



# ASAP WEBINAR

ON

## GENDER EQUALITY AND GBV PREVENTION AND RESPONSE SERVICES IN USAID'S PEPFAR PROGRAMS

FEBRUARY 25, 2021

Questions and Answers

**ACCELERATING SUPPORT TO ADVANCED LOCAL  
PARTNERS (ASAP)**

# Gender Equality and GBV Prevention and Response Services in USAID's PEPFAR Programs

If you have additional questions, please reach out to the Gender and Sexual Diversity Branch in the Office of HIV/AIDS in USAID/Washington:

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## Definitions and Data

### 1. What is considered gender-based violence?

According to the [United States Strategy to Prevention and Respond to GBV Globally](#), gender-based violence (GBV) is an umbrella term for any harmful threat or act directed at an individual or group based on actual or perceived biological sex, gender identity and/or expression, sexual orientation, and/or lack of adherence to varying socially constructed norms around masculinity and femininity. GBV is rooted in structural gender inequalities, patriarchy, and power imbalances. It is characterized by the use or threat of physical, psychological, sexual, economic, legal, political, social and other forms of control and/or abuse. GBV impacts individuals across the life course and has indirect and direct costs to families, communities, economies, global public health and development.

### 2. What is considered violence against children?

The [World Health Organization](#) defines violence against children (VAC) as all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers. The [U.S. Advancing Protection and Care for Children in Adversity](#) strategy notes that violence against children includes all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment, or exploitation, including sexual abuse.

There are multiple types of VAC, including but not limited to:

- Emotional or psychological violence
- Sexual Violence
- Intimate partner or domestic violence
- Maltreatment
- Bullying
- Youth violence

When directed at children or adolescents because of their biological sex or gender identity, any of these types of violence are also gender-based violence.

### 3. Do we have statistical data talking to the boy child exposure of violence?

[Together for Girls](#), in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), has conducted [Violence Against Children Surveys](#) (VACS) in over 19 countries. The VACS measures multiple forms of violence against girls and boys. VACS results are published in [national reports](#) that provide data on violence experienced by both girls and boys in childhood.

## **GBV Case Identification and First-line Support**

### **4. Please explain HIV index testing, GBV case identification, and first-line support (LIVES).**

A key requirement of safe and ethical HIV index testing is conducting the Intimate Partner Violence (IPV) Risk Assessment, otherwise known as routine enquiry for IPV. Within HIV index testing and partner notification services, the IPV Risk Assessment must be conducted for each named partner. There are six minimum requirements that must be met in order for a site to conduct the IPV Risk Assessment or routine enquiry for IPV. These six minimum requirements are:

1. Providers must be trained on and offer first-line support using the LIVES approach to all individuals who disclose experience of violence or to individuals providers suspect are experiencing violence;
2. There must be a protocol or standard operating procedure established for asking about and responding to experience or fear of violence;
3. Providers must be trained on and use a standard set of questions to ask about experience or fear of violence where providers can document responses;
4. Providers must be trained on how to ask about and/or identify signs and symptoms of violence;
5. Providers must only ask about violence in a private setting, always ensuring that they are maintaining the confidentiality of the client;
6. Sites must have an established process for offering referrals or linkages to other local GBV response services.

### **5. Are you able to share the set of standard questions for asking about violence?**

The questions that providers use to ask about violence depend on the population. For adult women, [WHO](#) recommends the following questions:

- Are you afraid of your partner?
- Does your partner or someone at home bully you or insult you?
- Has your partner ever humiliated you in front of others or intentionally made you feel afraid?
- Does your partner try to control you, for example not letting you have money or go out of the house?
- Has your partner or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?
- Has your partner forced you into sex or forced you to have any sexual contact you did not want?
- Has your partner threatened to kill you?

In addition to these questions, for key populations, providers can ask: Has your partner ever threatened to out you or reveal your sexual orientation, gender identity, or status as a sex worker?

