabinetes de Atendimento Integrado à Mulher e Criança Vítima de Violência* (Cabinets of Assistance to Women and Child Victims of Violence, hereafter "victim service centers"), usually staffed by female police officers. These victim service centers feature private spaces for GBV survivors to report cases; they are either in stand-alone buildings or situated

within police stations. In 2015, there were 22 stand-alone centers and 238 victim service centers in the country. The GBVI also built on existing efforts within the health sector to provide one-stop facilities for GBV survivors to access various co-located services, such as legal and psychosocial support. Although Mozambique continues to face challenges, the government, both independently and with assistance from the GBVI, has made several advances related to both GBV and HIV.

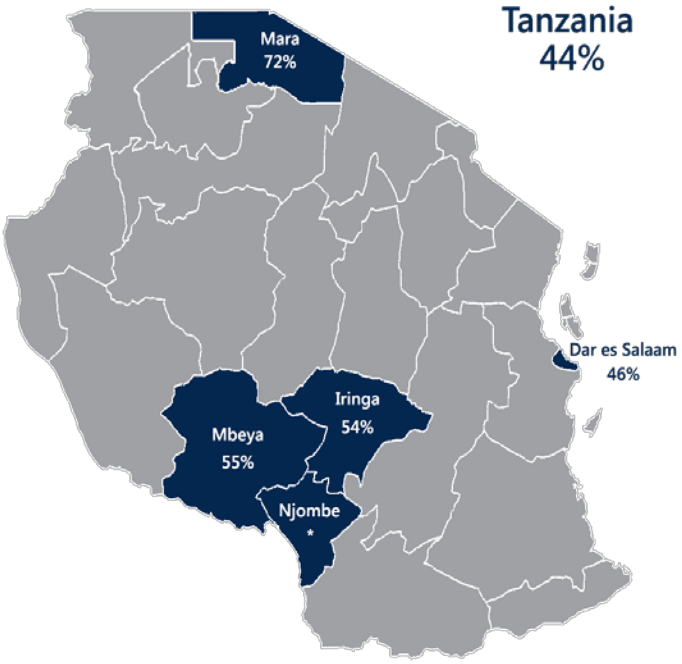
Tanzania

In Tanzania, the $21 million, three-year GBVI aimed to prevent and reduce GBV prevalence by addressing the underlying sociocultural norms and offering comprehensive post-GBV care services for survivors. The GBVI funding in Tanzania was divided into two parts. First, PEPFAR allocated $21 million to three U.S. Government agencies—USAID, CDC, and DOD—to implement GBV activities focused on leveraging the PEPFAR platform through five objectives (see Box 4), implemented by 19 partners (listed in Annex 1). Second, and separate from this primary funding, PEPFAR allocated $3 million to evaluate the GBVI program in Mbeya Region. This evaluation, named Tathmini (*evaluation* in Swahili) GBV, was conducted to inform scale-up of GBV prevention programs and response services in Mbeya Region and throughout Tanzania (see Box 5). The GBVI in Tanzania focused on four regions with some of the highest rates of GBV in the country (National Bureau of Statistics [NBS] Tanzania and ICF Macro 2011; (see Figure 3). The four regions—Dar es Salaam, Iringa/Njombe,[6] Mara, and Mbeya—were selected based on reported GBV prevalence among women and girls, U.S. Government presence, and existence of PEPFAR HIV activities that could be expanded to include GBV prevention and response. At the national level, USAID and CDC coordinated with the Government of Tanzania to manage, plan, and

Box 4. GBVI Tanzania Objectives

1. Services
2. Prevention and Community Protection
3. Enabling/Policy Environment
4. Coordination
5. Research and Evaluation

Figure 3. GBVI Regions of Tanzania with GBV Prevalence Rates



[6] At the start of the GBV, Iringa and Njombe were one region, called Iringa. Halfway through the program, the region split into two and became Iringa and Njombe.

implement activities across the five pillars of the GBVI. The PEPFAR program in Tanzania designated specific U.S. Government agencies to implement in different regions: USAID in Iringa/Njombe, DOD in Mbeya, CDC in Dar es Salaam, and USAID and CDC in Mara. To implement the GBVI, the agencies with a presence in a region coordinated with GBVI clinical and community implementing partners and reported back to the national level.

Although the Government of Tanzania has recently focused on policies and strategies to fight GBV and VAC, no laws specifically addressed GBV prior to the GBVI. Despite the country's economic progress, health disparities that affect women and girls in particular continue to plague the country. The most recent *HIV/AIDS and Malaria Indicator Survey,* dating from 2011–2012, showed that 5.1 percent of Tanzanians aged 15 to 49 were HIV positive (Tanzania Commission for AIDS [TACAIDS], Zanzibar AIDS Commission, National Bureau of Statistics [NBS], Office of the Chief Government Statistician [OCGS], and ICF International 2013). HIV prevalence in Tanzania is almost twice as high in women (6.2 percent) than among men (3.8 percent; TACAIDS et al. 2013). The 2010 Tanzania Demographic and Health Survey found that 44 percent of ever-married women had experienced physical or sexual violence from a partner, and 37 percent of ever-married women had experienced spousal violence in the prior 12 months (National Bureau of Statistics et al. 2011). Tanzania also has high rates of child marriage and violence against children.

The 1998 Sexual Offences Special Provisions Act, which incorporated sexual offense crimes into the law, was found to be outdated and poorly enforced during a 2012 review (Kipobata 2012). And although the 2011 Female Genital Mutilation Act has helped reduce female genital mutilation from 18 to 15 percent, Tanzania still has a high prevalence—more than 50 percent in Arusha, Dodoma, Manyara, and Mara (Kipobata 2012). Implementation of both laws has been constrained by limited reporting on the part of GBV survivors; weak linkages between the police, health facilities, and judicial system; and limited forensic capabilities at all levels of the system. The government also enacted the Law of Marriage Act, which mandates equality in marriage. However, marital rape as a form of GBV is not included within this law and is still legal in Tanzania. This act also allows girls to be married at the age of 14 or 15 with special permission. Reforming the Law of Marriage Act is a priority for many GBV advocates in Tanzania, but marital rape is still seen as a "family problem" among many Tanzanians and is just beginning to be discussed at the highest level of government.

The GBVI in Tanzania integrated GBV prevention and response into HIV programs by using a multisectoral, multilevel approach that involved health and social services, and legal and law enforcement at community, institutional/facility, and policy levels. This multisectoral model is similar to the approach used in Mozambique (see Annex 2), and every level at which the GBVI operated was closely connected to and influenced by the levels above and below it. Each activity required the engagement of the different sectors and staff at all levels. This approach helped to ensure synergies among stakeholders and can be applied to other contexts and regions moving beyond the GBVI's efforts.

Box 5. Tathmini GBV

Tanzania's Tathmini (evaluation in Swahili) GBV was unique because it was the only external evaluation of the GBVI initiative. The Tathmini GBV, conducted in Mbeya Region and funded through additional funds set aside by PEPFAR, was originally designed as an 18-month matched-pair cluster randomized trial. Due to the tight timeline under which the evaluation was to be completed and a delay in the start of the program, the evaluation design was modified from 18 months to 16. This reduction impacted the ability to conduct endline household surveys, which ultimately led to a randomized controlled trial on the facility side but a program evaluation on the community side. Even with the modifications, the evaluation yielded important preliminary results that were used for learning.

The evaluation found that GBVI-supported GBV prevention and response interventions in Mbeya Region increased the overall use of GBV services at the intervention health facilities in comparison to control health facilities. The GBVI activities also led to more delivery of certain GBV services, including psychosocial counseling, family planning counseling among female clients, and HIV testing services in health facilities. GBVI activities also increased referrals to legal services, safe houses, and higher clinical care. However, the evaluation also found that GBVI activities led to reduced delivery of other services in comparison to the delivery at control sites. Services that were reduced included assessments of physical injuries of patients, medical treatment for injuries, police reports and forensics, and pregnancy tests. Evaluation results also showed benefits from the design of the GBVI, including integration of the GBV program within the HIV program, engagement of health sector and community leadership, and strong local ownership of the program.

The Tathmini GBV evaluation and Mbeya regional partners reported an increase in awareness of GBV as an unanticipated outcome of the Tathmini GBV. The evaluation itself brought more visibility to GBV prevention and response activities in the region and found increased understanding of GBV, less tolerance of GBV, and greater responsiveness of community leaders through their evaluation. Mbeya regional partners reported that since the evaluation, their region—once recognized for having some of the highest rates of GBV in the country—is now being recognized for their efforts to combat GBV. An endline evaluation is planned for spring 2016.

GBVI SCOPE AND REACH

Efforts to track and monitor gender equality and GBV-related program outcomes were consolidated in the 2009 PEPFAR Next Generation Indicators, which included two GBV indicators—none of which were required.[7] In February 2013, PEPFAR issued Next Generation Indicators (U.S. President's Emergency Plan for AIDS Relief 2013) for FY2013 planning and reporting. These indicators included the following three as essential and required for the GBVI countries (and were optional for other PEPFAR countries):[8]

1. P12.5.D: Number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses GBV and coercion[9]
2. P12.6.D: Number of GBV service encounters at a health facility
3. P12.7.D: Percentage of health facilities with GBV and coercion services available[10]

These indicators met the minimum needs of PEPFAR to demonstrate progress in combating HIV and aimed to promote responsible program monitoring across and within PEPFAR-funded technical areas.

In March 2015, PEPFAR issued indicators for monitoring, evaluation, and reporting (MER; PEPFAR 2015). Replacing the Next Generation Indicators, these MER indicators included the GEND_GBV and GEND_NORM indicators:

1. GEND_GBV: Number of people receiving post-GBV care
2. GEND_NORM:[11] Number of people completing an intervention pertaining to gender norms that meets minimum criteria.

All GBVI partners were required to report on the GEND_GBV indicator in FY2014. The development of this indicator was informed in part by the experiences of the GBVI in piloting the Next Generation Indicators. The intention of GEND_GBV was to modify P12.6.D to count the number of individuals receiving post-GBV care instead of the number of GBV service encounters (which could be several per person). Other indicator data presented in this section do not include sex or age disaggregation, as this was also not included in the data received from USAID for this report.

