



ASAP WEBINAR

ON

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

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Questions and Answers

ACCELERATING SUPPORT TO ADVANCED LOCAL PARTNERS (ASAP)

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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:

- Amelia Peltz, Team Lead and Senior Gender Advisor (apeltz@usaid.gov)
- Emily Reitenauer, Gender Advisor (ereitenauer@usaid.gov)

GEND_GBV and the Minimum Package

1. In the advent of COVID-19, are there any plans to include COVID-19 testing as part of the Post Violence Minimum Package?

The minimum package of post-violence clinical care services, as defined by the World Health Organization and PEPFAR, are the minimum services that a site must have in place to respond to the clinical needs an individual may have as a result of experience of violence. Sites that offer COVID-19 testing may offer COVID-19 testing to survivors of violence who present for clinical services, but COVID-19 testing is not a part of the minimum package. There are currently no plans to add testing for COVID-19 to the minimum package for post-violence clinical care.

2. My observation is that PEPFAR funds do not cover treatment of injuries and STI treatment for gender-based violence (GBV) survivors. Why is this and how do we handle it?

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 (LIVES¹)
- Referrals to non-clinical GBV response services, such as longer-term psychosocial support, child protection, shelter, legal, police, economic empowerment, etc.

Although all of these services must be in place for a site to report on GEND_GBV, PEPFAR funds do not cover treatment of injuries, STI testing/screening and treatment, or emergency contraception. These are clinical services that are meant to be delivered in a clinical setting. Sites should already have clinicians available to treat injuries. Funding for STI testing/screening and STI treatment and emergency contraception should come from other funding sources, including funding from country governments or other international donors.

¹ LIVES is a mnemonic which stands for Listen; Inquire about needs and concerns; Validate; Enhance Safety; Support. Please consult *Health care for women subjected to intimate partner violence or sexual violence: A Clinical Handbook* (WHO, 2014) for further information.

If sites do not have access to other sources of funding and are unable to provide all of the services in the minimum package of post-violence clinical care services, they should not have GEND_GBV targets nor should they report on GEND_GBV. They can, however, report on custom indicators used to capture the provision of post-violence clinical care, including referrals to sites that provide the clinical violence response services that are not funded by PEPFAR.

3. Church organizations do not talk about contraceptives. I am concerned about the minimum package in their HIV and GBV program. What do you think can be done here?

Any organization that does not provide emergency contraception can still provide post-violence clinical care services. These organizations cannot, however, report on GEND_GBV. We encourage these organizations to instead use custom indicators to report their post-violence clinical care service delivery.

It's important to note, though, that emergency contraception is a key component of the post-violence minimum care package. If organizations do not provide emergency contraception, they should actively refer clients who experience sexual violence and are eligible for emergency contraception (i.e., clients are biologically female, child-bearing age, present within 120 hours) to sites that do provide emergency contraception. Given the time sensitivity of this service, ideally organizations would provide assistance to clients in completing the referral for emergency contraception in a timely manner. More information on emergency contraception can be found [here](#).

4. Can you report GEND_GBV if part of the minimum services are offered or provided in an outreach or satellite area?

To count an individual as reached under the GEND_GBV indicator, the site must be able to provide all of the services in the minimum package of post-violence clinical care, even if the client chooses not to take some of the services. A "site" in this case could include an outreach or satellite area as long as it has a direct connection to the main site (such as a hospital or clinic or one-stop center). For example, it could be a mobile site that is part of a health clinic's outreach services, or an adjacent building as part of a larger hospital complex. The key is that the outreach or satellite site has a direct connection to the main site that has GEND_GBV targets.

5. GEND_GBV is annually reported. How do we count those who experienced abuse twice or more during the reporting period?

An individual should be counted each time they access services for experience of gender-based violence, even if this is more than once during a reporting period.

