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AIDSFree Strengthening High Impact Interventions for an AIDS-free Generation

LESSONS FROM THE GENDER-BASED VIOLENCE INITIATIVE IN MOZAMBIQUE

JANUARY 2016

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ACRONYMS

GBV	gender-based violence
GBVI	Gender-Based Violence Initiative
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
USAID	U.S. Agency for International Development
USG	U.S. Government
WHO	World Health Organization

INTRODUCTION

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

The GBVI focused on multiplying the effects of the initial investment beyond PEPFAR activities to encourage adaptation of GBVI strategies and galvanize momentum. This included developing national guidelines, strengthening coordination across sectors, and building the capacity of clinic- and community-based services within the context of the existing HIV platform.

Little is known about the potential for synergy created by various models for GBV interventions, such as simultaneously addressing GBV prevention and response; taking a selected set of approaches or a multicomponent GBV program model across the PEPFAR platform; and combining facility-, community-, and individual-based GBV interventions. The PEPFAR Gender and Adolescent Girls Technical Working Group asked AIDSFree to synthesize lessons from all three countries on integrating GBV prevention and response within the HIV cascade of services. These lessons, in turn, can inform PEPFAR programming and other donor initiatives in the design of future investments in GBV prevention and response.

For Mozambique, the AIDSFree team reviewed 390 documents and gathered information in Sofala and Maputo provinces from more than 40 global and in-country stakeholders (implementing partners, community-based and nongovernmental organizations, government officials, US government agencies, United Nations organizations, health care workers, community leaders, HIV counselors and peer educators, and service providers) through semi-structured interviews, focus group discussions, and a two-week country visit.

This report describes lessons learned from the GBVI in Mozambique.

GBV and HIV Prevalence in Mozambique

Mozambique, with an estimated HIV prevalence of 11.5 percent, is one of the countries most burdened by the epidemic in sub-Saharan Africa; and women are disproportionately affected (INS, INE, and ICF Macro 2009). Women's vulnerability to HIV is also reflected in the magnitude of GBV prevalence: 37 percent of women ages 15-49 reported having experiencing any form of GBV in their lives (including emotional, physical, or sexual violence), and 12 percent reported ever being forced to have sexual intercourse—7 percent in the last 12 months (MISAU, INE, and ICFI 2011). Mozambique has the 10th highest rate of early marriage in the world, with 48 percent of women ages 20–24 reporting that they married before the age of 18 (Hodges 2015). Additionally, 19 percent of adolescent females reported forced sexual initiation (MISAU, INE, and ICFI 2011; Cruz, Domingos, and Sabune 2014). The bidirectional relationship between HIV and GBV globally has been established in the literature, providing ample validation for simultaneously addressing both epidemics (Jewkes et al., 2010; Ellsberg & Betron 2010).

Although country-wide survey data are lacking, emerging data suggest that sexual violence affects a significant proportion of orphans and other vulnerable children, including boys. While there is a paucity of data on key populations, such as men who have sex with men and people who inject drugs, it is well known that these groups often face additional barriers in accessing HIV and GBV prevention and response services due to stigma and discrimination, which places them at greater risk for both epidemics (Dunkle and Decker 2013).

Box 1. United States Government Definition of GBV

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

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

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

(U.S. Government 2012)