[7] P6.1.D, number of persons provided with HIV post-exposure prophylaxis; and P12.2.D, number of people reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS.
[8] Indicators 12.6.D and 12.7.D were developed specifically for the GBVI.
[9] This indicator was included in the Next Generation Indicators and predated the GBVI.
[10] Note that for P12.7.D, although the indicator called for *percentage* of health facilities, countries instead reported on the *number* of health facilities with gender-based violence and coercion services available.
[11] GEND_NORM was cut from MER 2.0 released to PEPFAR country teams in February 2016. This indicator can now be considered a custom indicator to monitor PEPFAR programs that address gender norms, including GBV, in the context of HIV.

Table 1. Number of Individuals Reached through the GBVI, FY2012–FY2014

P12.5.D: Individuals reached by an individual, small group, or community-level intervention or service that explicitly addresses GBV and coercion (FY2012 and FY2013)	1,241,150
GEND_GBV: Number of people receiving post-GBV care (FY2014)	76,528
Total number of individuals reached (FY2012 to FY2014)	1,317,678

GBVI interventions and services reached more than 1.3 million individuals across the DRC, Mozambique, and Tanzania over three years (see Table 1); clinic- and community-level services provided included GBV screening, post-GBV care, and HIV post-exposure prophylaxis (PEP). The number of individuals reached through the GBVI increased from 273,250 individuals in FY2012 to 967,900 during FY2013. An additional 76,528 individuals were reached with post-GBV care during FY2014.

The number of GBV service encounters at health facilities sharply increased in all three countries from FY2012 to FY2013, as did the number of health care facilities providing GBV services, which is reflected in the Next Generation Indicators. The numbers are considerably lower for GEND_GBV (due in part to the scope of the indicator); this did not include prevention interventions that would have been captured under 12.5.D. Also, GEND_GBV had a higher threshold that required several types of GBV services be made available and did not count routine GBV screening only as sufficient.

Overall, the GBVI achieved substantial increases in the number of individuals reached, the GBV services provided, and the health facilities equipped to provide GBV services in a short period. The Next Generation and MER indicators are displayed by country and year in Table 2.

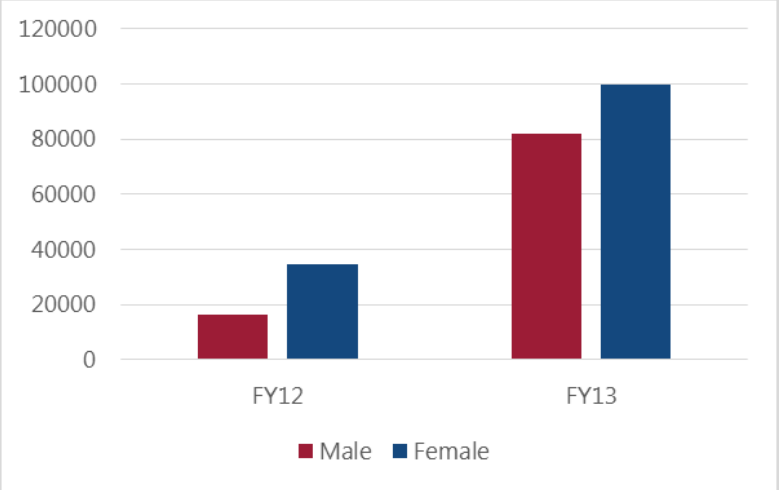
Table 2. GBVI Achievements, Expressed in Next Generation and MER Indicators, FY2012–FY2014

	P12.5.D		P12.6.D		P12.7.D		GEND_GBV
Fiscal Year	FY 12	FY 13	FY 12	FY 13	FY 12	FY 13	FY 14
DRC	51,203	181,422	161	35,620	8	239	1,612
MOZAMBIQUE	17,812	507,535	948	18,898	58	305	9,029
TANZANIA	204,235	278,943	631	8,136	139	230	65,887
TOTAL	**273,250**	**967,900**	**1,740**	**62,654**	**205**	**774**	**76,528**

DRC

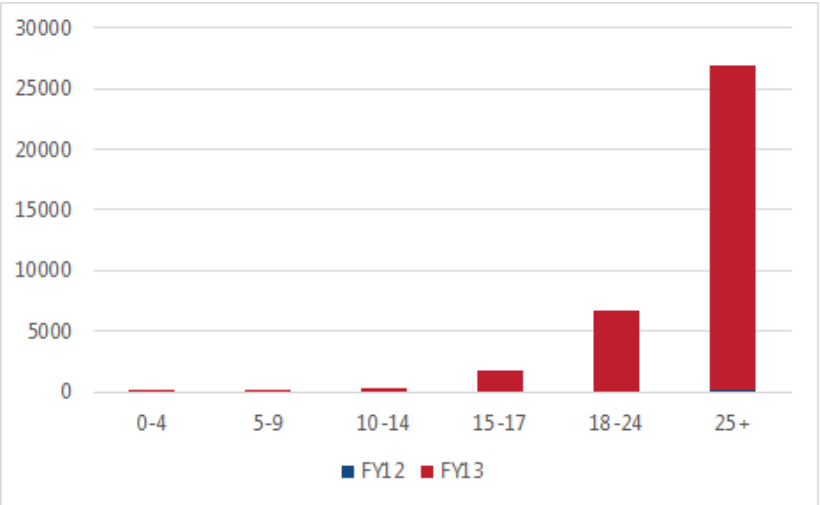
In the DRC, the GBVI reached a total of 232,625 individuals during FY2012 and FY2013 with GBV services and interventions (P12.5.D) and an additional 1,612 during FY2014 with post-GBV care (GEND_GBV). During FY2012, 16,395 females and 34,808 males were reached with GBV interventions or services. During FY2013, the number of individuals reached increased to 81,799 females and 99,623 males (see Figure 4). The GBVI in the DRC engaged with the military, which may account for the high proportion of men reached with interventions and services—specifically, under P12.5.D, which included prevention programming.

Figure 4. Individuals Reached with GBV Intervention or Service in DRC, FY2012–FY2013



When examining the GEND_GBV indicator, which reports on the number of individuals receiving post-GBV services, the majority of individuals reached were female. The number of females accessing these post-GBV services increased with age (see Figure 5). Only 11 men were reached with post-GBV services during FY2014. The number of men reached under GEND_GBV may be lower than during P12.5.D due to the fact that the new indicator did not count prevention interventions.

Figure 5. Individuals Reached with Post-GBV Services in the DRC, FY2014

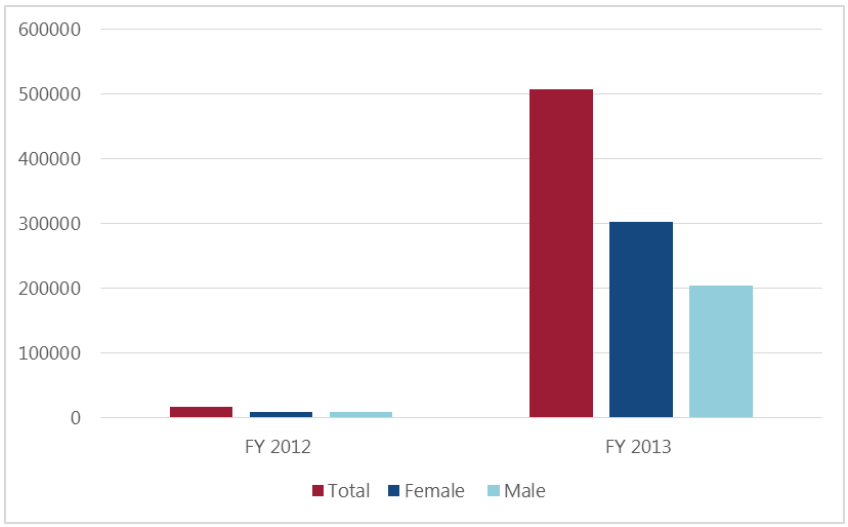


Overall rates of GBV service provision also increased in the DRC from FY2012 to FY2013. In FY2012, almost no GBV service encounters were reported at health facilities (161 total); none of these were for males. This number increased during FY2013 to 35,620 reported GBV service encounters. During FY2012, only eight health facilities were providing GBV services. This number rose to 239 during FY2013, with more clinical facilities providing GBV services than community facilities in both FY2012 and FY2013.

Mozambique

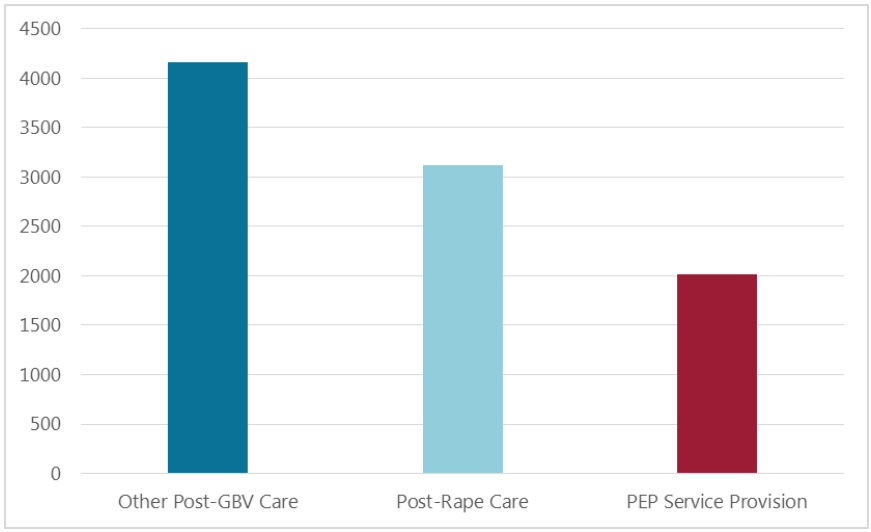
The GBVI in Mozambique reached 534,376 individuals over three years (see Figure 6) with GBV services and interventions (P12.5.D) and post-GBV care (GEND_GBV). During FY2012, 17,812 individuals (8,686 females and 9,126 males) were reached with GBV services and interventions. This number increased to 507,535 individuals (302,966 females and 204,569 males) in FY2013.[12] This dramatic increase from the previous year speaks to the speed at which the GBVI established GBV services and interventions in Mozambique. Prior to the GBVI, there were limited GBV prevention and response activities in the country.

