Gender Equality and Gender-based Violence Prevention & Response Services in USAID’s PEPFAR Programs

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Agenda

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Terminology
Sex: The classification of people as male or female. At birth, infants are assigned a sex based on a combination of bodily characteristics including: chromosomes, hormones, internal reproductive organs and genitalia.

Gender: The socially-defined set of roles, rights, responsibilities, entitlements, and obligations of females and males in societies. The social definitions of what it means to be female or male vary among cultures and change over time.

Gender Identity: A person’s deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth.

Sexual Orientation: An enduring pattern of romantic or sexual attraction (or a combination of these) to another person. These inherent attractions are generally subsumed under heterosexuality, homosexuality, bisexuality or asexuality.
The Gender Person

- Gender Identity
- Sexual Orientation
- Gender Expression
- Biological Sex
Gender-based Violence (GBV)

- 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.

- Rooted in structural gender inequalities, patriarchy and power imbalances.

- Characterized by the use or threat of physical, psychological, sexual, economic, legal, political, social and other forms of control and/or abuse.

- Impacts individuals across the life course and has indirect and direct costs to families, communities, economies, global public health and development.

Source: USG Strategy to Prevent and Respond to GBV Globally, 2016
Prevalence of GBV
Quiz! What is the global prevalence of violence against women?

A) 1 in 10 women will experience physical and/or sexual violence from a partner or sexual violence from a non-partner.

B) 1 in 5 women will experience physical and/or sexual violence from a partner or sexual violence from a non-partner.

C) 1 in 3 women will experience physical and/or sexual violence from a partner or sexual violence from a non-partner.
Quiz! What is the global prevalence of violence against women?

A) 1 in 10 women will experience physical and/or sexual violence from a partner or sexual violence from a non-partner.

B) 1 in 5 women will experience physical and/or sexual violence from a partner or sexual violence from a non-partner.

C) 1 in 3 women will experience physical and/or sexual violence from a partner or sexual violence from a non-partner.
1 in 3 women throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner.

Map showing prevalence of intimate partner violence by WHO region

Source: WHO Global and Regional Violence against Women Factsheet, 2013
Violence against women takes many forms, including:

- Intimate partner violence, including physical, sexual, and emotional abuse
- Honour killings
- Female genital mutilation
- Sexual violence, including conflict-related sexual violence
- Forced and early marriages
- Trafficking

The most common type of violence experienced by women is intimate partner violence.

Source: WHO
YES or NO:
Only women experience GBV.
Violence Against Children

All data among 18-24 year olds from the Violence against Children and Youth Surveys (VACS), led by the U.S. Centers for Disease Control and Prevention as part of the Together for Girls partnership.

Girls and boys experience high rates of sexual violence in childhood

% of females and males who experienced sexual violence prior to age 18

![Bar chart showing the percentage of girls and boys who experienced sexual violence in various countries.](chart)

Source: Together for Girls
Even when young survivors disclose their experience, they rarely seek or receive services, including post-rape care

Females who told someone, sought and/or received services for sexual violence, among those who experienced sexual violence prior to age 18

- % of females who told someone about an experience of sexual violence: 46%, 61%, 57%, 52%
- % of females who sought services for sexual violence: 7%, 10%, 10%, 1%
- % of females who received services for sexual violence: 3%, 9%, 8%, 0%

Source: Together for Girls
Types of Gender-based Violence

VIOLENCE AGAINST KEY POPULATIONS IS PREVALENT, FREQUENT, AND OFTEN SEvere

UKRAINE
43% of women who inject drugs reported physical violence by police and 13% reported sexual violence by police in their lifetime.9

DOMINICAN REPUBLIC
46% of trans women reported experiencing trauma since the age of 14, including sexual abuse (25%), psychological abuse (32%), torture (12%), and attempted murder (20%).9

INDIA
50% of female sex workers (FSWs) reported physical violence and 77% reported sexual violence in the past six months.9

CAMEROON
60% of FSWs experienced physical or sexual violence in their lifetime.8

PERU
42% of male sex workers reported experiencing violence, including physical (25%), emotional (27%), and sexual violence (16%), from intimate partners and clients in the past six months.13