6. Why is it that case management can't be included under GEND_GBV?

GEND_GBV captures the provision of the minimum package of post-violence clinical care and biomedical services. Case management, while often an important component of post-violence care, is not always feasible at every site in every country. We encourage partners and country

teams that do conduct case management for those who experience violence to report on this important activity using custom indicators.

7. You said the program does not include longer term psychosocial support. How about the person who has been severely emotionally tortured?

Psychosocial support is an important component of post-violence care. Many USAID HIV programs do provide psychosocial support to clients who experience violence, but this activity alone cannot be reported under GEND_GBV. GEND_GBV captures the provision of clinical services and referrals to non-clinical services, including referrals to longer-term psychosocial support.

8. When providing victims of SGBV emergency contraceptives, is it going to be a one off or for some days?

This depends on the form of emergency contraception administered.

- 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](#).

9. Can you elaborate on "comprehensive services for a survivor"? What are the elements included in this?

Every survivor has their own unique and individual needs. The term “comprehensive services for a survivor” often refers to the minimum package of post-violence clinical services that a site must provide in order to report on GEND_GBV. The minimum package 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.

This comprehensive package of clinical services should be offered to all survivors of violence as appropriate.

10. If a partner has to report on the indicator GEND_GBV but STI treatment and treatment of injuries do not exist on the PEPFAR sites but PEP exists, will the partner still not report the survivors accessing PEP in DATIM?

If any components of the minimum package of post-violence clinical care services, including STI testing/screening and treatment, are not provided at a site, that site cannot report on GEND_GBV or the PEP disaggregate of GEND_GBV in DATIM, even if the site does provide PEP. We encourage partners that provide post-violence care services, but not the full minimum package, to instead report on custom indicators. Results from these indicators can be reported into DATIM within indicator narratives for GEND_GBV or other relevant indicators.

11. When survivors present with physical injuries, how do we provide medical services since we only provide PEP on the USAID funded project?

If a survivor presents with physical injuries, they should receive medical treatment by the trained clinicians at that site. If the site does not have clinicians that can treat the injuries of survivors of violence, then the site should not report on GEND_GBV or the PEP disaggregate in DATIM. The site can still administer PEP to those who need it, and we encourage the site to report on the provision of this service using custom indicators, but the site cannot report on GEND_GBV.

Other Gender- and GBV-related Data and Measurement

12. GBV data isn't reported or captured by the Tuberculosis (TB) program. How then can this indicator be monitored within the TB program?

If sites that offer PEPFAR-funded TB services also offer the full minimum package of post-violence clinical care services, these sites can provide post-violence clinical care services and also report on GEND_GBV. If the site does not provide the full minimum package, then the site cannot report on GEND_GBV.

We currently do not recommend screening for experience of violence within TB service delivery; however, if an individual discloses experience of violence to a provider within the context of TB service delivery, the provider should be able to respond appropriately (provide first-line support) and refer that individual to local clinical and non-clinical GBV response services. The provision of first-line support and referrals to GBV response services could be captured using custom indicators.

13. What is the best source for guidance on community-based prevention activities, including measurement?

USAID PEPFAR programs implement numerous evidence-based, community-based HIV and GBV prevention programs, including (but not limited to) [SASA!](#) and [Stepping Stones](#).

These interventions can be reported on using the custom indicators, including [GEND_NORM](#) - a custom indicator which captures the number of people completing an intervention pertaining to gender norms that meets the minimum criteria. 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.

Additionally, USAID's [Passages Project](#), although not specific to HIV, has done work on the implementation, measurement, and scale-up of community-based norms change interventions. Much of their work is applicable to community-based prevention interventions.

14. Do we have data on violence against men?

There is limited data on violence against adult men who are part of the general population. Based on available data, we know that women, children, and key populations (including men who have sex with men) experience high levels of violence and the violence they experience makes them more vulnerable to HIV acquisition. As such, responding to violence against these populations are priorities for USAID PEPFAR programs.