OVERVIEW

The GBVI in Mozambique

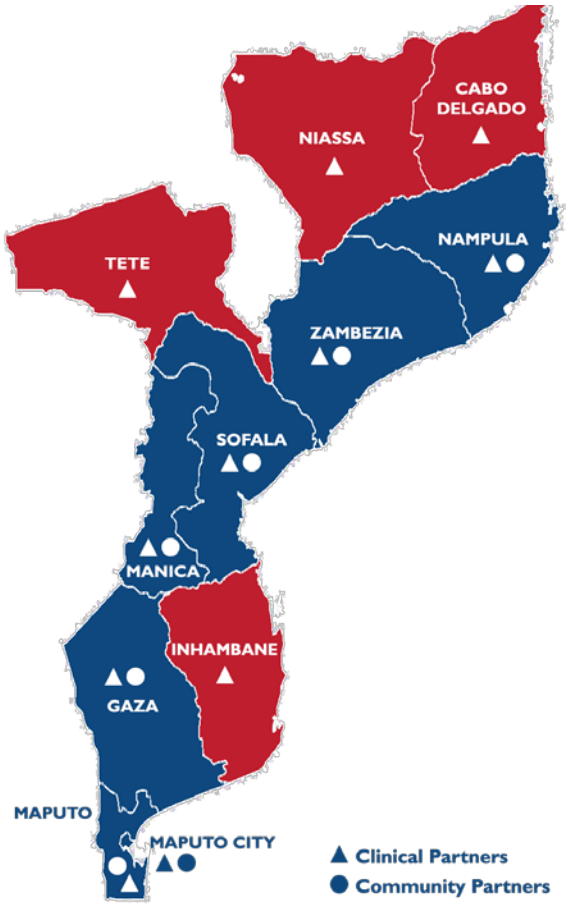
Box 2. GBVI Mozambique Objectives

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

In Mozambique, the US$21 million, 3-year GBVI was designed to prevent cases of GBV by addressing the sociocultural norms that condone it and offering comprehensive post-GBV care services for survivors. GBVI activities focused on the three primary objectives (shown in Box 2); 25 partners, listed in Annex 1, implemented activities to achieve these objectives with technical support from three US Government (USG) agencies: the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), and the Department of Defense.

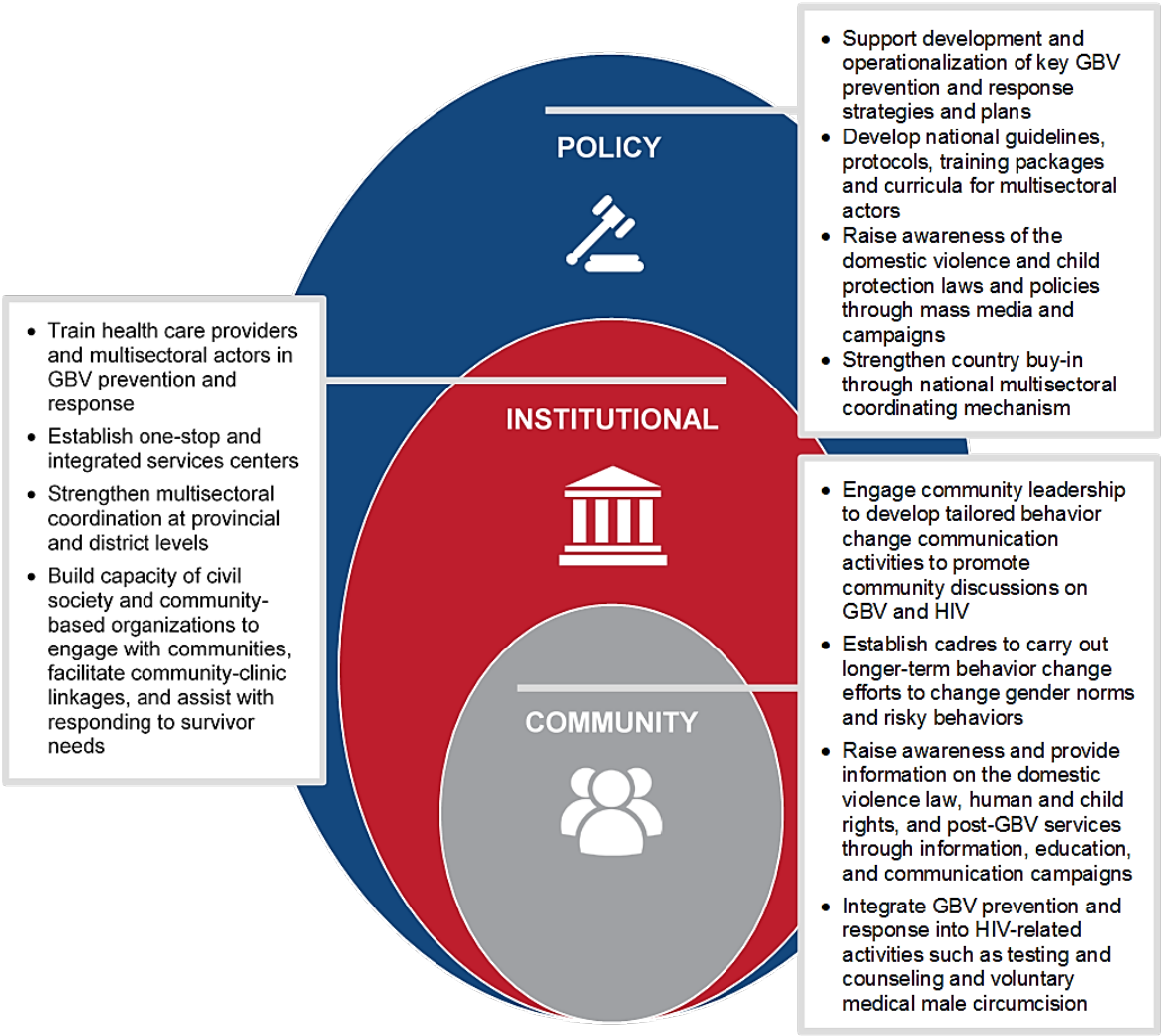
GBVI activities were implemented nationally. Each province had clinical and/or community partners, as illustrated in Figure 1. Exceptions were Niassa, Cabo Delgado, Inhambane and Tete provinces, which had clinical partners only. Priority areas within provinces were those with high HIV and GBV prevalence among women and girls, target groups (including special populations and military populations), USG presence, and current USG-supported PEPFAR activities that could be expanded to include GBV prevention and response. The GBVI in Mozambique did not set out to address specific types of GBV, but rather to respond organically to the country's existing needs.