SOUTH AFRICA
51% of FSWs reported physical assault and 22% reported sexual assault or rape in the past 12 months.8

THAILAND
69% of MSM and 89% of trans women experienced emotional, physical, or sexual violence in their lifetime.8

KENYA
57% of PWIDs, 44% of FSWs, and 24% of MSM were arrested or beaten by police officers in the past six months.8

Source: LINKAGES Project
Figure 1: Gender-based violence throughout the life cycle

Pre-birth
- Pre-natal sex selection

Infancy
- Female infanticide
- Neglect (health, care, nutrition)

Childhood
- Child abuse
- Child marriage
- Malnutrition
- FGM/C
- Trafficking

Adolescence
- Femicide
- FGM/C
- Forced marriage
- Forced sex (including initiation)
- IPV/dating violence
- Trafficking

Reproductive age
- Femicide
- Dowry-related violence
- IPV
- Non-partner sexual assault
- So-called ‘honour’ crimes
- Sexual harassment
- Political violence
- Economic abuse
- Trafficking

Elderly
- Elder/widow abuse
- Economic abuse

YES or NO:
While GBV is a human rights violation, it does not impact HIV outcomes.
NO
GBV & HIV Outcomes
How do you think GBV impacts HIV outcomes?
1 in 3 women worldwide have been beaten, coerced into sex, or otherwise abused in their lifetimes.

1 in 4 girls’ first sexual encounter was unwanted.

1.5 is the increased likelihood that women who experience intimate partner violence will acquire HIV.

47% of males living with HIV aged 15 and older are on ART, compared with 60% among females.

Exposure to GBV, particularly IPV, is associated with lower ART use, half the odds of self-reported ART adherence, and significantly worsened viral suppression among women.

Having gender inequitable beliefs or endorsing harmful gender norms – particularly norms sanctioning violence against and the control of women by male partners – decreased the odds of ART use among PLHIV.
Gender, GBV, and the Clinical Cascade

Prevention

Evidence-based HIV Prevention Approaches

Testing

Initiate on PrEP

Access HTS

Care and Treatment

Initiate on ART

95%

95%

95%

Harmful gender norms and inequitable attitudes about gender put individuals at risk for HIV and serve as a barrier to uptake of HIV prevention, testing, and care and treatment services.

Violence is a barrier to PrEP initiation and adherence. Qualitative evidence suggests that violence can also occur as a result of PrEP use.

Violence and harmful gender norms inhibit one’s ability to access HTS and disclose their status. Many people report fear of violence and/or abandonment if their partner learns their status.

Violence is associated with reduced linkage to HIV care services and initiation on ART.

Harmful gender norms often inhibit men’s health-seeking behaviors. Violence is also associated with reduced ART adherence among adolescents, transgender women, and drug users.

Women who experience violence are less likely to adhere to treatment and achieve viral suppression.
Figure 1: Potential pathways between intimate partner violence and women’s risk of HIV acquisition

**Structural Drivers of HIV and Intimate Partner Violence**
- Poverty and economic stresses
- Gender inequality and social norms condoning use of violence
- Social constructions of masculinity and femininity

**Intimate Partner Violence**
- Woman’s exposure to child sexual abuse
- Psychological distress: Chronic anxiety, Depression, Post-traumatic stress disorder, Substance use
- Man’s childhood exposure to violence
- Clustering of HIV risk factors among perpetrators: Binge drinking, Concurrent partners, Purchasing of sex

**Proximate Determinants of HIV**
- Increased sexual risk: Re-victimization, Multiple/concurrent partners, Transactional sex, Sex work
- Inflammation and immune activation
- Genital trauma
- Reduced access to information and HIV prevention
- Unprotected sex, Low adherence
- Higher likelihood that male partner is HIV positive

**Increased likelihood that woman acquires HIV**

Source: Lori Heise/STRIVE, Greenrae II, 2015
GBV and Health

GBV Increases Adverse Health Outcomes

Mental Health

TWICE as likely to experience depression

ALMOST TWICE as likely to have alcohol use disorders

Sexual and Reproductive Health

16% more likely to have a low birth-weight baby

1.5 times more likely to acquire HIV and 1.5 times more likely to contract syphilis infection, chlamydia or gonorrhoea