15. Does the data on GBV cover areas with conflicts or not?

There is existing data on GBV in conflict settings, and it has been well documented that there are often increases in GBV in areas of conflict, particularly those countries with a high baseline level of domestic and intimate partner violence. When looking at regional estimates of GBV, it's important to recognize that these regional estimates may mask national and sub-national estimates of violence, including in areas of conflict, that may be much higher than regional estimates.

16. Are the projected estimates of IPV when the COVID-19 outbreak persists based on current data on IPV? Are there global reports on IPV so far during COVID-19?

In April 2020, UNFPA, based on available data, predicted that 31 million additional cases of GBV would be reported if lockdowns continued for six months. UNFPA also predicted that for every three months the lockdowns continued, an additional 15 million cases of GBV would be expected. There are currently no global reports on data on intimate partner violence during COVID-19, but there have been anecdotal reports within countries about increases in violence, as well as reported increases in calls made to police and calls made to violence response hotlines.

It's important to note that collecting data about experience of intimate partner violence during lockdowns is difficult and, at times, can put survivors in unsafe situations. It's also important to note that there has been a drop in the number of individuals who are accessing post-violence clinical care services during COVID-19, which is often the result of government-mandated restrictions on mobility, fear of presenting at a clinic and contracting COVID-19, as well as being under the close watch of a perpetrator who limits the survivor's mobility and ability to speak to others.

GBV Case Identification

17. Please provide clarification on why GBV inquiry is not recommended at VMMC sites.

Routine enquiry for intimate partner violence should only be implemented within certain specific services where violence is a known risk factor for HIV and can impact HIV outcomes.

Evidence demonstrates that experience of violence serves as a barrier to uptake of HIV services for many women and key populations. It has been found that experience of violence negatively impacts adherence to PrEP, as well as adherence to and retention in care and treatment. Additionally, experience of violence impacts one's ability and willingness to disclose their HIV status to their partner. Experience of violence can also put a client at risk when partaking in index testing and partner notification services. Currently there is no similar evidence base on the link between violence and VMMC service delivery.

Given that the goals of GBV case identification within USAID's HIV programming are to do no harm, improve HIV outcomes, and link survivors to the HIV and GBV services that they need to be healthy and safe, the implementation of GBV case identification in clinical settings is only recommended for PrEP, index testing, and care and treatment service delivery.

18. There are some communities that are so quiet about GBV, in fact some feel that it's part of culture. This can make it difficult to do IPV enquiry. Are there any strategies that could be used to conduct proper IPV inquiry in these communities?

GBV case identification should only happen in the delivery of PrEP, index testing, and care and treatment services, or when assessing risk and vulnerability for enrollment into community-based programs, such as OVC and DREAMS. When determining which questions providers and healthcare workers should ask to determine if a client is experiencing violence, partners should consider the cultural and community context in which they are working and develop questions that are phrased in a manner that is culturally sensitive. It's also important for partners to train providers and healthcare workers on how to bring up the topic of violence and ask these questions in a manner that makes the client feel safe to disclose.

If the client chooses not to disclose experience of violence, but the provider or healthcare worker suspect that a client is experiencing violence, the provider or healthcare worker should still provide first-line support (LIVES) and give the client information about locally available GBV response services. Providers and healthcare workers should never force a client to disclose experience of violence.

19. Can you elaborate on identifying cases in the faith-based facility and referring them to sites that offer FP.

Faith-based facilities that provide PrEP, index testing, or care and treatment services should conduct clinical and, if necessary, routine enquiry for intimate partner violence. If a client discloses experience of violence or if the providers suspect a client is experiencing violence, the provider should provide first-line support (LIVES), as well as offer and/or refer the client to local GBV response services. Emergency contraception is an important clinical GBV response service, but is only needed if a client presents within 120 hours of experience of sexual violence. If sites provide clinical GBV response services but do not provide family planning services, including emergency contraception, those sites cannot report on GEND_GB. They can, however, refer clients who are experiencing violence to sites that do offer family planning services.