Figure 6. Individuals Reached with GBV Intervention or Service in Mozambique, FY2012–FY2013



In FY2014, 9,029 individuals (6,738 females and 2,651 males) were reached with post-GBV services (see Figure 7). The types of post-GBV services provided during FY2014 include post-rape care, PEP service provision, and other post-GBV care services.

Figure 7. Post-GBV Services Provided in Mozambique, FY2014



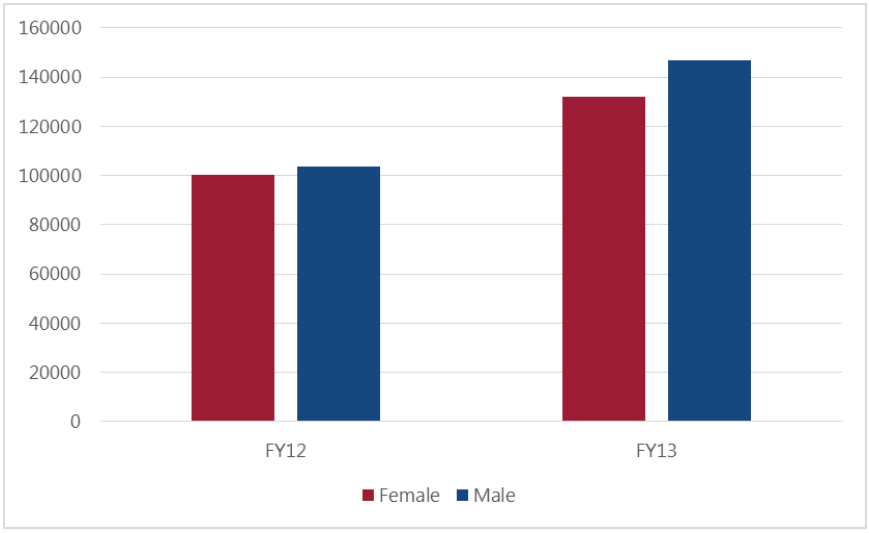
During an examination of the health facilities through which these services were delivered, 305 facilities reported that they offer GBV screening and/or assessment and provision or referral to the relevant service components for the management of GBV-related health needs (P12.7.D) in FY2013. Despite not targeting community facilities under P12.7.D, Mozambique reported 145 such facilities providing services during FY2013, in addition to 183 clinical facilities.

[12] Mozambique did not report age-disaggregated data in 2012 for the three Next Generation Indicators. This data was reported on in 2013, but there is no baseline against which it can be compared to show progress over time.

Tanzania

In Tanzania, the GBVI reached 549,065 individuals over three years with GBV services and interventions (P12.5.D) and post-GBV care (GEND_GBV). During FY2012, 204,235 individuals (100,399 female and 103,836 male) were reached with GBV services and interventions. This number increased to 278,943 in FY2013 (132,034 females and 146,909 males; see Figure 8). In Tanzania, the GBVI focused on engaging men at the community level through the Men as Partners and CouplesConnect programs. This could explain why more men than women were reached in Tanzania.

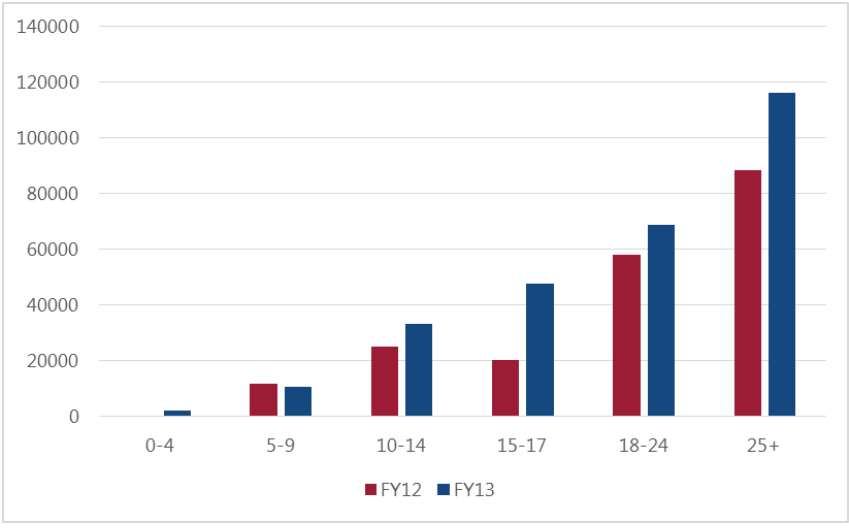
Figure 8. Individuals Reached with GBV Interventions or Services in Tanzania, FY2012–FY2013



The number of individuals reached with GBV services or interventions in Tanzania increased with age (with the exception of those ages 5 to 9) with the majority of individuals over the age of 25 (see Figure 9).

An additional 65,887 individuals (46,163 females and 19,724 males) were reached during FY2014 with post-GBV care (GEND_GBV; see Figure 10 on the following page). These totals reflect those who received GBV services (as per the GEND_GBV indicator definition) as well as those that were delivered at Tathmini GBV PEPFAR-funded sites. High levels of violence against women and/or higher numbers of women seeking services following an incident of GBV may account for the number of women reported under this indicator being higher than the number reported under P12.5.D.

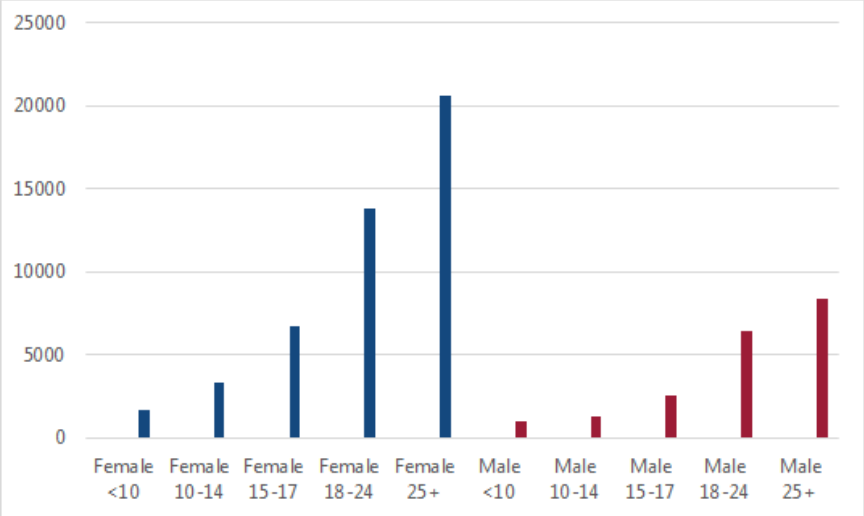
Figure 9. Individuals Reached with GBV Services or Interventions in Tanzania by Age, FY2012–FY2013



In Tanzania, the majority of GBV services were provided by clinical facilities. During FY2012, 138 clinical facilities and one community facility were providing services. The number of clinical facilities increased to 229 in FY2013, but the number of community facilities providing services remained

the same. Services delivered included GBV screenings and other post-GBV care. Much as in the DRC, engaging community facilities was a challenge, and a greater amount of traction was achieved in working with clinical facilities to provide GBV services.

Figure 10. Individuals Reached with Post-GBV Services in Tanzania during FY2014



Implications

The GBVI indicator data demonstrate that individuals can be reached with GBV interventions through existing HIV platforms. All three countries saw a sharp increase in the number of individuals reached by GBV services and interventions within a short time frame. Starting up integrated programming such as the GBVI takes effort and extensive coordination, but the number of individuals reached in only three years speaks to the value of integrating GBV prevention and response into existing HIV programming and to the need for such integrated services. The approaches and lessons learned from the GBVI can be applied to other countries and contexts to integrate GBV into existing HIV platforms.

GBVI SUCCESSES AND CONTRIBUTIONS

> *"One of the biggest contributions of the GBVI was to show that this work is possible —something can be done about GBV."* (Implementing partner)

Global Level

The GBVI made major contributions to integrating GBV prevention and response in HIV programs and services at both global and country levels. Although the focus of the initiative was on the three countries, several interview and group discussion respondents identified substantial lessons that could be applied globally.

The GBVI exemplified successful interagency collaboration between the State Department, CDC, USAID, and the DOD. This type of engagement around GBV and HIV integration had yet to occur at this level, and the GBVI set an excellent precedent not only for interagency collaboration but also for multisectoral coordination around GBV prevention and response, and HIV. By collaborating across agencies, the GBVI was able to influence a wider range of sectors than any agency could do alone, with those sectors ranging from military leadership to lawmakers developing national policy frameworks. These successes were focused on in-country activities but resulted from interagency collaboration at the global level.

> *"I would also say on an overlay of all of that—issue of violence and GBV is so complex—it has to be done in partnership. I know the GTWG was one of those stellar examples who worked very well together and part of the reason why is because they had a very clear shared vision of where they wanted to go and I just hope that that continues moving forward."* (U.S. Government agency)

These successes highlight the important role that leadership, collaboration, and interagency partnership played in the success of the GBVI and the role it can continue to play moving forward in efforts to integrate GBV prevention and response into PEPFAR programming.

In terms of building the PEPFAR knowledge base, the GBVI pilot indicators directly contributed to the development of current PEPFAR GBV indicators. Although piloting and adapting indicators during the GBVI caused frustration among partners in-country, the majority of partners and stakeholders agreed that the process resulted in stronger indicators. These new indicators track the number of people receiving post-GBV care as well as the number of people completing an intervention pertaining to gender norms that meets minimum criteria. Additionally, the GBVI shows that it is possible to apply an indicator threshold, in line with those of the WHO, to count post-GBV care. Although the numbers decreased from FY2012 to FY2013, when the P12.5.D indicator was used to count post-GBV services, the GEND_GBV indicator shows that post-GBV services can be delivered even when a threshold is applied. Given that the goal of the GBVI was not only to integrate and deliver GBV prevention and response programs and services but also to discover promising practices and lessons learned, part of which was the development of PEPFAR indicators, this is a major contribution.