Death and Injury

42% of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result

38% of all murders of women globally were reported as being committed by their intimate partners

Source: WHO
Questions?
USAID and USG Policies on Gender Equality and GBV
Addressing Gender Inequalities & GBV within USG Programs

USAID PEPFAR gender and GBV programs work to advance the **PEPFAR Gender Strategy**, **USAID Gender Equality and Female Empowerment Policy**, and **USG Strategy to Prevent and Respond to GBV Globally** in order to ensure that women, men, girls, boys, LGBTI individuals, and individuals of other gender identities – of all ages and abilities – are equally able to:

- Access and utilize HIV prevention, care, and treatment services;
- Protect themselves and practice healthy behaviors;
- Exercise their rights;
- Live lives free from violence, stigma, and discrimination.

Integrating gender and GBV considerations across PEPFAR programs is essential to reaching 95-95-95 goals.
USAID Gender and GBV Technical Priorities for PEPFAR Programs
Addressing Violence and Inequality Across the HIV Cascade

**Prevention**
- Evidence-based HIV Prevention Approaches
- **Initiate on PrEP**
- HIV prevention interventions that integrate violence prevention and link to clinical cascade.
- Survivors identified and provided support and referrals to GBV response services to increase PrEP adherence.

**Testing**
- Access HTS
- Survivors identified during self-testing, index testing, and PN services, and provided and/or referred to HIV treatment initiation and GBV response services.

**Care and Treatment**
- **Initiate on ART**
- Providers identify survivors via routine and/or clinical enquiry during ART initiation and routine clinical care. Survivors offered support and provided with or referred to GBV clinical care.
- **95% Adhere to ART & viral suppression**
- Improve quality of post-violence clinical care services in care and treatment sites.

**HIV prevention interventions that integrate violence prevention and link to clinical cascade.**

**Initiate on PrEP**

**Support and referrals to GBV response services to increase PrEP adherence.**

**Survivors identified during self-testing, index testing, and PN services, and provided and/or referred to HIV treatment initiation and GBV response services.**

**Survivors identified during routine and/or clinical enquiry during ART initiation and routine clinical care. Survivors offered support and provided with or referred to GBV clinical care.**

**Improve quality of post-violence clinical care services in care and treatment sites.**
Addressing **intimate partner violence (IPV)** in the context of **PrEP**, **index testing**, and **care and treatment** (routine and clinical enquiry for IPV).

Providing **post-violence clinical care services** in HIV care and treatment sites.

Improving **linkage** between **community-based HIV and GBV prevention interventions** and clinical post-GBV care services.

Improving **monitoring of GBV** case identification, prevention and response activities.
All PrEP sites must conduct **clinical or routine enquiry for IPV** with all clients.

All HIV index testing sites must conduct **clinical or routine enquiry for IPV** for clients who are offered partner notification services.

All care and treatment sites must conduct **clinical enquiry for IPV** with all clients.

After conducting routine and clinical enquiry for IPV, sites must then offer **first-line support** and **provision of or referrals to GBV response services**.
Minimum Requirements for Asking about Violence

The **minimum requirements** that must be in place for sites to ask about experience of violence are:

- **Providers offer first-line support (LIVES)**
- **A protocol/SOP for asking about experience or fear of violence**
- **A standard set of questions where providers can document responses**
- **Providers are trained on how to ask and/or identify signs and symptoms of violence**
- **Providers only ask about IPV or sexual violence in a private setting, confidentiality ensured**
- **A process for offering referrals or linkages to other services is in place**
First-line support is the immediate care given to a GBV survivor upon first contact with the health or criminal justice system.

**L**isten

Listen closely with empathy, not judging.

**I**nquire about needs and concerns

Assess and respond to the survivor’s needs and concerns – emotional, physical, social, and practical.

**V**alidate

Show that you believe and understand the survivor.

**E**nsure safety

Discuss how to protect the survivor from further harm.