Figure 1. Map of GBVI Mozambique Activities by Province



The GBVI was unique in Mozambique because it attempted to address GBV prevention and response using a multisectoral, multilevel approach that involved health and social services and legal and law enforcement at national, institutional/facility, and community levels. Figure 2 uses the socioecological model to illustrate the major GBVI activities in Mozambique and the interdependent relationship among the three levels. Every level on which the GBVI operated was closely connected to and influenced by the levels above and below it. Each activity required the engagement of the different sectors and staff at each level.

Figure 2. The GBVI Multisectoral Approach to GBV Prevention and Response



The outermost national/policy level shows the legal and policy environment that guided multisectoral GBV prevention and response activities conducted at the lower institutional levels. The GBVI helped to shape and operationalize plans and strategies, including a Multisectoral Plan and the National GBV Plan for the health sector. The GBVI supported the Ministry of Health, the Ministry of the Interior, and the Mozambican Armed Forces to develop GBV prevention and response pre-service curricula and modules, and conducted mass media campaigns and broader GBV and HIV awareness-raising activities at all levels.

At the institutional level, the GBVI supported activities to integrate GBV prevention and response within existing HIV clinical services, build clinical and medico-legal capacity, and establish comprehensive post-GBV care services. Activities were designed to build the capacity of nongovernmental and civil society organizations to include GBV within HIV prevention and behavior change communication activities. Journalists, including military journalists, were trained to report responsibly on GBV issues, including child sexual abuse and child protection.

The GBVI supported community-level prevention activities by harnessing existing HIV prevention initiatives. The GBVI used participatory and gender-transformative approaches to conduct information, education, and communication; social and behavior change; community engagement; and community-clinic linking activities. These included developing training manuals, communications packages, and audiovisual materials such as pamphlets, radio, and TV spots.

The Government of Mozambique's Response to GBV

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

In 2009, the Mozambican Parliament passed Law No. 29/2009: The Law on Domestic Violence against Women,[1] which civil society organizations and international partners, including those within the GBVI, have been disseminating throughout all levels of society and government. The recently revised penal code increased the penalty for sexually assaulting children.

In 2012, the government released the Multisectoral Mechanism for Integrated Assistance to Women Victims of Violence (hereafter "Multisectoral Mechanism"). This document outlines the roles and responsibilities of four ministries: the Ministry of Health, the Ministry of Justice, the Ministry of the Interior (police), and the Ministry of Gender, Children, and Social Action. The latter was assigned as the lead ministry for this mechanism and co-chairs a Gender Coordinating Group with *Forum Mulher* (Women's Forum), a local network of 84 women's organizations. The Gender Coordinating Group includes USAID, other donors, the United Nations, and civil society organizations. The first-ever national

[1] Article 36 of the law provides for gender equality so that in certain instances, the law applies to men as well.

multisectoral meeting was held in May 2015 with more than 250 participants from the four ministries and all government levels.

To guide the health sector response to GBV, the Ministry of Health, with support from GBVI partners, is currently developing a five-year National GBV strategy that is expected to be approved in 2016. The Ministry of Health has a GBV specialist and a focal point within the *Direcção Nacional de Assistência Médica* (National Department of Medical Care) and is working on defining GBV within sub-sector strategies, such as adolescent health.

The government has made several advances within the four Multisectoral Mechanism sectors, although significant challenges remain. Within the Ministry of the Interior, the government established the *Gabinetes de Atendimento Integrado à Mulher e Criança Vítima de Violência* (Cabinets of Assistance to Women and Child Victims of Violence, hereafter "victim service centers") usually staffed by female police officers. The victim service centers feature private spaces for GBV survivors to report cases, and are either stand-alone buildings or situated within police stations. There are 22 stand-alone centers and 238 victim service centers in the country.

The Government of Mozambique, independently and with assistance from the GBVI, has made several advances. However, the country continues to face a number of challenges. Shelters for GBV survivors are lacking, except for a few small centers established by civil society organizations. There are major human resource shortages in related sectors. For example, among Mozambique's 1,435 health units, there are only 78 psychologists, and the country ranks 163rd out of 175 countries for health worker density overall (WHO 2014).