20. Are there any referrals that you can make apart from clinical services?

When an individual who has experienced or is experiencing violence has been identified, they should be provided with first-line support and offered referrals to clinical and/or non-clinical GBV response services as needed. Non-clinical GBV response services where clients can be referred include long-term psychosocial support, child protection, legal, shelter, police, economic empowerment, or case management from a social worker.

21. Are the tools for clinical enquiry different from the tools for routine enquiry?

Clinical enquiry is when a trained provider identifies signs and symptoms of violence. When an individual exhibiting these signs and symptoms is identified, the provider asks a series of questions to determine if the individual is experiencing violence. Routine enquiry is when all individuals who present for certain, specific services, such as PrEP and index testing, are asked about experience of violence using a tool that contains a standard set of questions where providers can document responses. The questions used to ask about violence in clinical and routine enquiry can be similar or the same, but the process is different. Nevertheless, for both clinical and routine enquiry, sites must meet these minimum requirements in order to ask about experience of violence:

- 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.

Training and Resources

22. Do we have a standardized PEPFAR training package for LIVES?

The World Health Organization'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 has adapted this training for USAID HIV programs and is currently rolling out this training to USAID HIV country teams and implementing partners. Please contact Amelia Peltz (apeltz@usaid.gov) and Emily Reitenauer (ereitenauer@usaid.gov) for more information.

23. Does USAID have in-country facilitators that will orient and train implementers and providers on GBV? It is an area where we still need more information.

If partners have specific technical or training needs, please communicate this to your A/CORs or Activity Managers. USAID country teams have Gender Advisors and/or Points of Contact that can provide support on GBV programming. The Gender and Sexual Diversity Branch in the Office of HIV/AIDS in USAID/Washington is also available to provide technical assistance to USAID country teams and implementing partners as needed.

24. Are there guidelines for first-line support at the community-level and is there a discussion guide to tailor community case workers' conversation with survivors as part of administering first-line support?

At both the community- and facility-level, first-line support should be provided to all individuals who disclose experience of violence. The principles for the provision of first-line support using the LIVES approach are the same at the community-level as they are at the facility-level. Within LIVES:

- **L** stands for **Listen**. This means listen closely to the survivor with empathy and do not judge them.
- **I** stands for **Inquire**. This means assessing and responding to the survivor's emotional, physical, social, and practical needs and concerns.
- **V** stands for **Validate**. This means that when someone discloses that they have experienced violence, the provider shows that they believe and understand the survivor.
- **E** stands for **Ensure Safety**. It is important to discuss how to protect the survivor from further harm.
- **S** stands for **Support**, which involves helping the survivor connect to clinical and/or non-clinical GBV response services and other forms of social support.

There isn't a standardized discussion guide for the provision of first-line support with USAID HIV programs, but the World Health Organization'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 that are applicable to community health workers.

25. Do you have training, guidelines, standards or caveats for partner notification services?

PEPFAR has developed guidelines, standards, and training on index testing and partner notification services. This includes guidance and training on the implementation of routine enquiry for intimate partner violence (IPV). Within partner notification services, this is often referred to as the IPV Risk Assessment. These tools and guidelines can be found on the [PEPFAR Solutions Platform](#). Please reach out to your USAID country team HIV Testing Advisors for more information.

Violence Against Children and OVC Programming

26. Where were the VAC surveys conducted? What is the experience with violence in schools and is there anything to address the challenge?

Countries that have conducted Violence Against Children Surveys (VACS) and have published the findings include:

- Botswana
- Cambodia
- Colombia
- El Salvador
- Eswatini
- Haiti
- Honduras
- Lao PDR
- Kenya
- Malawi
- Nigeria
- Rwanda
- Tanzania
- Uganda
- Zambia
- Zimbabwe

Published VACS reports can be found [here](#). School-related GBV remains a challenge. Many USAID HIV programs do address violence within schools through OVC and DREAMS programming through a number of evidence-based and innovative methods. For example, in Zimbabwe’s DREAMS program, FHI360 supports the placement of anonymous boxes in schools that are opened two to three times a week by a GBV Committee in schools. Additionally, within USAID’s broader developmental programming, school-related GBV is also addressed by USAID education programs.