**6. Does USAID/Washington offer the LIVES Training?**

WHO's [Caring for women subjected to violence: A WHO curriculum for training health-care providers](#) trains providers on the provision of first-line support (LIVES). USAID adapted this training and facilitated this training as a training of trainers (TOT) for USAID HIV country teams and implementing partners. Currently, there are no plans for further USAID/Washington-facilitated sessions of this training.

**7. Can you please share LIVES materials?**

WHO developed the [Caring for women subjected to violence: A WHO curriculum for training health-care providers](#) training to train providers on the provision of first-line support (LIVES). Additionally, WHO's [Health care for women subjected to intimate partner violence and sexual violence: A clinical handbook](#) provides many helpful tools and job aids for communicating with survivors and administering first-line support using the LIVES approach.

**8. Is training in LIVES only restricted to trained counselors?**

All individuals who ask clients about experience of violence in PrEP, index testing, and care and treatment services, as well as DREAMS and OVC programming, should be trained on how to ask about experience of violence and how to provide first-line support (LIVES). Additionally, community health workers and DREAMS mentors who facilitate HIV and violence prevention interventions should also be trained on the provision of first-line support using the LIVES approach, even if they do not directly ask clients about experience of violence.

**9. What was the rationale of screening DREAMS on enrollment only? Given their age vulnerability, it may be difficult for the adolescent girls to disclose violence to somebody they are not familiar with during enrolment.**

Active identification or screening for GBV in the community is not recommended and should not be conducted. Adolescent girls and young women (AGYW) should, however, be asked about experience of violence when determining eligibility for DREAMS enrollment as per PEPFAR's DREAMS Guidance. Those who ask about experience of violence should be trained on how to ask about violence and how to provide first-line support (LIVES) if and when violence is suspected and/or disclosed.

Additionally, staff who facilitate HIV and violence prevention interventions who may not directly enroll AGYW into DREAMS, such as DREAMS mentors, should be trained on the provision of first-line support in the event that AGYW disclose experience of violence throughout the course of the DREAMS program.

## **Provision of Post-violence Clinical Care**

**10. Can you give an example of an emergency contraceptive?**

There are different forms of emergency contraception.

- Emergency contraception pills with ulipristal acetate (UPA) are taken as a single dose.
- Emergency contraception pills with levonorgestrel (LNG) are taken as a single dose or in two doses 12 hours apart.
- Combined oral contraceptives are taken as a split dose 12 hours apart.
- Copper-bearing IUDs can be implanted in one visit.

More information on emergency contraception, including more details on dosages and the timing of dosages, can be found [here](#).

**11. 120 hours of emergency contraceptive access, does this mean there are now those effective within 5 days instead of 3 days?**

While national guidelines may vary, per WHO, emergency contraception is most effective up to 120 hours after unprotected intercourse. More information on emergency contraceptives can be found [here](#).

**12. What service can you offer a client who is physically abused by a boyfriend but is not willing to report to the police?**

A client can and should be offered all of the services in the minimum of post-violence clinical care appropriate for their situation. A client does not need to, nor should a client ever be forced, to report to the police in order to receive post-violence clinical care services.

**13. What can you do when there is no health facility with the complete package to provide services to a survivor?**

All sites should conduct a referral mapping activity to determine what resources, organizations, and facilities are locally available that can provide clinical and/or non-clinical violence response services to survivors. Sites should create and maintain a referral directory with this information, updating it at least once a year.

If there aren't any facilities locally available that provide the full minimum package of post-violence clinical care services, identify sites that can provide most of the services and work with those sites to provide quality, compassionate care to survivors.

**14. For treatment partners that work in hospitals, survivors may be referred to a family planning unit within the hospital. Is this okay?**

This is ok if the family planning unit is at the same hospital. Ideally, the survivor would be actively escorted to the family planning unit and the escort would privately, while maintaining the confidentiality of the survivor, inform the staff in the family planning unit of the survivor's situation. Situations that involve forcing a survivor to share their story repeatedly should always be avoided.