GBVI SUCCESSES AND CONTRIBUTIONS

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

The GBVI has made many contributions to clinical and community-based approaches for comprehensive GBV prevention and response within the context of existing HIV prevention, care, and treatment services. It has created a space for discussion and dialogue on GBV, gender-related issues, and HIV prevention, care, and treatment across USG agencies, ministries, implementing partners, community-based organizations, and within communities. The GBVI activities have contributed to increased awareness of GBV in Mozambique and changes in the discourse on the sociocultural acceptability of violence, particularly against women and children, as well as increased dialogue about the important integration of GBV and HIV prevention and response activities. The proportion of men and boys affected by GBV also became apparent throughout the implementation of the initiative, and resulted in increased attention to this issue at all levels. Overall, the GBVI was reported to have contributed to increased visibility of GBV as a human rights issue with serious public health consequences. Government respondents, in particular, described the fundamental role of the GBVI in developing important GBV prevention and response policy documents and strategies. The GBVI is seen to have contributed to enhancing capacity building and operationalizing policies such as the Multisectoral Strategy at central, provincial, and district levels.

National/Policy-level Contributions

> *"Now everyone is on board, they are willing to open up a budget line to address prevention regarding GBV. Even the other day, someone from the Ministry of Culture, said they want to do a radio soap opera on GBV. It wasn't like this before. There is space to address GBV now."* (Government representative)

> *"Legal reform really takes a long time, but we see changes, like the Gabinete da Mulher e da Criança—we've now changed it to Gabinete da Familia, so that men can feel included…we've really achieved so much in so little time. A lot!"* (Government representative)[2]

One of the primary, overarching contributions of the GBVI was increasing the visibility of GBV. As in many countries, GBV was seen as a private issue to be addressed within the home or immediate family. To change such notions, the GBVI developed and supported numerous country-wide media and communications campaigns throughout the year, with increasing effort during the 16 Days of Activism Against GBV (November 25th to December 10th). Other strategies included developing radio spots and

[2] Respondent is referring to the Victims Service Desk, which used to refer exclusively to violence against women and children and now refers to violence against the family.

educational television soap operas that highlighted discussions about GBV and increase awareness of Law 29/2009 on domestic violence. The GBVI events and ongoing activities also drew attention to the availability of post-GBV care (such as post-exposure prophylaxis) and the relationship between GBV and HIV.

Over the years, the GBVI had an enduring influence on government priorities and became entrenched in the country's agenda, and other sectors and departments have also developed an interest in reducing GBV. The results of the extensive discussions about GBV and those it affects are also reflected in the government's decisions to change the names of key ministries and departments to recognize that men and boys also experience GBV.

The GBVI also influenced dialogue among and within USG agencies working in the country. Respondents from these agencies reported having comprehensive discussions on GBV and its societal implications beyond health. For example, the high GBV prevalence among girls raised awareness of child protection issues and the need to consider engaging institutions beyond health facilities, such as schools. Additional initiatives emerged as a result of discussions and activities facilitated by the GBVI.

In addition to policy documents, an array of key materials for post-GBV service delivery was produced through the GBVI. Several of these materials built on existing activities. In coordination with the Ministry of Health, the GBVI developed clinical materials for the country, produced national guidelines for post-GBV service delivery, training manuals, protocols, and algorithms (see Box 3).

Box 3. GBVI-supported Policy-level Achievements

Ministry of Health

- **Development of a National GBV Strategy for the Ministry of Health** (approval anticipated in 2016)
- **Inclusion of GBV in the Health Sector Strategic Plan** (Plano Estratégico do Sector Saúde—PESS 2013–2017), including funding to train forensic pathologists
- **Establishment of a supervision system** using GBV performance standards to ensure quality
- **Development of National Clinical and Policy Guidelines** for post-GBV response and care and accompanying handbook
- **Inclusion of GBV modules in pre-service curricula** for maternal and child health nurses and doctors
- **Establishment of a national recording system for GBV/post-exposure prophylaxis (PEP) cases**, including a data collection sheet and register book for GBV/PEP
- **Production of standardized GBV materials**, including posters, algorithms, and job aids for use in all health facilities.

Legal Medicine

- **Establishment of a National Institute for Legal Medicine** following the first National Legal Medicine meeting
- **Development of an official data collection form linking GBV survivors to the legal system**
- **Development of a three-month training curriculum on forensic pathology** for physicians.

Ministry of Gender, Children and Social Affairs/Multisectoral Activities

- **Operationalization** of the Multisectoral Mechanism for the Integrated Care and Response to Women Victims of Violence
- **Collaboration with other donors to include GBV** in the Government's Quinquennial Plan (2015–2020)
- **Inclusion of GBV** in the Social Economic Plan (Plano Economico Social).