27. Can you please explain the best way of providing first-line support to a child?

There are unique considerations that need to be addressed when providing first-line support to a child who has experienced abuse. Many of these considerations are discussed in the World Health Organization’s [Responding to children and adolescents who have been sexually abused: WHO clinical guidelines](#). Additionally, 4Children’s [Integrating violence against children prevention and response into HIV services](#) is a training for providers that reviews the provision of first-line support to children who experience sexual abuse.

28. Do we consider sexual violence against children as 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. Many forms of violence against children, including sexual violence against children, are gender-based violence. Structural inequalities and power imbalances due to age and gender perpetuate GBV against children. Forms of GBV against children can include child abuse, including sexual abuse; female infanticide; neglect; child marriage; female genital cutting/mutilization; trafficking; etc.

29. How do we clarify the reporting duplication when an OVC partner reports a GBV case based on referral and a treatment partner who provided services like HTS, and post-GBV?

GEND_GBV captures the provision of post-violence clinical care based on the minimum package. If an individual receives post-violence clinical care at a site that provides the full minimum package, that site should report on GEND_GBV. If within the context of receiving services for post-violence care a survivor is tested for HIV, the site would report that individual under HTS_TST. This would not be double-counting as these indicators capture the delivery of different services. Furthermore, the provision of HTS and/or post-violence care is different from a referral for GBV services, which is what an OVC partner would report under OVC_SERV.

30. What resource did you refer to for children and adolescents?

Here are six key resources for responding to GBV against children:

- WHO. [Responding to children and adolescents who have been sexually abused: WHO clinical and guidelines](#)
- WHO. [INSPIRE: Seven Strategies for Ending Violence Against Children](#)
- AIDSFree. [Clinical management of children and adolescents who have experienced sexual violence](#)
- AIDSFree. [Strengthening linkages between clinical and social services for children and adolescents who have experienced sexual violence: A companion guide](#)
- LVCT Health. [Integrating Violence Against Children Prevention and Response into HIV Services - Training for health care providers](#)
- Together for Girls. [Resource Bank](#)

31. Would you have guidelines for GBV assessment, prevention or management of GBV in COVID-19 Quarantine Centers or in isolation at home for children?

While PEPFAR does not currently have guidelines for the provision of GBV-related services in COVID-19 Quarantine Centers, technical guidance on gender-based violence and child protection within PEPFAR programs during COVID-19 can be found [here](#) (on page 33). Please also see UNICEF's [COVID-19: Protecting Children from Violence, Abuse and Neglect in the Home](#) for suggestions on prevention and response strategies.

32. Knowing that community collaboration and cultural respect is important for sustainability of programs, how do you expect to integrate child protection correctly without being culturally insensitive, i.e. mild child spanking?

For more information on the US government's approach to child protection programming, please see [Advancing Protection and Care for Children in Adversity: U.S. Government Strategy for International Assistance, 2019-2023](#).

33. What is the proper way to mainstream GBV activities in child safeguarding?

There are many resources on addressing violence against children listed in Question 30. Please also see USAID's [Fact Sheet on Preventing Sexual Exploitation and Abuse](#).

34. We have realized that once VAC is incorporated into GBV it loses its importance. For VAC, the children are protected by statutory laws, including the Child Welfare and Protection Act. We have seen cases of children who have not been reported for violence response interventions. How can we best ensure that authorities are aware of the difference of the two?

Many countries have laws and policies addressing violence against children as well as gender-based violence or violence against women. It is important for all stakeholders working with these populations to be aware of the rights outlined in the laws and policies, and the roles and responsibilities of duty bearers to prevent and respond to violence.