## 15. Are there any interventions for provider vicarious trauma?

A key component of addressing vicarious trauma among post-violence clinical care providers and first-line responders is self-care. Self-care is a framework for how we treat ourselves, think about ourselves, and comfort ourselves. Self-care can include activities and proactive that can be performed to reduce stress and maintain short- and long-term health and wellness, including relaxation, exercise, sleep, spending time in nature, spending time with family and friends, meditation, etc.

Another important component of preventing and responding to vicarious trauma is good supportive supervision staff who can support the safety and wellbeing of providers and first-line supporters. Supervision staff can provide training opportunities to build skills for the provision of quality, client-centered post-violence care and provide staff with the space to debrief and discuss difficult cases.

Additional resources on identifying and responding to vicarious trauma can be found at the following links:

- [Trauma- and Violence-Informed Care Toolkit](#)
- [Guidelines for the prevention and management of vicarious trauma among researchers of sexual and intimate partner violence](#)
- [Compassion Fatigue Awareness Project](#)

## **GEND\_GB**V and Custom Gender and GBV Indicators

### 16. What other indicators are reported for GBV and Gender norms?

GEND\_GB

V is the PEPFAR Monitoring, Evaluation, and Reporting (MER) indicator that captures the number of people who have received PEPFAR-supported post-violence clinical care services based on the minimum package. Results from the indicator are reported into DATIM during the second quarter (Q2) and the fourth quarter (Q4) of the fiscal year. Implementing partners are also asked to report their GEND\_GBV data quarterly through the USAID/Office of HIV/AIDS' (OHA) Custom Indicator Reporting Process.

Implementing partners can also collect data on other custom indicators to capture their gender norms change and GBV prevention work. One such indicator is [GEND\\_NORM](#) - a custom indicator which captures the number of people completing an intervention pertaining to gender norms that meets the minimum criteria. USAID partners implementing DREAMS can report their GEND\_NORM data quarterly through the USAID/OHA Custom Indicator Reporting Process.

USAID also asks that partners implementing gender and GBV programming report on these key [custom indicators and disaggregates](#) to capture GBV case identification and the provision of first-line support within HIV index testing and care and treatment services, as well as the provision of first-line support within community-based HIV and violence prevention interventions.

Additional custom indicators that can be used to capture community-based GBV prevention interventions can be found in the [Compendium of Gender Equality and HIV](#) custom indicators

and [Compendium of Violence Against Women and Girls](#) custom indicators developed by MEASURE Evaluation.

**17. If the site can refer survivors to other sites to receive emergency contraception, can the site report on GEND\_GBV?**

No. In order for a site to report on GEND\_GBV, all of the services in the minimum package of post-violence clinical care services must be available at that site. The minimum package of post-violence clinical care services includes:

- Treatment of injuries
- HIV testing
- Post-exposure prophylaxis (PEP)
- Sexually transmitted infection (STI) testing/screening and treatment
- Emergency contraception
- Counseling/first-line support (LIVES)
- Referrals to non-clinical GBV response services, such as longer-term psychosocial support, child protection, shelter, legal, police, economic empowerment, etc.

If any services within the minimum package are not available at a site and that site must therefore refer for those services, that site cannot report on GEND\_GBV. That site can, however, report under a custom indicator to capture the important work it is doing in GBV service provision and referral. The work can and should continue, but the implementing partner should not report under GEND\_GBV, but should instead report under a custom indicator.

**18. Can we count clients under GEND\_GBV if they have not received the full package?**

Yes. A site can only report under GEND\_GBV if the full minimum package is available and offered at that site. A client does not, however, have to receive all of those services in the minimum package in order to be reported under GEND\_GBV. The client should be offered the services appropriate for their situation and if the client accepts even just one of those services, the client can be reported under GEND\_GBV.

**19. If the site doctor gives a prescription to a survivor to buy emergency contraception in the pharmacy out of the site can that be counted under GEND\_GBV?**

All services within the minimum package of post-violence clinical care services should be offered to survivors free of charge and should be provided on site. If a survivor must pay for a service that can only be accessed off-site, that site should not report on GEND\_GBV.