> *"I think the experience with the GBVI indicators helped us create what is a better indicator for all of PEPFAR."* (U.S. Government agency)

The GBVI also elevated the focus and improved understanding of GBV, gender equity, and HIV within existing PEPFAR programming.

> *"There has been an evolution in perspectives within PEPFAR in terms of using and analyzing data that is also getting country teams to look at treatment and prevention data in general—talking about things like how does the number of people receiving services, male and female, compare with the breakdown within the epidemic? Within the last four years, there is more sensitivity in looking at gender-based differences in the data generally."* (U.S. Government agency)

Interview and group discussion respondents explained that the GBVI contributed to this shift and helped increase the focus on gender integration in PEPFAR programming.

By increasing awareness and understanding of GBV in PEPFAR's work, the GBVI is also seen to have contributed to gender integration in existing and future PEPFAR initiatives. For example, many interview and group discussion respondents said that the GBVI significantly influenced and contributed to the development of DREAMS (determined, resilient, empowered, AIDS-free, mentored, and safe), an ambitious partnership initiative to reduce HIV infections among AGYW in 10 sub-Saharan African countries. The GBVI is credited by several interview and group discussion respondents with having raised the issue of GBV to the level where an initative such as DREAMS is now possible.

> *"I think the GBVI has been somewhat a precursor to DREAMS in terms of raising the visibility of gender within PEPFAR. Now looking at how DREAMS is coming out, there is a feeling like the efforts we put into the GBVI are paying off today, four years later."* (U.S. Government agency)

Country Level

At the country level, the GBVI was seen to have contributed to increased integration of GBV into HIV programming across the three countries. These contributions occurred at the national, institutional, and community levels, with a focus on multipartner collaboration and synergy across the sociological model. The GBVI also contributed to the evidence base around integration of GBV prevention and response into HIV programs, improved country ownership, and sustainability of GBVI activities.

National/Policy-level Contributions

At the national level, the GBVI was seen to have improved government engagement and response to GBV prevention and response in all three countries. In Mozambique and Tanzania, although governments were already working to integrate GBV prevention and response into HIV interventions, existing efforts were not well coordinated or fully integrated. The GBVI helped to formalize government response to GBV prevention and response and HIV prevention and care through capacity building, improved coordination, and policy development in all three countries.

> *"Seeing the way the Ministry of Health and Social Welfare was organizing all of these and taking the lead for most of the activities that were happening, you can see the ownership of the government. Even guidelines, training, they were coordinated by the [GBVI] partners, but the ministry was the lead to all of these."* (Regional government)

The lessons learned from the GBVI efforts and successes at this level can be applied to programs seeking to formalize government response to GBV prevention and response and to improve their integration into existing HIV platforms. Another important aspect of the GBVI was that it worked across sectors to engage stakeholders from different government ministries and expanded the reach of HIV programming beyond the health sector. The GBVI included the military, the police, the education sector, and the justice system, and ensured that national-level cooperation and coordination were in place to roll out programming to regional and community levels. This national-level effort was vital to the success of the GBVI.

The GBVI also contributed to the integration of GBV prevention and response into HIV programs and services through the development of national guidelines, training programs, resources (including screening tools, job aids, and other forms), and the standardization of procedures, protocols, and frameworks for integrating GBV into the existing HIV platform. This institutionalization at the national level facilitated the rollout of GBV prevention and response integration into HIV programs across the three countries. Putting the framework into place at the early stages of the GBVI in each country ensured successful dissemination of standard protocols and procedures from the national level down to the community level.

This awareness helped facilitate community engagement and response to these issues and supported the rollout of policies and programs to integrate GBV prevention and response into the HIV response.

> *"It was the first time the donor had asked us to make a link between HIV and violence. For me it was a 'prise de conscience,' a starting point, and I began to really understand more in depth what these links are about and that we should talk about these links every time, not as separate things."* (Implementing partner)

This was one of the greatest contributions of the GBVI: the continued raising of awareness not only of issues of GBV and the link between GBV and HIV, but also awareness about the ability of governments, institutions, service providers, and communities to respond to the challenges associated with GBV and HIV.

Institutional-level Contributions

The GBVI was seen to have successfully integrated GBV prevention and response into HIV prevention, care, and treatment programs at all levels; helped actors within different sectors understand the dual risks of GBV and HIV; and increased the likelihood of programmatic sustainability and scale-up within the three countries. The institutionalization of GBV response services was achieved by working through the existing HIV platform and engaging the government and other stakeholders.

One of the GBVI's main contributions was the completion of the *Protocole de Prise en Charge Medicale des Victimes des Violences Sexuelles*, a national protocol in the DRC for the medical management of sexual violence survivors, undertaken by the Kinshasa School of Public Health in collaboration with the Ministry of Health's National Reproductive Health Program. This comprehensive document provides detailed guidance for health care providers on GBV treatment and response. The protocol was developed through a series of workshops that engaged a variety of government ministries, including health, social affairs, justice, and gender. The GBVI also supported the Kinshasa School of Public Health to draft two training curricula on GBV and HIV. One focused on the medical management of GBV cases by health care providers, while the other was directed at community-level actors to help promote community awareness of GBV, its consequences, and available services. The Kinshasa School of Public Health and the Ministry of Health National Reproductive Health Program adopted a training of trainers approach for the medical management training in order to reach as many facilities and communities as possible, focusing first on Kinshasa and Kisangani. Other GBVI and PEPFAR implementing partners whose activities focused on clinical services further extended the rapid adoption of the national GBV medical protocol and training across the large networks of health facilities in multiple provinces.

In Mozambique, the GBVI expended considerable effort partnering with government to produce sustainable, long-term strategies and plans, including the development of a national protocol, to help guide GBV prevention and response long after the GBVI ends. As a result of GBVI support, the country now has protocols and guidelines for responding to GBV survivors at many health facilities as well as a cadre of committed, trained health care providers throughout the country. GBV survivors are now able to access PEP and a host of vital services, where previously there were few. In several provinces, survivors are now spared potential re-victimization because they are able to access many services, such as the police and psychosocial support, in one-stop facilities. The GBVI's contributions at the institutional level in Tanzania focused on capacity building for health, police, and social welfare service providers. Capacity building included training providers on user-friendly GBV service prevention and response, understanding and filling out revised Police Form Number 3 to link survivors to services, data collection training, and integration of GBV prevention and response programming into existing HIV services.

The key to engagement at the institutional level in all three countries was capacity building. The GBVI approached capacity building through multisectoral training and engaged with stakeholders in the health, social welfare, police, and judicial systems in the development of protocols in all three countries.

> *"Many cases never went to court in the provinces and districts due to the absence of evidence that the forensic reports provide, so cases would be dropped. Many cases that were suspended in the districts are now being judged. Last week, the two attorneys told me they were able to solve so many cases that beforehand we wouldn't have been able to solve if you hadn't trained those doctors on legal things. We are judging way more cases than before. It is a capacity that didn't exist before."* (National government)

The skills and knowledge of both the GBVI and PEPFAR implementing partners were used in the development and dissemination of protocols and training. Capacity building efforts differed slightly depending on the sector, service provider, and service level (community, regional, or national) but played an important role in improving the overall institutional response to GBV and HIV.

Community-level Contributions

The GBVI's contributions at the community level were reported as a key part of its success in all three countries. First and foremost were the initiative's awareness-raising efforts. The GBVI sought to raise awareness not only about GBV but also about the links between HIV and GBV. In all three countries, to address harmful attitudes and social norms that contribute to the continuation of the cycle of violence, the GBVI used social and behavior change communication efforts and community-based training programs such as the Stepping Stones and Men as Partners curricula to engage both men and women. As stated by an implementing partner, "At first there was a focus on women, then [there was] a focus on men, but in fact, both need to be involved." These programs were developed in other countries and adapted for use by GBVI partners. This is an example of how the GBVI built upon existing promising practices and adapted them for specific country contexts and communities to ensure relevance and sustainability.

> *"The community has been sensitized, and more cases are being reported to the responsible authorities for support. More cases are being reported and this means people are aware of the GBV and VAC. People now fear doing GBV/VAC because they would be reported."* (Implementing partner)

The GBVI also engaged men and boys in all three countries to increase their awareness of harmful gender norms, gender inequality, and the links between GBV and HIV. The GBVI used existing promising practices to raise awareness at the community level while still allowing communities the flexibility and ownership needed to develop their own responses to GBV and HIV.

In addition to awareness raising, the GBVI built capacity at the community level by engaging and training community leaders and volunteers. This included training *activistas* in Mozambique and *relais communautaires* in the DRC to build capacity and ensure that their efforts were successfully integrated into the broader institutional response to GBV and HIV. Technical assistance was also provided to local organizations already working on HIV at the community level to ensure that GBV prevention and response was integrated into their programming. In Tanzania, the GBVI used community volunteers, community-based organizations, and religious and political leaders in prevention, linkage, and data collection activities. The GBVI's efforts to engage community volunteers and leaders from the beginning and in all aspects of the program—from awareness raising to referrals and service provision—made the programming community-based and -owned.

The GBVI also helped to expand the points of entry for survivors and to increase GBV awareness beyond the health sector in local communities. For example, schools are often a location where

survivors report GBV or where GBV is identified. The GBVI addressed this in all three countries by training school leadership and teachers on their role in identifying and responding to GBV. In the DRC, the GBVI also trained teachers to identify and understand inequitable gender norms and ways in which they may have been reinforcing those norms in the classroom. The GBVI's engagement of different community-level sectors helped to reinforce national-level synergies, contributed to the integration of GBV prevention and response into HIV programs, and demonstrated that this is a practice that can be applied to future programming.