35. What should be the strongest link between OVC community programs and ART sites on GBV prevention and response services, in terms of clinical and non-clinical GBV care?

It is very important to have strong, bi-directional referrals between clinic and community programs to ensure that all survivors have access to services that meet their needs. Each case is different, and service provision for children should always be guided by the principle of the best interests of the child or adolescent, the principle of evolving capacities of the child or adolescent, the principle of non-discrimination, and the principle of participation.

Key Populations and LGBTI

36. What does the LGBTI individual stand for?

“LGBTI” is an umbrella term that stands for Lesbian, Gay, Bisexual, Transgender, and Intersex.

37. What is most important to address in our country - HIV or GBV the two? Because LGBTI have a lot of problems in relation to GBV.

HIV and GBV are mutually reinforcing epidemics. Given the impact of GBV on HIV outcomes, it is necessary to address both HIV and GBV concurrently within USAID PEPFAR programming. Key populations (KP) and gender and sexual minorities (GSM) experience high levels of violence that often put them at an increased risk for HIV acquisition and make it difficult for those who are living with HIV to adhere to and be retained in treatment. Within USAID’s key populations programming, it’s important to respond to violence against KP and GSM and ensure that those who are experiencing violence are linked to the HIV and GBV services they need to be healthy and safe.

38. Will you send the data on GBV amongst key population on the website dedicated for GBV?

USAID’s PEPFAR-funded [LINKAGES](#) project and [EpiC project](#) contains data, resources, tools, and visualizations on violence experienced by key populations. These are good resources for data on violence against key populations.

39. In our context, we face a challenge to address GBV, this challenge is about denunciation. Some survivors, mostly female sexual workers, do not want to identify their authors because of the lack of their protection. So what mechanism can we put in place to protect those survivors?

Female sex workers face extremely high levels of violence, stigma, and discrimination, and are often subjected to violence by law enforcement. Protecting female sex workers’ rights to privacy and confidentiality are essential when providing them with HIV and GBV services. Two helpful

resources are USAID’s PEPFAR-funded LINKAGES project’s [Violence Prevention and Response in Key Populations Programming](#), and the [Implementing Comprehensive HIV/STI Programmes with Sex Workers](#), also known as the Sex Worker Implementation Tool (SWIT).

Questions for the Zambia Centre for Communication Programmes (ZCCP) Kwatu

40. Are there significant differences in the number of cases being reported now during COVID compared to other quarters? Which types of GBV are you seeing most?

Unlike what is happening around the world where the number of reported cases for GBV is increasing, we have seen a decrease in the cases being reported during the COVID-19 period. Physical assault is the most reported followed by psychological/emotional abuse. However, we know that this isn’t the true picture as most of the cases are going unreported. We have some anecdotal evidence that people are shunning health facilities to access post GBV services for fear of contracting COVID-19 from health facilities. In addition, it is believed that perpetrators are spending more time at home which makes it difficult for the survivors to find space to report.

41. Can Doreen provide a link to ZCCP's COVID-19/GBV initiatives?

We trained our Community Activists (CAs), faith and traditional leaders in GBV and COVID-19 prevention and response. We are now working with various chiefdoms to cascade the training at chiefdom and village levels. During the community dialogues on GBV and HIV prevention and response, CAs discuss COVID-19 messages as part of their dialogues and conversations with community members.

We are airing radio programmes on community radio stations and the discussions include COVID-19 prevention and response. The project worked with the Ministry of Health (MoH) to develop scripts on COVID-19 for the radio programmes. MoH staff are part of the discussants for the radio programmes and they provide detailed information on COVID-19 prevention and response.

However, we do not have a specific link for ZCCP’s various initiatives on COVID response in relation to GBV. We use the links below as our guides; PEPFAR link - <https://www.state.gov/pepfar/coronavirus/>, for SASA! and SASA! Faith we use the Raising Voices guides SASA! - <https://raisingvoices.org/sasa/> and SASA Faith - <https://raisingvoices.org/sasa-faith/>

42. How do you measure the programmatic index for human participation, e.g. people reached by sensitization through radio programs, IPC, and community stakeholder involvement?