**20. If a site experiences a temporary stockout, it can't report GEND\_GBV right?**

Correct. If any services within the minimum package of post-violence clinical care services are not available at a site, even if just for a short time due to a stockout, that site should not report on GEND\_GBV. Sites are encouraged to plan for how they can procure drugs within the minimum package to avoid stockouts. For example, a site may have an agreement with another facility whereby if the site experiences a stockout of critical drugs within the minimum package, the site can “borrow” these drugs from the other facility.

**21. If a client reports after 3 days, what services will the client get and can they be reported under GEND\_GBV?**

If a client experiences sexual violence and reports for services after 3 days, that client is no longer eligible for post-exposure prophylaxis (PEP), but is eligible for every other service in the minimum package, including:

- Treatment of injuries
- HIV testing
- Sexually transmitted infection (STI) testing/screening and treatment
- Emergency contraception
- Counseling/first-line support (LIVES)
- Referrals to non-clinical GBV response services, such as longer-term psychosocial support, child protection, shelter, legal, police, economic empowerment, etc.

If the client receives even just one of these services, the client can be reported under GEND\_GBV.

**22. If the site is located in a hospital and the client received treatment of injuries at the same hospital and was paid for all fees through social health insurance? Is the client counted for GEND\_GBV?**

Yes. If the client received post-violence clinical care services, including treatment of injuries, in the same hospital, that client can be reported under GEND\_GBV. Additionally, clients should never be forced to pay for post-violence clinical care services.

**23. Please go over the PEP completion again.**

GEND\_GBV is disaggregated by age, sex, type of violence, and PEP completion. The PEP completion disaggregate captures the number of people who received post-violence clinical care services and were reported under the GEND\_GBV numerator who also completed a PEP regimen.

**24. What's the denominator for PEP completion?**

While there is no official denominator, the number of individuals who are reported under the sexual violence disaggregate of GEND\_GBV is often used as an “unofficial” denominator for PEP completion. Nevertheless, there are many reasons why a client who has experienced sexual violence may not initiate on and complete a PEP regime. For example, not every individual who receives services for sexual violence will be eligible for PEP (e.g., HIV-positive, presented after 72 hours, or not otherwise clinically indicated).

**25. So GEND\_GBV is recording sexual violence and all other violence will be custom indicator?**

No. GEND\_GBV is disaggregated by sexual violence and physical/emotional violence. Therefore, clinical services received for sexual violence, physical violence, and emotional violence in alignment with the minimum package of post-violence clinical care services are reported under GEND\_GBV.

**26. Are referral services counted on GBV\_REPORT\_COMM?**

[GBV\\_REPORT\\_COMM](#) is a custom indicator that captures the percentage of individuals who were provided with or referred to post-violence services among those who disclosed experience of violence within community settings. The numerator for this custom indicator is the number of individuals who disclosed to program staff or outreach workers outside of clinical facilities that they experienced violence within the past three months from any type of perpetrator and were *referred for or provided* clinical or non-clinical post-violence care.

**27. How can community-based organizations that identify GBV cases report their results?**

If through the implementation of a community-based program a participant discloses experience of violence, the community-based organization should immediately provide first-line support (LIVES) and refer the participant to local clinical and/or non-clinical violence response services as appropriate. The community-based organization can report this under a custom indicator, such as [GBV\\_REPORT\\_COMM](#).

## **Gender and GBV Prevention Programming and Training**

**28. Do you have any evidence-based approaches you use for engaging men and boys?**

The following evidence-based interventions have been proven successful at engaging men and boys and transforming harmful gender norms:

- [Program H](#)
- [Men as Partners](#)
- [One Man Can Campaign](#)
- [Community mobilization training manual for preventing men's use of violence against women](#)
- [Dos and Dont's for Engaging Men and Boys](#)

**29. Are there plans for a follow-up webinar or can you recommend an additional resource to help us sensitize ourselves and teams on matters relating to gender sensitivity?**

The [Gender and Sexual Diversity \(GSD\) Training](#), developed by HP+ with PEPFAR funds, works to mainstream GSD competency within the HIV response. The training helps participants understand how stigma and discrimination negatively affect the lives, health, and HIV outcomes of gender and sexual minorities.