Multisectoral and Partner Strategies

A major focus of the GBVI was establishing and supporting multisectoral partnerships to address GBV and HIV. Although the GBVI primarily engaged with the health sector due to its focus on existing HIV platforms, a major goal was to engage other sectors, including the legal, education, and military sectors, to help ensure long-term sustainability. Community leaders and established local organizations were also key GBVI partners. The GBVI focused on building multisectoral synergies, which resulted in collaboration among GBVI implementing partners and other PEPFAR partners, and between the GBVI implementing partners and other institutions more broadly, including the country governments. Examples of successful multisectoral partnerships were found in all three countries.

In the DRC, the GBVI facilitated an inventory of GBV services to update a national resource guide, and expanded the capacity of the country's national HIV hotline (*La Ligne Verte*) to incorporate GBV counseling. GBVI partner efforts were complementary in that hotline counselors could provide information from the inventory about GBV services to callers across the country and help improve the GBV referral system. In Mozambique, the GBVI brought together ministries across several sectors to ensure that GBV survivors were able to access other services on the referral pathway, such as psychosocial and legal support. In Tanzania, quarterly meetings with the Ministry of Community Development, Gender and Children, the Ministry of Home Affairs, and the Ministry of Health and Social Welfare (all now combined as the Tanzanian Ministry of Health, Community Development, Gender, Elderly, and Children) enhanced relationships and collaboration among ministries around GBV and HIV. The GBVI promoted multisectoral collaboration and developed multicomponent models such as One Stop Centers and Drop-in Centers, where GBV survivors receive comprehensive services in a single location.

In all three countries, the GBVI delivered multisectoral trainings and engaged actors not traditionally involved in GBV prevention and response, such as the military. For example, with GBVI support, the Armed Forces of Mozambique included GBV prevention and response within their HIV prevention activities with their personnel and enthusiastically participated in a GBV prevention slogan campaign. Cooperation with the military in the DRC yielded similar synergies and successes. The GBVI also engaged the media to increase awareness of GBV at national and community levels through national radio programs, billboards, and informational campaigns. This approach was particularly successful in the DRC, where GBVI partners built the capacity at the provincial level to report appropriately on GBV cases and to reinforce knowledge among newspaper readers and radio program listeners about the links between HIV and GBV, the

consequences of GBV, and the resources available at the local level to address GBV-related needs. These efforts further promoted multisectoral synergies and the effective integration of GBV and HIV prevention strategies at all levels.

Building the Evidence Base

The GBVI was designed to promote national and project-specific data collection, including the piloting of three PEPFAR GBV Next Generation Indicators, and to capture outputs related to specific programmatic approaches and multicomponent models. However, the tight time frame, the need to coordinate with local governments, and indicator piloting posed challenges for GBVI partners in all three countries to collect data and monitor and evaluate their activities.

Some GBVI partners were able to collect baseline data and establish data collection mechanisms and systems, although this was challenging due to the short implementation period, the rapid rollout of activities, and the need to report on these same activities shortly after the start of implementation. In cases where data collection mechanisms and systems were not yet in place and existing government forms did not fulfill PEPFAR GBV reporting requirements, GBVI partners developed their own data collection forms. In some cases, inconsistent and duplicative data collection efforts resulted.

> *"There is a lack of communication and coordination. We need to get better at this . . . . We need standardized data collection. Otherwise, the implementing partners need their data, so they improvise a tool and leave it there at the health facility. Then we end up with 15 different data collection sheets, each with different data points to collect, which is just not right . . ."* (National government)

This challenge is reflected in the level of disaggregation available for country-level data. For example, Mozambique did not report age-disaggregated data for the three Next Generation Indicators during FY2012 but did so during FY2013. Similarly, the DRC did not report on the type of post-GBV care provided in the first year of the new GEND_GBV 1 indicator, FY2014.

Despite the duplication of data collection instruments and other associated coordination challenges, GBVI partners worked arduously with the governments to develop and harmonize standard data collection systems. In Mozambique, the GBVI worked with the Ministry of Health to develop a national data collection sheet and register books; these are set to be approved in 2016. Another positive outcome in Mozambique was the GBVI's development of a clinical site-monitoring tool used during partner health facility visits to improve the quality of post-GBV services and to identify facilities requiring additional support. GBVI partners in Tanzania provided technical assistance to the Ministry of Health and Social Welfare, Reproductive Child Health Section, to draft the national GBV and VAC clinical monitoring and evaluation plan. This plan outlined protocols and standards for collecting, reporting, and using data for GBV and VAC programs throughout Tanzania. A GBVI partner also collaborated with the Tanzania Commission for AIDS and the Ministry of Health and Social Welfare to draft and harmonize GBV and VAC indicators into the Tanzanian national health monitoring information system. This included using the existing clinical registries and aligning Government of Tanzania indicators with PEPFAR GBV indicators. Rollout of harmonization was tiered to ensure that all regions understood and were

properly trained on the indicators. However, because of this tiered approach, many partners suggested that, although the indicators were harmonized at the national level, implementation of the harmonization at regional levels remains incomplete.

The PEPFAR GBV pilot indicators also posed a challenge for GBVI and non-GBVI implementing partners that were required to report on them. Interview and group discussion respondents spoke of difficulties understanding how to interpret the indicators and of challenges in keeping up with changes to the indicators part way through the funding period. However, the piloting of the PEPFAR Next Generation Indicators directly contributed to the development of the current PEPFAR MER GBV indicators:

> *"The indicators today were in direct response to these indicators being tested. You should compare the existing and previous ones to see the difference. The GTWG came up with the indicators with input from countries. It was a requirement with the funding. Partners had to roll out and collect data and we had a series of consultations with them on successes and challenges."* (U.S. Government agency)

Despite the challenges associated with the piloting, this evidence base was a major contribution of the GBVI, and those implementing at the country level directly contributed to the successful development of the current PEPFAR GBV indicators.

Country Ownership and Sustainability

The GBVI contributed to country ownership and sustainability at the levels at which it intervened in various ways. For example, the GBVI promoted the institutionalization of GBV and HIV service integration by creating and distributing post-GBV clinical guidelines and protocols, health service provider training, and a GBV screening tool to improve the quality of service delivery, while strengthening government ownership of GBV and HIV integration.

> *"Initially these guidelines were not there. The trainings were not there. Seeing these different units and different stakeholders working together—it was a good thing."* (U.S. Government agency)

The GBVI also helped insert GBV into the national public discourse by reinforcing messages about the linkages between GBV and HIV across the three countries, through collaboration with the media, government, other PEPFAR partners, and local communities.

The GBVI also served to strengthen existing government efforts in all three countries by raising the profile of GBV as a government priority—particularly in HIV prevention, care, and treatment—and ensuring that GBV prevention and response were highlighted in policy agendas. The GBVI also increased the visibility of GBV as a public health issue and a human right and reached partners at the national, institutional, and community levels. Many GBVI activities have been institutionalized within government structures and are now included in government plans, strategies, and budgets. For example, not only is GBV included in Mozambique's five-year development strategy and health, social, and economic plans, but GBV modules are now part of the pre-service curricula of nurses, physician assistants, and police officers; and both training and funding for forensic pathology are included in health sector plans.

Community organizations that work on GBV and HIV prevention activities, especially those that engage community volunteers, face challenges because although they have become part of GBVI implementing partner activities, many have not been included in government protocols or funding structures. GBVI partners emphasized the commitment and dedication of community-based organizations and volunteers, but these organizations need support from governments to continue their work and increase the sustainability of community response to GBV and HIV. The GBVI faced challenges engaging community-based organizations in GBV service provision efforts as illustrated in Figure 6 on page 18[13]. This exhibit shows the proportion of clinical versus community facilities offering either GBV screening or assessment, and provision or referral according to the GBVI targets and actual results. The proportion of community clinics providing GBV services was less than the targets.

However, Tanzania made progress in this sphere; GBVI partners were still holding quarterly meetings during the review, and interview and group discussion respondents hoped the meetings would become the basis for a community of practice.

> *"This is tremendous, and I'm sure this would not have happened without PEPFAR and the GBVI."* (U.S. Government agency)

Although the GBVI helped to institutionalize GBV prevention and response into existing policy frameworks, interview and group discussion respondents expressed concern with the government's commitment to and prioritization of GBV prevention and response after the end of GBVI funding. The greatest threat to the sustainability of GBVI activities, especially among community-based organizations, is lack of funding across the board. Yet GBVI partners remained optimistic, certain that enough progress has been made in GBV prevention and response that regardless of the financial outcome, residual community activities and basic post-GBV care services would remain available.

[13] Data are based on reported targets and results for indicator P12.7.D; data include all three countries and both FY2012 and FY2013, except for Mozambique, which did not report disaggregated data for this indicator in FY2012.

LESSONS LEARNED

Although the three GBVI countries were contextually different in terms of GBV and HIV prevalence and patterns, socioeconomic demographic context, and security status, many of the GBVI's achievements and lessons learned were consistent among them and can also be applied to other regions and in other efforts to prevent and respond to GBV in HIV programs globally. However, it is important to note that the main focus of programming was on women and children as GBV survivors, heterosexual transmission of HIV, and the role of men as partners in preventing GBV and HIV. Many of the lessons learned from the GBVI in these areas can be adapted and applied to other efforts, contexts, and regions.

Global Level

Lessons Learned

1. Political will and commitment by leadership is key to an interagency initiative.
2. Decentralization of funds facilitates country ownership.
3. Establishing a baseline and conducting research to understand the country context are important steps.
4. Establishing a centralized monitoring and evaluation plan to collect and report data across partners and countries and headquarters can better measure overall program outcomes.
5. Developing a robust communication plan to share promising practices and knowledge across countries is key.