**S**upport

Help the survivor connect to services, social support.
Expanding Integrated HIV and GBV Clinical Services

- Integrating HIV and GBV services is a key component of USAID’s strategy to identify survivors and reach them with comprehensive post-GBV care.

- The two predominant models for GBV service delivery in USAID’s PEPFAR programs are standalone GBV sites or integrated into public health facilities.
  - **Priority for standalone GBV sites:** Ensure survivors are linked into HIV cascade.
  - **Priority for integrated sites:** Ensure survivors being identified using *clinical enquiry* and that services are accessible.

- Both models need to ensure quality and accessibility of care.
Improving linkages b/w community prevention interventions & clinical post-GBV care services

All those administering DREAMS and/or OVC screening and enrollment tools where experience of violence is assessed must be trained on how to ask about violence, respond (provide first-line support, i.e., LIVES), and immediately refer to clinical and/or non-clinical GBV response services.

All community-based programs delivering HIV or GBV prevention activities must ensure that facilitators are trained on providing first-line support (per WHO’s LIVES framework) so they can respond appropriately to someone who discloses violence.

Facilitators should have referral cards and information available to help survivors access GBV response services.

For survivors who access post-GBV response services at dedicated GBV sites (e.g., one-stop centers) and test negative, ensure linkage to HIV and GBV prevention programs.
Improving monitoring of GBV case identification, prevention, & response

MER and custom indicators/disaggregates should be integrated into IP workplans to measure GBV case identification, prevention, and response activities, as well as gender norms change activities.
What is the PEPFAR MER indicator that captures the number of people who receive post-violence clinical care services?
GEND_GBV
MER Indicator: GEND_GBV Overview

—
Understanding GEND_GBV

GEND_GBV: Number of people receiving post-GBV clinical care based on the minimum package.
Post-violence Clinical Care Minimum Package

All survivors of **physical, emotional, and sexual violence** should be offered:

- Treatment of injuries
- Rapid HIV testing
- STI testing/screening and treatment
- Counseling (first-line support - LIVES)
- Referrals to other services as necessary

Additionally, survivors of **sexual violence** should also be offered:

- PEP (within 72 hours)
- Emergency contraception (within 120 hours)

**Note:** The full minimum package must be available at a site for that site to report on GEND:\_GBV, but a client does not need to receive all services in the minimum package to be counted under GEND:\_GBV.
What is not included under GEND_GBV

GEND_GBV does **NOT** include community-based GBV prevention and norms change activities or non-clinical GBV response activities.

For example, GEND_GBV does not include:

- Case management
- Shelter services
- Longer-term psychosocial support
- Education
- Couples counseling
Data should be disaggregated by:

❖ Sex

❖ Finer age bands

❖ Type of violence (*sexual violence or physical/emotional violence*)

❖ Number of people who completed a course of post-exposure prophylaxis (PEP)
**GEND_GBV**

<table>
<thead>
<tr>
<th>Description:</th>
<th>Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of people receiving post-gender-based violence (GBV) clinical care based on the minimum package. This indicator DOES NOT include GBV prevention activities or non-clinical community-based GBV response.</td>
</tr>
<tr>
<td>Denominator:</td>
<td>N/A</td>
</tr>
<tr>
<td>Indicator changes (MER 2.0 v2.2 to v2.3):</td>
<td>• Age/sex disaggregates updated. • Language added to the “disaggregate descriptions &amp; definitions” section of the indicator to ensure that clients are not double-counted under this indicator.</td>
</tr>
<tr>
<td>Reporting level:</td>
<td>Facility &amp; Community</td>
</tr>
<tr>
<td>Reporting frequency:</td>
<td>Annually</td>
</tr>
<tr>
<td>How to use:</td>
<td>This indicator measures delivery of a basic package of post-GBV clinical services (including PEP and EC). NOTE: This indicator DOES NOT include GBV Prevention activities or non-clinical community-based GBV response (e.g., shelter programs, case management). This indicator will enable PEPFAR to: • To determine the number of individuals that are suffering from GBV and reporting to clinical partners. • To assess whether post-GBV clinical services are being used. • Gain an understanding of the uptake of post-GBV clinical services offered across PEPFAR countries. • Provide important information to key stakeholders about PEPFAR programs that mitigate women and girls' and other marginalized populations' vulnerability to HIV/AIDS. • Support efforts to assess the impact of post-GBV clinical services by correlating the reach (i.e., number of people served) of these services over time with outcomes related to GBV (and HIV/AIDS), as described through other data collection efforts such as survey data (DHS/PHIA/VACS). • Identify programmatic gaps by analyzing the number and ages of people receiving services, as well as the reach of services in particular geographic areas.</td>
</tr>
</tbody>
</table>