The project has specific tools that collect coverage information. For sensitization activities like mobile video shows and drama, we approximate the numbers. For radio programmes, we equally approximate the reach based on the coverage of that community radio although with modern technology, some radio stations are able to provide information on the number of people tuned in at a particular time.

For community engagement, we use either training registers or meeting attendance sheets which help to have the actual numbers for participants.

43. What is your experience with the religious leaders; did they encourage reporting of GBV cases among their following?

We consider religious leaders as a key stakeholder in the fight against GBV and we involved them from the project inception and some of them are our community activists at community level. The issues of reconciliation and forgiveness are real in churches.

At National level, we engaged the Ministry of National Guidance and Religious Affairs to get Government support on addressing issues of GBV and HIV in religious groupings. We also engaged different faiths from the top level through the Zambia Interfaith Networking Group which is a body that brings together all faith mother bodies in the country. With this acceptance at the top level, it was easier to engage at a lower level and the project use churches as local structures where prevention of GBV has been encouraged.

In addition, we trained the local faith leaders (district and community level) in SASA! Faith which has helped them to understand the importance of GBV and HIV prevention and the need to take action.

44. What provisions do you have to ensure prompt referral for post GBV services, especially for those who cannot even afford to pay for these services or where there are challenging issues of logistics, for those in hard to reach locations?

Strengthened multidisciplinary network has helped to ensure prompt referral of survivors for post GBV services. We are currently building the capacity of the One Stop Centre (OSC) staff, clinicians from surrounding health facilities, police, social welfare and other key players in multidisciplinary management of GBV survivors. This training has helped the different disciplines to understand their role and the need to refer survivors to other services.

Provision of phone credit for the OSCs has also helped them to communicate with communities and respond to cases accordingly.

All GBV related medical services are free (e.g. medical reports, x-ray, scan, lab tests) and that is mandated by the Anti GBV Act of 2011. For any advanced medical investigation e.g. CT scan, a social worker is involved as they are mandated to provide evidence for exemption of fees.

In terms of reaching people in the hard to reach areas, radio programmes have helped in providing COVID-19 and GBV awareness messages. Information on prevention and response is publicized including the use of the toll-free Lifeline/Childline hotlines (116 and 993) which provides further referrals to the OSCs.

For logistics, a vehicle per OSC was provided by the previous project and handed over to Government – MoH at the close of the project. These vehicles are used by the OSCs to follow up

on cases. Where the health facility has some challenges to provide for fuel due to late access of grants from the Government, the project is able to step in but we are quite strict because we want to support sustainable operations of the OSCs.

45. Was it easy to engage traditional and faith leaders in the process? Did they really participate and give their help?

The traditional and faith leaders have been involved in the project from inception. Most of these leaders are very supportive and have been trained in either SASA! or SASA! Faith which helps them to understand the importance of preventing GBV and HIV. The project uses local structures e.g. church or chiefdoms for cascading GBV prevention messages. Some of the activities these leaders have been involved in are:

- Chiefs and their headpersons have owned the project activities especially that they are community based.
- Chiefs have allowed for chiefdom by-laws to be codified with support from the project and this supports the fight against GBV, HIV and Violence Against Children.
- The project established Chiefdom Secretariats in selected chiefdoms which are a first response centre for GBV at chiefdom level and referrals are made to the OSC and other service providers.
- Some faith leaders have helped us organise SASA! conversations in their churches.
- Faith leaders have been trained specifically for men to get involved in prevention of HIV and to encourage men to test for HIV.
- Faith mother bodies have been trained and are willing to participate in project activities.

46. Do you have a child protection committee at community level, and how have they supported GBV prevention, identification and referral for Post GBV care during the COVID-19 period?