**30. What are some of the best practices or recommended approaches in integrating violence prevention to HIV prevention interventions?**

There are a number of resources dedicated to identifying best practices and key recommendations for integrating violence prevention into HIV prevention interventions. Some such resources include:

- [Integrating Gender and GBV into HIV Prevention Programming in Mozambique](#)
- [A global comprehensive review of economic interventions to prevent intimate partner violence and HIV risk behaviors](#)
- [International technical guidance on sexuality education](#)

- [Stepping Stones](#)

**31. Do adverse events only apply to HTS index, or even to other services at different entry points across the HIV cascade?**

In relation to HIV index testing, USAID works to prevent and monitor intimate partner violence (IPV) as a result of partner notification services. Providers' number one priority is to do no harm, so it is essential to ensure that providers' actions through partner notification never put a client at risk, especially a client who is experiencing or has experienced intimate partner violence.

In the context of PrEP and care and treatment services, if a client is identified as experiencing violence, providers should work with the client to strategize how the client can take their drugs with or without their partner's knowledge in order to mitigate a violent event. Providers should also work with clients to develop safety plans, which should include identifying how the client can avoid prevention or treatment interruption when needing to leave a violent situation.

**32. I am always struggling when it comes to designing gender transformative activities for HIV/AGYW (DREAMS), etc. Any tools with USAID?**

Evidence-based gender transformative interventions approved for use within PEPFAR DREAMS programming can be found in the DREAMS Guidance. Resources for gender transformative programming and examples of gender transformative programs include:

- [Interagency Gender Working Group](#)
- [Passages Project](#)
- [What Works to Prevent Violence Against Women and Girls](#)
- [SASA!](#)

### Questions for NACOSA

**33. In Zambia, we have noticed that Zambia Police service GBV numbers are high compared to our one stop centers (It may also be because we capture numbers using different parameters). We are looking at trying to work with the police to ensure their numbers and ours are not too different. What is the South African experience?**

In South Africa there are only 54 Thutuzela Care Centre's that operate as "One-Stop" GBV service points. These facilities often have to cover a very vast geographic area. The result of this is that South Africa in many districts have a similar experience that at local community level cases are reported at police stations but due to a lack of resources or transport for the client access to this one stop facilities are hampered or delayed. The USAID funded GBV award implemented by NACOSA aims to address barriers to access and uptake of GBV services through (1) awareness raising of available services and demand creation at community level, (2) provision of emergency transport to survivors, (3) in partnership with the Department of Health, Clinical Forensic Medicine and the Department of Social Development explore decentralized GBV support services at local primary and community health care facilities.

**34. How do you adhere to COVID-19 SOPs as you engage the community? And how easy is it in South Africa ?**

NACOSA has developed a rigorous protocol for safely implementing community based and group based events or activities. This includes:

- Each event/group has a COVID19 Compliance Officer that will ensure that all COVID19 Infection Prevention measures are followed.
- The Compliance Officer will conduct an orientation with participants to highlight COVID19 protocols and guidelines required of that specific event
- Health check and Temperature Screening conducted before the event commences
- Selection of venues in communities is done in alignment with lockdown level restrictions:
  1. No more than 50% capacity at any given time
  2. If indoor venues are used they must be well-ventilated
  3. Preference given to outdoor events using gazebo's
- Sanitizer is available in the venue and surfaces are to be sanitized at least every hour.
- All participants are expected to wear a face mask for the duration of the event – additional masks are available should that be required. No mask no entry principle strictly enforced
- All participants are instructed to avoid using other participants' phones, tables or other tools and equipment, when possible. If it is necessary, clean and disinfect before and after use
- Social distancing guidelines of 1.5 m is strictly enforced and visually demarcated by means of table or chair spacing or if it is an outside venue cones that indicate required distance.
- Continuously re-enforcing COVID19 prevention messaging through IEC materials and in engagements with community members and youth.