1. **Political will and commitment by leadership is key to an interagency initiative.** Although gender equality was already a PEPFAR priority, it took the right leadership and level of commitment for the development and implementation of the GBVI. PEPFAR and the GTWG led the way, and their engagement across agencies set a positive example for how interagency initiatives can result in synergies, collaboration, and innovation in preventing and responding to GBV and HIV.
2. **Decentralization of funds facilitated country ownership.** The decentralized funding and programming to PEPFAR country teams had positive implications for building capacity and autonomy. This approach allowed PEPFAR country teams to shape programming for their country context, integrate GBV into existing HIV programs, and disseminate funds to implementing partners without having to coordinate incremental funding with contracting officers or representatives.
3. **Establishing a baseline and conducting research to understand the country context are important steps.** Understanding country contexts helped the GBVI develop a multicountry program that sought to achieve overarching initiative goals while allowing countries flexibility and the potential for adaptation. Establishing a baseline prior to implementation allows for tracking progress and outcomes. The absence of a baseline measurement was a gap for the GBVI and resulted in the lack of a standard against which to measure progress. Future programming should establish a baseline before implementation begins.

4. **Establishing a centralized monitoring and evaluation plan to collect and report data across partners and countries and headquarters can better measure overall program outcomes.** Data collection was a challenge across the GBVI countries. A centralized plan and structure, established at the outset, for identifying indicators and collecting and rolling up data from all countries to the global level and back to the country level allows for data collection and dissemination across all levels. PEPFAR is aspiring to this data collection structure, which, in conjunction with simple data collection tools that are harmonized with country-specific indicators and developed during start-up, can help to ensure that data are collected, analyzed, and reported to the global level. This data collection structure can also help ensure that the findings are synthesized at the global level and disseminated back to and shared among those working at the country level.
5. **Developing a robust communication plan to share promising practices and knowledge across countries is key.** For multicountry or regional initiatives, have a communication plan in place to disseminate research and evaluation findings from the global level to the country level and on to the implementing partners. The structure should be designed in a way that also facilitates provision of global-level technical assistance and ensures that the knowledge and skills of those at the global level are available to those working at the country and community levels.

Country Level

Country-level lessons learned are presented in three key areas: collaboration and coordination; programming and service delivery; and country ownership and sustainability.

Coordination and Collaboration

Lessons Learned

1. Create a strategic master plan and central leadership at the national level to ensure successful rollout of programming across the country.
2. Establish regular coordination and communication at all levels.
3. Collaborate with a broad range of stakeholders during the project development phase to ensure buy-in, commitment, and sustainability.
4. Create, strengthen, and expand multisectoral synergies at all levels.

1. **Create a strategic master plan and central leadership at the national level to ensure successful rollout of programming across the country.** Prior to program implementation, collaboratively create a plan that sets clear roles and responsibilities for all stakeholders (donor and host-government actors, civil society, clinic and community partners), and maps out all partner locations, activities, and resources to avoid duplication and increase efficiency. Include an overall leader or manager to facilitate collaboration among and between all in-country stakeholders, as well as focal points within each partner and, in the PEPFAR context, within U.S. Government agencies. This approach was used by the GBVI and helped build national government commitment. Also ensure that local and national

government partners know which implementing partners are responsible for which activities, to avoid duplication by partner organizations or the government. When duplication occurred during the GBVI, it was often the result of poor coordination and communication.

2. **Establish regular coordination and communication at all levels.** Once a central plan is established, schedule regular meetings to ensure that communication, collaboration, and coordination by multisectoral partners are occurring at all levels. Organizing this early in the process will help to avoid duplication and miscommunication, identify programmatic gaps, share lessons learned, and develop efficient, collaborative solutions. A central plan at the national level will be ineffective without stakeholder buy-in at all levels. Develop and disseminate protocols, guidelines, and training and communication materials with the involvement and buy-in of local government agencies and stakeholders across sectors. Ensure that all stakeholders have the same understanding of and coordinated messaging around GBV. These meetings can also be used to develop country action plans, define targets, monitor progress, and evaluate results based on indicators. This approach was used in all three GBVI countries to establish working groups at all levels and was especially successful in Tanzania and Mozambique, where partners continue to meet using the GBVI-formed structure. These working groups were also called upon during the DREAMS planning process.
3. **Collaborate with a broad range of stakeholders during the project development phase to ensure buy-in, commitment, and sustainability.** The GBVI regularly engaged with local governments during the development and rollout of the initiative, but this was not always consistent across sectors or levels. Failure to engage all levels of government can obstruct successful service delivery and the development of referral systems. For example, in Tanzania, Ministry of Justice officials were not engaged in PEPFAR quarterly meetings and were the "missing piece" in the country's GBV programming. Government partners should have a continuous role in program planning, design, and implementation, and the development of all materials related to GBV prevention and response. It is also important to involve implementing partners, community-based organizations, and service providers to encourage ownership and buy-in and to establish relationships with those who will ultimately be responsible for delivering services. Encourage governments or other initiatives to work directly with nongovernmental and community-based organizations, particularly those with the capacity and willingness to work on GBV prevention and response. Ensure that government ownership of activities is encouraged from the start and that implementing partners have well-developed exit/transition strategies to ensure long-term sustainability.
4. **Create, strengthen, and expand multisectoral synergies at all levels.** The GBVI worked to improve multisectoral synergies from the national to the community level. Developing and strengthening these synergies at all levels is key to integrating GBV prevention and response into existing HIV platforms. National-level commitment is important to help model expectations and enforce multisectoral service delivery across the system. Multisectoral synergies should be formalized and leveraged to implement mutually reinforcing GBV activities that both include and expand beyond the health sector through a well-functioning

referral system to achieve the greatest possible impact with limited funding. This system should include trained and sensitized service providers in other sectors, such as the police, schools, and community-based organizations. Designate community volunteers, health care or social welfare workers to be points of contact for referral and follow-up. These points of contact are vital to help ensure coordination and should be properly trained in GBV response, referral mechanisms, and referral-data entry into community-level monitoring tools. Map GBV services, linkages, and referrals in communities, and disseminate across relevant partners to increase awareness of where GBV services can be accessed. Developing these synergies at the beginning of a program will help to establish referral networks and mutually reinforcing activities to strengthen GBV and HIV response at all levels.

Programming and Service Delivery

Lessons Learned

1. Build capacity and awareness at all levels to deliver effective GBV and HIV services.
2. Engage a broad range of community stakeholders on GBV and HIV prevention and response, with a focus on men and boys.
3. Develop simple monitoring plans, including coordinated data collection systems and indicators.

1. **Build capacity and awareness at all levels to deliver effective GBV and HIV services.** Building clinical service-provider capacity is important, but the GBVI's focus on also training government officials, community and traditional leaders, and non-clinical service providers was also critical. Those involved in policy making, training, supervision, and community leadership need training on GBV and HIV. Building multisectoral capacity can help to create an enabling environment in which clinical and other service providers can ensure the delivery of GBV and HIV programming. Implementing partners, service providers, and government officials at all levels need consistent and continuous GBV training. Training should include GBV sensitization and awareness, post-GBV care, and proper referral services and processes and should emphasize GBV integration into the cascade of HIV, family planning, and sexual and reproductive health services. Training and capacity building also need to extend beyond technical and clinical aspects to include behavior change communication and sensitization, because service providers, policy makers, and community leaders often hold the same harmful gender attitudes as the broader population.
2. **Engage a broad range of community stakeholders on GBV and HIV prevention and response, with a focus on men and boys.** Community awareness and mobilization efforts are key and should use evidence-based behavior change communication programming and activities to shift norms around gender inequality and GBV. By focusing on community-level interventions and using existing community organizations and volunteers to carry out awareness-raising and sensitization activities, GBV and HIV programs can achieve major gains even with limited resources. In all the GBVI countries, community leaders and volunteers acted as extension agents and helped to rollout the initiative at the community

level. Awareness-raising and sensitization activities are supportive strategies often used in community-based approaches. Media campaigns using radio, television, and billboards can be expanded to the community level to help shift harmful social norms. These activities were implemented in all of the GBVI countries and could benefit from having indicators to monitor the effectiveness of these awareness-raising efforts.

Targeting men and boys should be a critical aspect of all programming to address GBV and HIV. The goal of this targeting should be to examine and help breakdown harmful gender norms and stereotypes that contribute to HIV risk among men and boys and perpetuate the cycle of GBV against males and females. The GBVI addressed this goal using community-based behavior change curricula. Future programs should consider greater engagement with youth, schools, the faith-based community, and community-based organizations working with orphans and other vulnerable children to accelerate behavior change at the local level. Sociocultural norms dictate much of what happens to GBV survivors within communities, whether they seek services in time to receive PEP or are able to seek justice. Behavior change, especially within the context of GBV prevention and response, is a long-term endeavor that requires deep, continued, and inclusive community involvement.

3. **Develop simple monitoring plans, including coordinated data collection systems and indicators**. Consistent, targeted, realistic, and focused indicators that are synchronized and aligned with the government, the donor, and implementing partners are critical to monitoring and evaluation of GBV and HIV prevention and response programs. Such measures should also allow for learning and adapting over time. Activities for measuring quality indicators should focus on follow-up with GBV survivors, completion of PEP regimens, and HIV cases averted. Other indicators could trace survivors in schools and in communities and measure the dissemination of messages promoting GBV prevention and response. Coordinated data collection systems, including the use of agreed-upon indicators, should be a priority for all stakeholders. Although different stakeholders may have different data needs, there should be a common GBV data collection system that is clear, suits both government and donor needs, and can be implemented by facilities and other stakeholders. In Mozambique, GBVI partners worked with the government to develop tools and instruments, such as a national data collection sheet and register book. This collaboration represented a huge accomplishment that contributed to the sustainability of the GBVI's efforts. Although collaboration is a time-intensive process, a lack of harmony between stakeholders' systems can create confusion about what is being reported and the validity of information; ultimately, the disharmony limits the ability of stakeholders to use data and improve program response to GBV and HIV.

Country Ownership and Sustainability

Lessons Learned

1. Use a phased approach to develop and roll out programming.
2. Integrate GBV and VAC programming into the standard health package.
3. Harmonize GBV and HIV prevention and response efforts with national and provincial government structures.