Ministry of the Interior

- **Recognition of victims' service centers** as a legal entity with dedicated budget
- **Inclusion of GBV modules in pre-service curriculum** for the police basic training and officer training programs.

Armed Forces of Mozambique

- **Inclusion of GBV-related guidelines** into the revised Military Code of Conduct
- **Contribution to the decision to ban alcohol** across the Mozambican Armed Forces due to link with GBV.

The national guidelines for the care and treatment of GBV victims are specific to the health sector response to GBV, and are based on World Health Organization (WHO) clinical and policy guidelines (WHO 2013)[3] for responding to intimate partner violence and sexual violence against women. In coordination with the Ministry of Health, the GBVI produced an accompanying training manual for the national guidelines and a health care worker manual. GBVI partners also produced algorithms and job aids for the provision of post-rape care at health facilities for both adults and children; and posters, brochures, and pamphlets about GBV and post-GBV care services, including post-exposure prophylaxis. The materials for children were based on the PEPFAR Technical Considerations for post-rape care for minors. These were distributed throughout the country. GBVI partners also developed pre- and in-service curricula for health care workers and relevant stakeholders, as well as training manuals and performance standards to be used with the national GBV guidelines.

The GBVI's influence went beyond the health sector and Ministry of Health to increase openness to discussing GBV and addressing the issue in the Mozambican Armed Forces and the Ministry of the Interior. This was because the GBVI provided ample opportunities for sectors that do not normally engage with GBV to participate in multisectoral meetings and other joint actions. For example, the 2012 International Military HIV/AIDS Conference in Maputo included a session on HIV and gender, featuring the head of the Mozambican Armed Forces Gender Unit, who presented on strategies for GBV prevention. At the annual Department of Defense meeting, high-level military personnel engaged in discussions around GBV, likely as a result of awareness-raising efforts on the issue.

The Ministry of the Interior also became more open to discussing GBV. After participating in the first national multisectoral meeting in 2015, representatives of the Ministry of the Interior shared Mozambique's successful experience addressing GBV across sectors at the Southern African Development Community meeting. This engagement piqued their interest in the issue and gave them more confidence to speak about GBV in their own country.

In sum, many respondents from non-health sectors reported welcoming the invitation to participate in GBV meetings or activities. Some from these sectors believed that this involvement resulted in a deeper level of ownership and buy-in, especially from traditionally male-dominated sectors.

[3] According to WHO guidelines, at a minimum, protocols/guidelines for health system response should address: a) empathic and nonjudgmental listening by health professionals; b) measures to enhance a woman's safety; and c) provision (directly or via referrals) of mental health and legal support. Comprehensive post-rape care services include: a) first-line support or psychological first aid; b) emergency contraception to women who seek care within five days; c) referral to safe abortion if a woman is pregnant as a result of rape, in accordance with applicable laws; d) STI and/or HIV post-exposure prophylaxis, as per applicable protocols; and e) hepatitis B vaccination.

Institutional-level Contributions

> *"Beforehand, health care workers had no information and no capacity to address a problem that's existed for a long time."* (Implementing partner)

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

The primary GBVI activities at the institutional level were training to build capacity to prevent or respond to GBV. Prevention activities varied. One GBVI activity, for example, supported civil society organizations and community-based organizations working on HIV prevention. The GBVI helped these organizations use formative research to tailor behavior change interventions to specific communities.

The GBVI strengthened existing projects by providing partners with funding and technical guidance to tackle an issue most already knew to be a concern based on their experience. Almost all of the GBV prevention implementing partners commented on the complementary nature of the GBVI to their existing activities. Most of these partners were working in HIV prevention, HIV testing and counseling, prevention with positives, and voluntary medical male circumcision. These activities already required discussions about sociocultural norms, which made it easier to include GBV information, post-GBV services, child protection policies, and the domestic violence law. For example, one GBVI partner employed peer educators to carry out activities on prevention with positives. Fear of disclosure due to partner violence is a common concern, so including discussions about unequal gender dynamics within the household and gender-based violence was a natural fit.

The GBVI also strengthened mass media in the country. Building the capacity of media actors was fundamental to ensuring proper reporting of GBV cases, use of accurate data sources, and adherence to ethical and fair portrayal of survivors. Working with community radio was also an important activity for discussing gender norms and roles and GBV. These activities reached many people, because radio is an important form of communication in Mozambique.

The GBVI identified creative entry points for integrating GBV and HIV into the armed forces and reducing sexual harassment within businesses. For instance, GBV was included within a radio program called "The Hour of the Soldier." Armed Forces communications staff was also trained on gender, GBV, and child protection. Within businesses, the GBVI successfully collaborated with ECoSIDA (Associação dos Empresários Contra HIV e SIDA, Tuberculose e Malária, the private-sector response to the HIV epidemic) to develop sexual harassment materials to distribute in the workplace, and made the materials available for all partners to use.