**35. Cezanne, can you please provide more details on the implementation of evidence-based activities that have worked in your program?**

NACOSA is currently implementing Impower and Stepping Stones as two evidence-based curricula.

**IMPOWER/IMSAFER:**

- It is an evidence informed programme developed by No Means No Worldwide that aims to prevent sexual violence against women
- Targets Adolescent Girls and Young Women aged 10-20 years
- Girls master conflict management techniques including boundary setting and diffusion tactics, verbal assertiveness and negotiation, as well as physical self-defense skills should they become necessary.
- Facilitated by young women in 6 x 2-hour sessions
- IMSAFER is the COVID-19 risk adapted version of the programme consisting of 4 x 2-hour sessions. The core foundation of the programme is similar to that of Impower,

however only basic self-defense skills are demonstrated due to COVID19 social distancing and infection prevention protocols.

#### **STEPPING STONES:**

- Designed as a tool to help promote sexual health, improve psychological well-being and prevent HIV developed by the South African Medical Research Council
- The workshops address questions of gender, sexuality, HIV/AIDS, gender violence, communication and relationship skills
- Target Beneficiaries are both adolescent girls and young women and adolescent boys and young men
- Stepping Stones is a 10 x 3-hour session group-based workshop series

More details on these two programmes can be found at the links below:

#### **36. What can be a recommendation to prevent and stop GBV in rural areas for young girls due to poverty experienced? What can be done in case some families cover for violence done to their children in case their children want to report?**

Addressing GBV is a multi-faceted challenge that requires a package of interventions that address individual, community, and structural factors that increase girls' HIV risk, including gender inequality, gender-based violence, and limited access to education and economic opportunities. A package of services is required (like the DREAMS core package) that provide evidence-based/informed, age-appropriate, comprehensive package of biomedical, behavioral, and structural interventions across multiple sectors. In looking at your HIV Prevention and GBV prevention programming and for young girls, it is important to take into consideration and plan for a **comprehensive service package** that addresses vulnerabilities across the different levels and sectors.

Within your country it is important to understand which Legislation and Acts protect children against violence and abuse. In South Africa for instance The Constitution of the Republic of South Africa (Act 108 of 1996) clearly states that "Children that have the right to protection from maltreatment, neglect, abuse or degradation – section 28(1)(d). This is further supported by the Children's Act 38 of 2005 and the Criminal Law Sexual Offences Amendment Act 32 of 2007. Within this legislation, mandatory reporting requirements are stated that guides how children that have experienced violence or abuse should be supported and how the abuse must report to the required authorities (ie. Police Service, Social Welfare/Development). All partners working with children should have organizational Child Protection Policies that guide the Standard Operating Procedures for disclosures of child abuse/violence and that provide clear instruction on mandatory reporting requirements. Staff working with children should also be trained in the LIVES approach to ensure that they are capacitated to deal with disclosures of violence and ensure

that survivors are actively referred and linked to other required services. From a community and family strengthening and support perspective, it is important that there is awareness raising on the effect of child abuse and violence on mental health and HIV and high risk sexual behavior for children and that parents are provided with the necessary support, education and skills to effectively support their children affected by violence or abuse.

**37. What do you do if there is a parent who is not willing to report a case of her abused child. Cezanne, can you please respond in writing if possible?**

As a partner working with children and possibly violence against children it is important that the work that you do is guided by relevant Legislation and Acts that protect children against violence and abuse in your country. The legislation should be guiding your actions with regards to mandatory reporting requirements and required statutory support services for children that are survivors of violence or abuse. Support to the family should be provided to understand the mandatory reporting requirements, to understand long term effects of child abuse on mental health and wellbeing of children and to assist them to access relevant legal, psychological and health services.