1. **Use a phased approach to develop and roll out programming.** Rolling out programming too quickly can result in many activities being developed and implemented at the same time. This limits the amount of time allocated to adequately develop each one and can negatively affect quality. The tension between activity quantity and quality was a challenge across the three GBVI countries. Funding should allow for planning and piloting of materials (Year 1), implementation with assigned targets (Year 2), and so forth. This approach can help to ensure quality and sustainability across programming. Focusing on quality of care, training, data, and forensics throughout program development and implementation can lead to higher-quality, more sustainable programming. Do not wait to focus on quality until after programs have rolled out, but incorporate quality assurance and improvement measures and metrics into every step of implementation. Use supportive supervision and mentoring to ensure that service providers across sectors are delivering quality programming and adhering to established standards.
2. **Integrate GBV and VAC programming into the standard health package.** Use the GBVI model to integrate guidelines, screening, and curricula on GBV and VAC into the standard package of health services beyond the HIV platform and across the broader health sector. Begin with sectors most likely to be in contact with GBV and VAC survivors, such as family planning and maternal and child health care. Identify strategic entry points within a facility to screen and provide emergency services to GBV and VAC survivors. Ensure that clinical and non-clinical service providers are trained at each entry point. In addition to establishing and training service providers on screening protocol, clear service provision directives and referral systems must be in place for survivors who self-present in addition to those who are screened for GBV and VAC. An emphasis on screening without establishing the necessary services and referral networks is an ineffective approach. Training on direct service provision and referral protocols is key to ensuring a solid response. The GBVI integrated GBV prevention and response into the HIV platform, but the methods used to accomplish this can be applied to other potential points of entry to increase the number of individuals accessing GBV and VAC services.
3. **Harmonize GBV and HIV prevention and response efforts with national and provincial government structures.** Engage government counterparts from the beginning in planning, design, implementation, and evaluation. Put government in the leading role in coordination across sectors and partners. Work closely with the government to institutionalize guidelines, policies, and curricula into national, regional, and community-level protocols to ensure sustainability. Take a systematic approach to engaging government stakeholders to advocate within their ministries in getting a budget line, even if small, to incorporate GBV into national

and regional budgets. This approach was successful in the DRC and helped increase attention to GBV at the national level. In Mozambique, GBVI partner efforts to engage with the government led to the development of a five-year national GBV strategy that aligns with both GBVI and government priorities. Engaging governments at all levels in program and protocol development can slow the start-up phase, but ultimately, GBV and HIV initiatives need to align with existing systems. This approach can help increase commitment on the part of the government and service providers and ensure long-term sustainability.

IMPLICATIONS FOR FUTURE PROGRAMMING

> *"The big success was getting GBV integrated into HIV—that is to say, the technical integration. They are now inseparable. We have gone past the initiative. This integration is profound and leads to sustainability, and this all started with the GBVI."* (U.S. Government respondent)

> *"I will recall that previously, there was nothing before the GBVI. . . . We now have programs where GBV is integrated, we have messages that are delivered, and we have information—the impact is there. But there is still a lot to be done."* (Implementing partner)

The GBVI has implications for the successful integration of GBV prevention and response into the HIV platform of services and long-term sustainability of future PEPFAR programming. Phase III of PEPFAR, or PEPFAR 3.0, is focused on sustainably controlling the HIV epidemic to achieve the 90-90-90 targets of the Joint United Nations Programme on HIV/AIDS (UNAIDS), which aims to accomplish the following 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.
- 90 percent of all people receiving antiretroviral therapy will have viral suppression.

To achieve this goal, PEPFAR is working to increase the number of people on treatment in order to lower the burden of the HIV epidemic to the point where it is manageable for country governments in terms of both capacity and financing. This will help to reduce the burden of disease and increase sustainability and accountability of local government efforts. The GBVI's lessons on country ownership and government engagement can be applied to help prepare countries for transition by working in partnership and allowing countries to help define priorities, take the lead on implementation, and develop the core policy changes necessary to stop the spread of HIV.

Funding

PEPFAR funding has plateaued and is expected to remain flat. This highlights the importance of integrating GBV prevention and response into existing HIV programming and of developing interventions that create multisectoral synergies to achieve the greatest possible depth and breadth using available resources. PEPFAR's goal is to achieve the greatest impacts for its investment, especially for gender equality and GBV attributions, which have decreased significantly. The GBVI achieved a number of these successes, which contributed to these types of investments across the three countries. The lessons learned in this sphere can be applied to PEPFAR more broadly to ensure maximum programmatic impact despite constrained resources.

Sustainability

Local Government Commitment

Political will on the part of local governments is vital for the success, accountability, and sustainability of PEPFAR initiatives. The GBVI selected its three countries based in part on government commitment to address GBV, and this practice can be applied to PEPFAR's strategies moving forward. The PEPFAR funding plateau means that resources will need to be directed toward countries that are most committed to ending GBV and HIV and that will take on the responsibility for programming and implementation over the long run. Accountability is another PEPFAR priority for increasing the sustainability of its programming. Investing in countries that are willing to commit to addressing these issues and that will take steps to implement programming will be a priority, and the lessons from the GBVI can be applied to this context to help increase accountability and sustainability of PEPFAR programming moving forward.

Partnerships

Partnerships between the U.S. Government, other donor countries, local governments, implementing partners, and local organizations and communities will be key to achieving the 90-90-90 targets. The GBVI successfully developed multisectoral partnerships in all three countries at the national, institutional, and community levels to promote the integration of GBV prevention and response into HIV programming. The GBVI's success in this area can be applied to the continued development and strengthening of PEPFAR partnerships moving forward.

Community Linkages

The GBVI can also serve as a model for community and clinical linkages that can help ensure sustainability of PEPFAR interventions The GBVI's efforts in this sphere can be adapted to ensure sustainability by building local capacity to take on both GBV and HIV prevention and response. The push to focus on HIV testing and treatment offers an excellent entry point for GBV screening and service provision. There are clear links between GBV and HIV, and identifying individuals who are experiencing GBV can reduce rates of HIV transmission and ultimately contribute to the control of the epidemic.

Priority Populations

Targeting adolescents with HIV prevention, care, and treatment is a major PEPFAR priority. The youth bulge in sub-Saharan Africa means that the number of individuals at risk for HIV infection is actually increasing. AGYW are at high risk for acquiring HIV, and developing community and clinical linkages is crucial to reach this population with GBV and HIV prevention. AGYW—specifically, those between the ages of 10 and 20—account for approximately 30 percent of new HIV infections and become infected five to seven years earlier than their male peers (Dellar, Dlamini, and Karim 2015). These AGYW have aged out of clinical programs for children and in many cases are not yet accessing maternal health programs. The opportunities to reach these AGYW (those who are not accessing antenatal care through clinical interventions are extremely

limited. The GBVI successfully developed and promoted GBV and HIV entry points across communities at schools and police desks and through community-based organizations. These alternative entry points are crucial for identifying and providing HIV and GBV services to AGYW before they become infected and moving forward should be integrated into PEPFAR interventions, especially the DREAMS Initiative.

These entry points are also important for reaching the males that AGYW are having sex with, males who are often between their same age and eight to 10 years older and who, due to the age–sex disparity of initial HIV infection, greatly contribute to the high rates of HIV infection among AGYW (Dellar, Dlamini, and Karim 2015). These men do not access the clinics in the same ways as women, and reaching these men with prevention efforts, and more importantly, with treatment, is vital in stopping the spread of HIV to AGYW. Voluntary medical male circumcision is an important prevention option for reaching these men and can be used as an entry point for GBV and additional HIV prevention. Developing community entry points and linking them to clinical services is extremely important and is an area still in need of improvement. The GBVI's gains in this area can be adapted for future PEPFAR initiatives. Entry points should be developed to reach other key populations, including sex workers, people who inject and/or use drugs, men who have sex with men, transgender persons, and people in prisons and other closed settings. Although the GBVI did not specifically focus on these populations, elements of the GBVI model can be used to integrate GBV prevention and response into the existing HIV and other health platforms that serve these individuals.

Intervention Components

Behavior Change

Behavior change activities are another crucial component for preventing both GBV and HIV. The GBVI succeeded at adapting and implementing evidence-based GBV and HIV behavior change programming to specific country contexts. PEPFAR should identify, build upon, and adapt these promising practices to reach as many people as possible quickly. Behavior change takes a long time, and these efforts will require patience. But evidence-based interventions exist and can be successfully adapted for future PEPFAR interventions.

GBV and HIV Integration

Integrating GBV prevention and response into the cascade of HIV services will be a key factor in achieving epidemic control, a PEPFAR 3.0 priority. The links between GBV and HIV are well established, and the GBVI's success at integrating GBV prevention and response into the existing HIV platform can be applied to future PEPFAR interventions. Integrating GBV prevention and response into existing HIV programming and building multisectoral partnerships has the potential to help PEPFAR investments achieve greater impact in preventing and controlling the HIV epidemic.

REFERENCES

Canada: Immigration and Refugee Board of Canada. 2012. *Democratic Republic of the Congo: Domestic and Sexual Violence, Including Legislation, State Protection, and Services Available to Victims (2006–March 2012)*. Ottawa: Refugee Board of Canada. Document number COD104022.E. http://www.refworld.org/docid/4f9e5e532.html.

Davis, Laura, Paola Fabbri, and Ilot Muthaka Alphonse. 2014. *Democratic Republic of Congo Gender Country Profile 2014*. Kinshasa, DRC: Swedish Embassy, DFID, the European Union Delegation, and the Embassy of Canada. http://www.swedenabroad.com/imagevaultfiles/id_22003/cf_347/gender_country_profile.pdf.

Dellar, Rachael C., Sarah Dlamini, and Quarraisha Abdool Karim. 2015. "Adolescent Girls and Young Women: Key Populations for HIV Epidemic Control." *Journal of the International AIDS Society* 18(2), 19408. doi: 10.7448/IAS.18.2.19408. http://www.ncbi.nlm.nih.gov/pmc/articles/pmc4344544.

Dunkle, Kristin L., and Michele R. Decker. 2013. "Gender-Based Violence and HIV: Reviewing the Evidence for Links and Causal Pathways in the General Population and High-Risk Groups." *American Journal of Reproductive Immunology* 69 (Suppl. 1): 20–26. doi: 10.1111/aji.12039.