We have child protection committees (CPCs) at district level and which are replicated at community level although some communities are not functional and others are in the process of forming the committees with support from the project.

Other than working with CPCs at community level, in communities where these structures are not functional, the project is working with Community Welfare Assistance Committees (CWACs) and Community Development Assistants (CDAs). CWACs are volunteers under the Social Welfare Department and CDAs are employees under the Community Development Department of the Ministry of Community Development and Social Services (MCDSS). One of the roles of CWACs at community level is to assess the vulnerability of community members that includes GBV therefore, they identify and refer GBV cases to the OSCs for post GBV care services. The CWACs also handle child protection issues at community level. CDAs supervise the CWACs at community level.

For GBV prevention, some CWAC members are our community volunteers who spearhead GBV prevention activities in the communities. In addition, these CWACs work hand in hand with the community structures that we work with e.g. Chiefdom Secretariats, therefore, they are well equipped in providing prevention messages.

During the COVID-19 period CAs, CWACs and Chiefdom Secretariats are able to communicate with the toll-free line or the OSCs to link the identified cases in the community for services.

47. Could you share any tool or module on GBV and PLWD that one can use?

We don't have a specific module as disability is mainstreamed in the project however, some of the guides that have helped us are below.

- https://www.usaid.gov/sites/default/files/documents/1866/Mainstreaming_Disability_Across_The_Program_Cycle_and_Beyond_Toolkit_Digital_revised_9_5_2019.pdf
- https://www.usaid.gov/sites/default/files/documents/1861/July_21_Disabilities_and_GBV
- <https://www.usaid.gov/documents/1865/addressing-gender-based-violence-through-usaid-s-health-programs-guide-health-sector>
- https://www.usaid.gov/sites/default/files/Guide_How_Integrate_Disability_Gender_Assessments_2010.pdf
- The SASA! modules - SASA! - <https://raisingvoices.org/sasa/>
- The Coaching Boys into Men Handbook
- Safe Spaces Stepping Stones Module

Other

48. What about GBV prevention?

GBV prevention is an important component of USAID's HIV prevention programs and is part of the third technical priority for USAID's gender and GBV programming in HIV services. USAID partners should implement evidence-based HIV and GBV prevention interventions. This is often done through community-based DREAMS, OVC, and/or key populations programming. Results from these interventions can be captured using custom indicators, including [GEND NORM](#), as well as indicators from [these two](#) compendiums developed by MEASURE Evaluation.

Outside of asking about experience of violence when assessing risk of or vulnerability to HIV for the purposes of enrollment into community-based programs, such as DREAMS and OVC, sites should not actively identify survivors of violence in community-based HIV and GBV prevention interventions. However, if individuals do disclose experience of violence within the context of HIV and GBV prevention interventions, they should be linked to clinical post-violence care services. Additionally, those who present for clinical post-violence care services should be linked to community-based HIV and GBV prevention interventions as appropriate.

49. How can one assist women’s suffering from violence and HIV during COVID-19, because there are transport problems, as well as concerns about drugs and equipment?

There are numerous ways to assist women who are living with HIV and experiencing violence during COVID-19. USAID Implementing partners can ensure that clinical HIV service providers provide first-line support (LIVES) to those who disclose experience of violence and refer to local clinical and/or non-clinical GBV response services. Implementing partners that support one-stop-centers or specialized GBV response centers should continue to support the provision of clinical violence response services, as well as increase virtual outreach and safety planning via the phone and/or internet. Implementing partners can also adapt existing physical spaces (e.g., pharmacies) to provide or link survivors to services, or use ‘alert chains’ to call for help.

Partners that support community health workers can provide additional training and supportive resources on GBV first-line support and managing disclosures of violence. Partners can also support community health workers to conduct safety planning while under lockdowns, including how to assist clients who have not disclosed their HIV status to their partner or family about how they can safely take their ARVs.