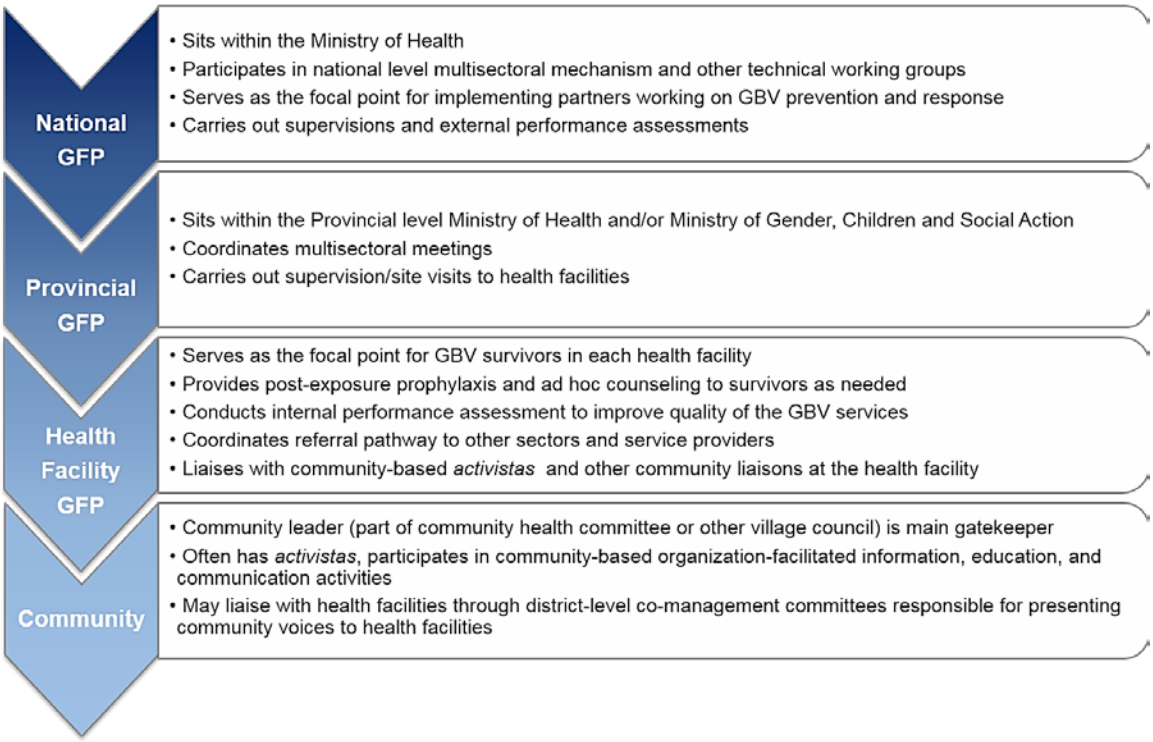
With GBVI support, the Multisectoral Mechanism and nascent National GBV Plan were expanded upon and operationalized throughout provincial and district health facilities. These strategies helped health

care workers and others understand their role in supporting GBV survivors, and the way in which each service provider's efforts fit with the rest. Several steps, outlined below, were taken to roll out these steps, although the precise order differed by province and implementing partner, since certain organizations had pre-existing projects and relationships with local government representatives.

First, GBVI partners coordinated with the provincial and district Directorates of Health and of Gender, Children and Social Affairs to conduct multisectoral trainings on GBV at provincial and district levels and in the health facilities. The trainings involved each level's assigned gender focal point (see Figure 3) and used the standardized clinical training manual (for maternal and child health nurses and physician assistants) developed by the GBVI in collaboration with the Ministry of Health at the central level.

Similar multisectoral trainings were conducted within health facilities.

Figure 3. Gender Focal Points (GFPs)



Second, each health facility identified a gender focal point. The gender focal points were usually nurses, who were also tasked with administering post-exposure prophylaxis and rape kits to GBV survivors. With GBVI support, the gender focal point in many USG partner-supported facilities developed an internal patient flow chart indicating the referral pathway for the GBV survivor. Patient flow charts were tailored for each facility, since each location offers different levels of services. According to respondents, most of the USG-supported health facilities established the maternal and child health department as the referral point for female GBV survivors (largely because this department is usually open 24 hours a day); the emergency room for male GBV survivors; and the pediatric ward for sexually assaulted boys. The gender focal point was also responsible for contacting the police and other services on behalf of survivors.