Ellsberg, Mary, and Myra Betron. 2010. *Spotlight on Gender: Preventing Gender-Based Violence and HIV: Lessons from the Field*. https://aidsfree.usaid.gov/resources/preventing-gender-based-violence-and-hiv-lessons-field.

Hodges, Anthony. 2015. *Child Marriage and Adolescent Pregnancy in Mozambique: Policy Brief*. Maputo, Mozambique: United Nations Children's Fund, United Nations Population Fund, and the National Coalition to Eliminate Child Marriage in Mozambique. http://www.unicef.org.mz/wp-content/uploads/2015/07/en_moz_child_marriage_aw-low-res.pdf.

Instituto Nacional de Saúde (INS), Instituto Nacional de Estatística (INE), and ICF Macro. 2009. *INSIDA 2009 : Inquérito Nacional de Prevalência, Riscos Comportamentais e Informação Sobre o HIV e SIDA em Moçambique*. Calverton, Maryland: INS, INE, and ICF Macro. http://dhsprogram.com/pubs/pdf/ais8/ais8.pdf.

Jewkes, Rachel K., Kristin Dunkle, Mzikazi Nduna, and Nwabisa Shai. 2010. "Intimate Partner Violence, Relationship Power Inequity, and Incidence of HIV Infection in Young Women in South Africa: A Cohort Study." *The Lancet* 376 (9734): 41–48. doi:10.1016/S0140-6736(10)60548-X.

Joint United Nations Programme on HIV/AIDS [UNAIDS]. 2015. *On the Fast-Track to End AIDS by 2030: Focus on Location and Population*. Geneva, Switzerland: UNAIDS. http://www.unaids.org/sites/default/files/media_asset/wad2015_report_en_part01.pdf.

Kipobota, Clarence. 2012. *A Comprehensive Study of the Efficiency of the Enforcement of the Penal Code, Cap. 16 Against the Gender Based Violence in Tanzania*. Commissioned by the Women in Law and Development in Africa, Tanzania Chapter (WiLDAF Tanzania). 5–26.

Ministère du Plan et Suivi de la Mise en Œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP), and ICF International. 2014. *Enquête Démographique et de Santé en République Démocratique du Congo 2013–2014* (EDS-RDC). Rockville, MD: MPSMRM, MSP, and ICF International. http://www.dhsprogram.com/pubs/pdf/fr300/fr300.pdf.

Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE), and ICF International (ICFI). 2013. *Moçambique Inquérito Demográfico e de Saúde 2011*. Calverton, Maryland: MISAU, INE, and ICFI. http://www.pdf.usaid.gov/pdf_docs/pnaeb134.pdf.

National Bureau of Statistics (NBS) Tanzania and ICF Macro. 2011. *Tanzania Demographic and Health Survey 2010*. Dar es Salaam, Tanzania: NBS and ICF Macro. http://www.dhsprogram.com/pubs/pdf/fr243/fr243%5b24june2011%5d.pdf.

République Démocratique du Congo, Ministère du Genre, de la Famille et de l'Enfant. 2009. *Stratégie Nationale de Lutte contre les Violences Basées sur le Genre*. Kinshasa, DRC: Ministère du Genre, de la Famille et de l'Enfant. Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International. 2013. *Tanzania HIV/AIDS and Malaria Indicator Survey 2011–12*. Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and ICF International. http://www.dhsprogram.com/pubs/pdf/ais11/ais11.pdf.

U.S. President's Emergency Plan for AIDS Relief [PEPFAR]. 2013. *Next Generation Indicators Reference Guidance Version 1.2 (February 2013)*. http://www.pepfar.gov/documents/organization/206097.pdf.

———. 2015. *PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide. Version 2.1 (March 2015)*. http://www.pepfar.gov/documents/organization/240108.pdf.

World Health Organization [WHO]. 2013. "Gender, equity and human rights." Geneva, Switzerland: WHO. http://www.who.int/gender/hiv_aids/en.

WHO, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council. 2013. *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence*. Geneva, Switzerland: WHO. http://www.who.int/reproductivehealth/publications/violence/9789241564625/en.

ANNEX 1. GBVI PARTNERS BY COUNTRY

DRC

Communication for Change Project (C-CHANGE, implemented by FHI 360)

Kinshasa School of Public Health

Population Services International

University of North Carolina

Mozambique

Abt Associates Inc.

Ariel Glaser Foundation

Centro para Colaboração em Saúde (Center for Collaboration and Health)

FHI 360[14]

Global Health Communication Gorongosa Restoration Project

ICAP

I-Tech

International Centre for Reproductive Health

IREX

Jhpiego

Johns Hopkins University Center for Communication Programs

Mozambique Ministry of Gender, Children, and Social Affairs

Mozambique Ministry of Health

N'weti

Palladium (formerly Futures Group)

Pathfinder

Population Services International

Save the Children

Thembalethu Development

[14] FHI 360 did not receive GBVI funds but worked on One Stop Centers using orphan and other vulnerable children funds.

The Elizabeth Glaser Pediatric AIDS Foundation

United Nations Development Programme

University of Connecticut

Vanderbilt University (Friends in Global Health)

World Vision

Tanzania

Africare

Angelican Church of Tanzania

American International Health Alliance

Deloitte BOCAR (Building Organizational Capacity for Results)

EngenderHealth

Evangelical Lutheran Church in Tanzania

Henry M. Jackson Foundation Walter Reed Project

International Training and Education Center for Health

Intrahealth

Kihumbe (Kikundi cha Huduma Majumbani Mbeya)

Management and Development for Health Lab

Marie Stopes International

Mbeya Regional Medical Officer

Ministry of Health, Community Development, Gender, Elderly and Children Reproductive Child Health Section

Muhimbili University of Health and Allied Sciences Tanzania AIDS Prevention Programme

Pact

Pathfinder

Tanzania Commission for AIDS

Tanzania Youth Alliance

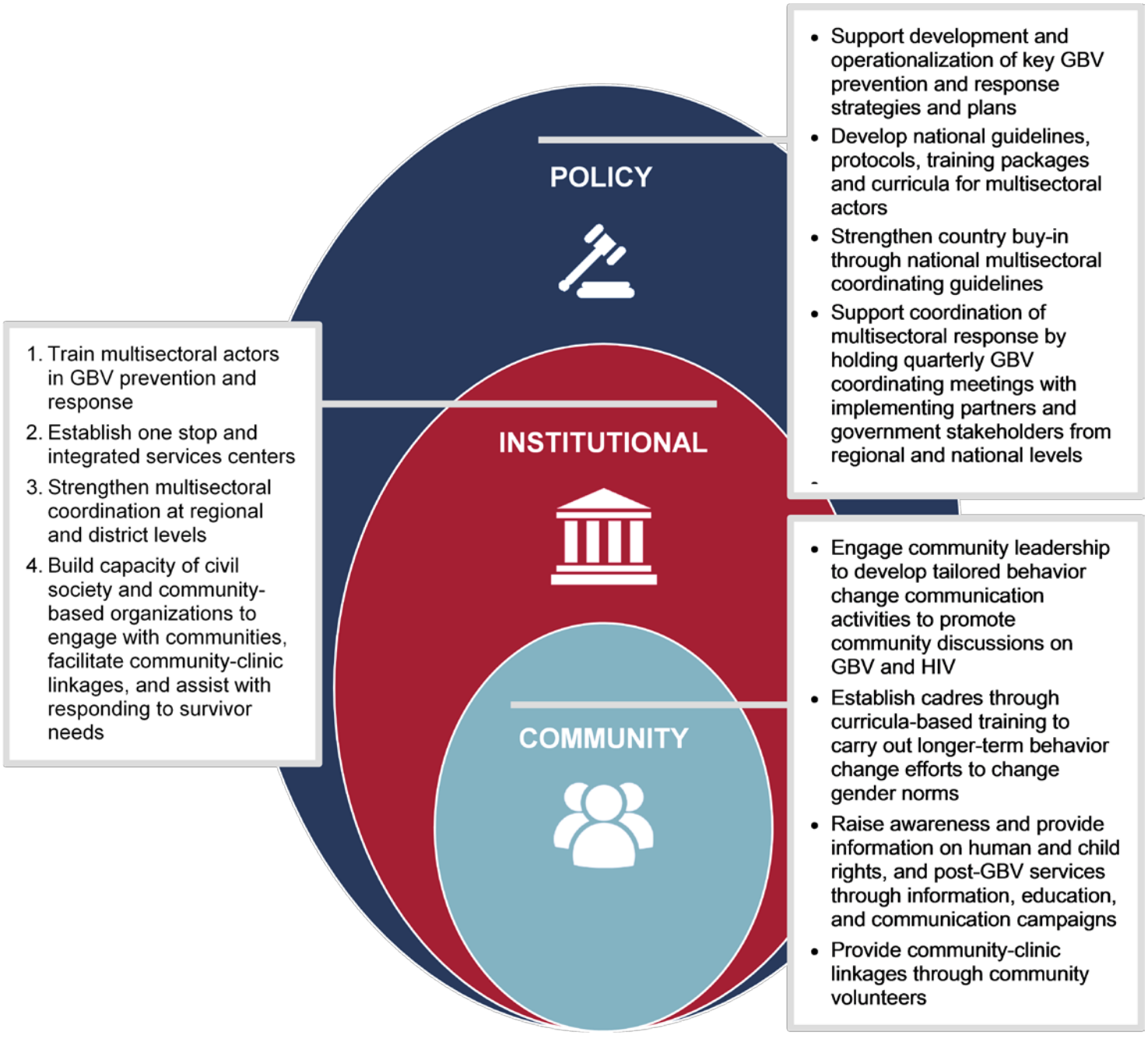
UNICEF

University of California, San Francisco

Women in Law and Development in Africa Tanzania

Youth Empowerment through Sport Tanzania

ANNEX 2. THE GBVI MULTISECTORAL APPROACH



AIDSFree
1616 Fort Myer Drive 16th Floor
Arlington, VA 22209
Phone: 703-528-7474
Fax: 703-528-7480
Web: aidsfree.usaid.gov