**GEND_GBV** is an **annual** indicator. IPs should report GEND_GBV to country teams more regularly, either **monthly** or **quarterly**.
Questions?
COVID-19 and GBV
Reports of domestic and intimate partner violence have increased in countries affected by the COVID-19 pandemic.

- Abusive partners may withhold necessary items such as ARVs, hand sanitizer, or disinfectants.
- Abusive partners may share misinformation about the pandemic to control or frighten survivors, or to prevent them from seeking appropriate medical attention if they have symptoms.
- Travel restrictions may impact a survivor’s escape or safety plan.
- An abusive partner may feel more justified and escalate their isolation tactics.
  - Greater isolation = more risk to individuals in violent or controlling relationships.

If the lockdown continues for 6 months, 31 million additional GBV cases can be expected.

For every 3 months the lockdown continues, an additional 15 million cases of GBV are expected.

Sources: UNFPA (2020); National Domestic Violence Hotline (2020)
We need solutions that work for all

Those that use a combination of in-person and technology-based approaches...

- Ensuring HIV service providers provide first-line response to those who disclose experience of violence and refer to GBV services.
- Supporting one-stop or specialized centers to continue providing services or doing more virtual outreach and safety planning via phone or internet.

To low-tech options...

- Adapting existing physical spaces (e.g., pharmacies) to provide or link to services, or the use of ‘alert chains’ to call for help.

To those that reach the extremely isolated and vulnerable.

- Using code words or ‘silent alarms’ to signal that a survivor needs assistance.
And that includes supporting the health care and social service workforce

• Additional training and supportive resources on GBV **first-line response** and managing disclosures of violence.

• Tips on adapting **safety planning** to a pandemic and global lockdown, including how to assist clients who have not disclosed their HIV status to their partner/family about how they can safely take their ARVs.

• Managing the **trauma and psychosocial distress** experienced by survivors or among those providing care.
COVID-19 & GBV Response: Experiences from a USAID Local Partner

Zambia Center for Communications Program (ZCCP) Kwatu

Stop GBV Project
What was the program like/services before COVID-19

❖ Program based on interpersonal contact.

❖ Awareness creation and sensitization through community mobilization and dialogues.

❖ Survivors report cases of GBV to the Chiefdom Secretariats, Police Victim Support Unit and One Stop Centers (OSC).
The impact/challenges of COVID-19 on reaching people and delivering services

- Community members are shunning services in fear of contracting COVID-19.
- Reduced time for interpersonal contact.
- Difficult to mobilize community members for community dialogues and awareness meetings.
- Court sessions halted as a result of COVID-19 impacting the disposition of GBV cases.
Programmatic solutions to COVID-19 related challenges

❖ Use of **hotline & community radio** to provide GBV & COVID-19 prevention and mitigation messages, psychosocial support, and information on accessing services

❖ Leveraged influence of **traditional and faith leaders** to sensitize communities

❖ **Trained One-Stop Center staff** on COVID-19 and provision of safe and timely GBV services; provided COVID-19 prevention commodities

*Continued engagement of traditional leaders:*
Chief Madzimawe
1. **Weekly tracking** of GBV cases through One-Stop Centers, Childline/Lifeline and Zambia Police Service Victim Support Unit.

2. One-Stop Centers have **dedicated Data Entry Clerks** to provide timely data.

3. **Collaboration** with GBV cooperating partners to determine and establish best practices.
Technical Resources
USAID and PEPFAR


WHO

Questions and Discussion
Thank you!

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