Where possible, the GBVI attempted to support provision of integrated post-GBV care services and make use of existing human resources such as lay counselors, or establish linkages with a nearby police station. However, health facilities in Mozambique differ greatly in terms of type, size, structure, and available personnel. Provincial hospitals often had psychologists, a forensic pathologist, or a police officer present, while district hospitals and smaller health facilities lacked such human resources.

For some GBVI partners, a main entry point within health facilities was post-exposure prophylaxis, or PEP, for HIV. While PEP existed to address occupational exposure, non-occupational PEP for post-rape care had not been extensively established prior to the GBVI. The GBVI built on the health sector's familiarity with PEP and trained health care workers on the connection between HIV and GBV, and post-GBV care.

The GBVI in-service training and ongoing supervision at the health facility level was bolstered by guidelines, algorithms, and other job aids, as well as necessary equipment and medication, including PEP and rape kits. The impression of many GBVI partners working on GBV response was that access to PEP and rape kits is mostly available, even in rural areas, and that there is a critical mass of trained health care workers. Many clinics also trained support staff and others so that all employed at the facility could direct someone in need of services to the right place.

It is important to recognize these successes, particularly in light of the challenges faced by the Mozambican health system. Not only were many facilities understaffed, but existing staff were often overwhelmed by patient loads, existing programs (such as Option B+),[4] and reporting requirements. There was a high staff turnover as health care workers transferred to different locations. Despite this, the GBVI was seen to have made a significant contribution to clinical efforts to respond to GBV and HIV, especially given the country's limited capacity pre-GBVI.

In line with the Multisectoral Mechanism, the GBVI contributed to building capacity of other GBV service providers (such as forensic pathologists and the police) and strengthening the linkages between the different available service providers. This was achieved through regular multisectoral meetings at the provincial and district levels, awareness raising, and training (see Box 4).

The GBVI made a particular effort to promote medico-legal services. In cases of physical and sexual violence, medical and forensic evidence may be the only corroboration produced to support a GBV survivor's formal complaint. A key GBVI success included supporting training of forensic pathologists and *peritos ocasionais*, general practitioners trained in medico-legal service provision.

The police play a key role in preventing and responding to GBV. The GBVI included human rights, GBV, and HIV modules in the Mozambican police training curriculum (in progress). Some GBVI partners mentioned that the police had become more sensitized to GBV, aware of the need to refer survivors to health facilities within 72 hours, and open to collaborating with health facilities, due in part to their involvement in community-level trainings.

Thus, although the GBVI focused on the health sector, it also engaged other sectors that have now become more involved in GBV prevention and response.

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[4] Option B+ services entail placing all pregnant women who test HIV-positive on combination antiretroviral therapy for life, regardless of CD4 count or clinical stage.

Box 4. GBVI-supported Institutional-level Achievements

Ministry of Education

- Teachers' Guide and training on identification of children and adolescents survivors of physical and sexual abuse.

Ministry of Health

- Training clinical staff to provide integrated care to GBV survivors based on Ministry of Health protocol and package of post-GBV services
- Development of training package for maternal and child health nurses on the integrated care and treatment of sexual violence survivors
- Inclusion of a GBV component within task shifting, Quality Improvement and Humanization
- Strategy and positive prevention training packages
- Development of a psychosocial support training module "Psychosocial Support for GBV Survivors."

Legal Medicine

- Provision of forensics trainings for physicians
- Development of a three-month training curriculum on forensic pathology (for generalists).

Ministry of Gender, Children and Social Action/Multisectoral

- Support for thirteen one-stop models for post-GBV care
- Trainings to increase awareness of GBV to health clinic staff, Ministry of Health provincial staff (including medical chiefs) and district staff, police officers, community case managers, community counselors, and *activistas*
- Support for consistent multisectoral meetings at the provincial level, including technical support, ongoing mentoring, and refresher trainings.

Ministry of the Interior

- Joint trainings between health staff and the police at provincial and district levels to improve linkages with the legal system, including the Victims Service Desk
- Development of a GBV prevention training manual for new recruits and officers.

Armed Forces of Mozambique

- Social marketing campaign to promote gender equality and discourage GBV. Soldiers participated in a competition to develop a campaign slogan; the winner (which will was used on all materials) was "Let's make the Mozambican Armed Forces a true battlefield against GBV!"
- Training of Armed Forced Gender Unit and Armed Forces Communications Officers on GBV prevention and child protection policy.

Other Activities

- Training provided to civil society and community-based organizations on the integration of GBV into behavior change strategies and HIV-related activities
- Development of radio spots, *telenovelas*, and other communications materials
- Training on community radios on how to talk about gender-related issues and GBV
- Provision of mentorship and training opportunities for journalists to ethically present GBV and child protection in the media; roundtable discussions with students, civil society, government, journalists, editors, and nongovernmental organizations
- Development of sexual harassment materials for distribution within the workplace, in collaboration with ECOSIDA (Associação dos Empresários Contra HIV e SIDA, Tuberculose e Malária, the private-sector response to the HIV epidemic).