**38. How does SA respond to cases of unlawful sexual relationship of teenage girls with older men? Because the challenge we face is that police or court do not address these cases to completion. In most cases perpetrators are not prosecuted.**

The Sexual Offences Amendment Act clearly states the following:

- Section 57 (1) states “Notwithstanding anything in any law contained, a male or female person under the age of 12 years is incapable of consenting to a sexual act.”
- Section 15. (1) states “A person (‘A’) who commits an act of sexual penetration with a child (‘B’) who is 12 years of age or older but under the age of 16 years is, despite the consent of B to the commission of such an act, **guilty of the offence** of having committed an act of consensual sexual penetration with a child”
- Section 15. (1) A person (‘A’) who commits an act of sexual penetration with a child (‘B’) is, despite the consent of B to the commission of such an act, **guilty of the offence** of having committed an act of consensual sexual penetration with a child, unless A was either 16 or 17 years of age and the age difference between A and B was not more than two years

It should further be remembered that the prosecuting authority, besides the provisions contained in the Act dealing with those who breach sections 15 or 16, is the one with the final say – based on its discretionary powers – to institute criminal proceedings or not. In all instances, prosecutors will still manage these matters on a case to case basis and will still exercise their prosecutorial discretion in deciding whether to prosecute or not on the merits of each case.

**39. Young people seem not to adhere to the Covid -19 prevention measures, what youth friendly ideas could we use for them to easily take them into consideration?**

Within communities it is important to consistently emphasize and model the Department of Health non-clinical measures for preventing COVID19 in all events, group sessions and interactions (social distancing, mask wearing, sanitizer, hand washing). These prevention measures should be consistently integrated in all interactions with youth and capacitating them with up to date, correct and relevant information. Visual demonstrations/representation of COVID19 prevention and control measures can be adapted in an age appropriate manner to support increased understanding as well as optimized for use on digital and media platforms. Young people today are more connected than any previous generation. With many critical activities and institutions moving online, young people are well positioned to respond and adapt to COVID-19. Young people can also be critical in bridging the digital divide by providing information and knowledge to communities that do not have access to digital technologies, and tailoring messaging and channels to reach diverse audiences and reflect multiple voices. When capacitated with information young people play a critical role in disseminating accurate information on COVID-19, tackling myths and stigma, policing fake news, and supporting information-sharing programmes on risk reduction, national preparedness, and response efforts. Through social media, they are finding ways to remotely check on, and support, others' mental health.

**40. Community leaders are afraid to report violence and abuse because police and case worker informed the suspect who reported him or her to them ...so how can we solve such in the community in order to protect the reporter of the abuse?**

A critical element of GBV Prevention and Response is shifting community norms to create a supportive and enabling environment for survivors to report violence and abuse. Addressing barriers to reporting GBV should be a critical advocacy issue for organizations in communities providing GBV services. Where police services and/or social welfare services become part of the barrier to accessing GBV services that should be addressed with the relevant departments, Victim Empowerment Coordination structures, local and district health and social welfare forums or councils.

**41. In South Africa, how do you deal with sexual violence among children? Can a child be convicted?**

Section 15 of the Sexual Offences Act aims to criminalize acts of sexual penetration by adults with children between the ages of 12 and 16 years, despite their consent. Section 16 is intended to criminalize acts of consensual sexual violation committed by adults with children between the ages of 12 and 16 years.

The Act provides, among others, that children who engage in certain acts with each other, such as kissing, cannot be prosecuted for doing so if both agreed to such acts and the age difference

between the two children is not more than two years. The Act even goes further to ensure that children who innocently engage in certain acts with each other are not prosecuted by affording the Directors of Public Prosecutions with the discretion to decide whether prosecutions should be instituted or not in those cases where there are two children involved. The provisions of section 16, read with sections 56(2)(b) and 66(2)(a)(vi), of the Act have been carefully drafted so as to avoid the situation that teenage sexual experimentation of a non-penetrative nature attracts criminal prosecution, but, at the same time, ensuring that persons who sexually abuse children do not go unpunished.

**42. How can we consider the fact that girls aren't sent to school, because their parents say they are good only for marriage? Is it a GBV?**

The South African Constitution states that every child has the right to education. Forced or early marriage is considered to be a form of GBV.