Successful Models/Approaches

One-stop and Integrated Services Models

> *"I think the best thing we have managed to do is install these rooms [for survivors] in the health facilities and create connections with the police. The police are in the same place and prevent the victim from having to seek out the police…there are also activistas inside the health facility."* (Implementing partner)

One of the pillars of the Multisectoral Mechanism was establishing one-stop models for post-GBV care, which the GBVI and non-USG partners and donors supported. One-stop models provide clinical services co-located with police, legal, and psychosocial support services. The *Centros de Atendimento Integrado* (Centers for Integrated Services) model sites were initially established in a few key hospitals, such as Ndlavela Hospital in Maputo province. With GBVI support, at least one model site was gradually established in the provinces of Cabo Delgado, Gaza, Sofala, and Maputo city to serve as a GBV demonstration site in that province. There are now 14 one-stop models, which many respondents considered evidence of this model's success. The Centros de Atendimento Integrado sites frequently feature a specific space or building for post-GBV care services that includes medical treatment, psychosocial support, and access to the police and legal services. The one-stop centers were either within the hospital or in a building on the grounds of the hospitals (Ndjavela and Xai Xai hospitals).

At one of the one-stop sites, in Ndlavela Hospital, GBV prevention and response partners (USG partners and others) collaborated to provide technical assistance to the site. The GBV implementing partners provided clinical mentoring, supportive supervision, and technical assistance, and the GBV prevention partners conducted behavior change communication and awareness raising in the surrounding communities. These activities comprised HIV prevention, care, and treatment. GBV prevention and sensitization activities (e.g., community discussions, home visitations, and couples counseling) were conducted by peer educators (lay counselors who perform HIV community counseling and testing).

To strengthen the linkages between health facilities and communities, the GBVI provided a community point person at the health facility responsible for coordinating referrals and counter-referrals between the peer educators and the clinic. The point person was part of a sophisticated system that used a tablet to register GBV survivors, send text messages to communicate with them, and confirm arrival with community workers.

In addition to providing high-quality, comprehensive post-GBV care services, the demonstration sites are centers for learning and field visits, and illustrated delivery of integrated post-GBV care services in an ideal setting. Although resource-abundant sites such as Ndlavela are undoubtedly an exception in the Mozambican landscape, important lessons were learned.

One source of pride for Ndlavela was the consistent increase in the numbers of GBV survivors seeking services over the years. Respondents attributed the rise in patients to various factors, including a strong relationship between the surrounding community and the clinic, solid collaboration between the

government and implementing partners, and the high-quality of services provided at the site. Others mentioned the importance of partner efforts to disseminate information on the domestic violence law, the consequences of GBV, and availability of post-GBV care. The site's chief medical officer was also mentioned as an influence, given his leadership and ability to manage the implementing partners in Ndlavela's success.

Integrated services models, different from one-stop models, provide clinical services for GBV survivors and then refer them to nearby services. Where one-stop centers were not available, the GBVI provided technical assistance to integrate clinical post-GBV care (such as PEP) into health facilities, and connect survivors with available resources (such as the police) in the referral pathway. Providing clinical post-GBV care services across many parts of the country was achieved, but other services such as psychological and legal/justice support differed in quality and availability. In some cases, there was limited or no availability of private counseling and treatment space, psychologists and other clinical service providers, or space for police officers in health facilities and shelters.

The absence of one-stop centers did not keep integrated post-GBV care from being offered, at least in larger hospitals. Several hospitals supported by the GBVI were able to work with other sectors to offer the full range of post-GBV care services, and there were many instances of police officers physically present in health facilities to ease referrals. Gender focal points or activistas also played an important role connecting survivors to other services. In cases where counselors were not available, the focal point provided this service, and sometimes escorted the survivor to the police station if a police officer was not physically present.

There were four key factors behind both one-stop and integrated models:

1. Provincial and district multisectoral trainings (and ongoing GBVI support through regular meetings) to increase knowledge and awareness of GBV and HIV among all actors
2. Multidisciplinary health facility trainings for both clinical and non-clinical staff to address patient flow in large health facilities and encourage ownership by all
3. Champions and leaders at facilities to encourage integrated post-GBV service delivery. At one one-stop site, the chief medical officer took it upon himself to bring together the GBV prevention and GBV response implementing partners to identify gaps, necessary resources, and prioritize activities
4. A gender focal point, activista, or point person in the health facility to assist with referrals, and act as a strong connection between the health facility and surrounding communities.

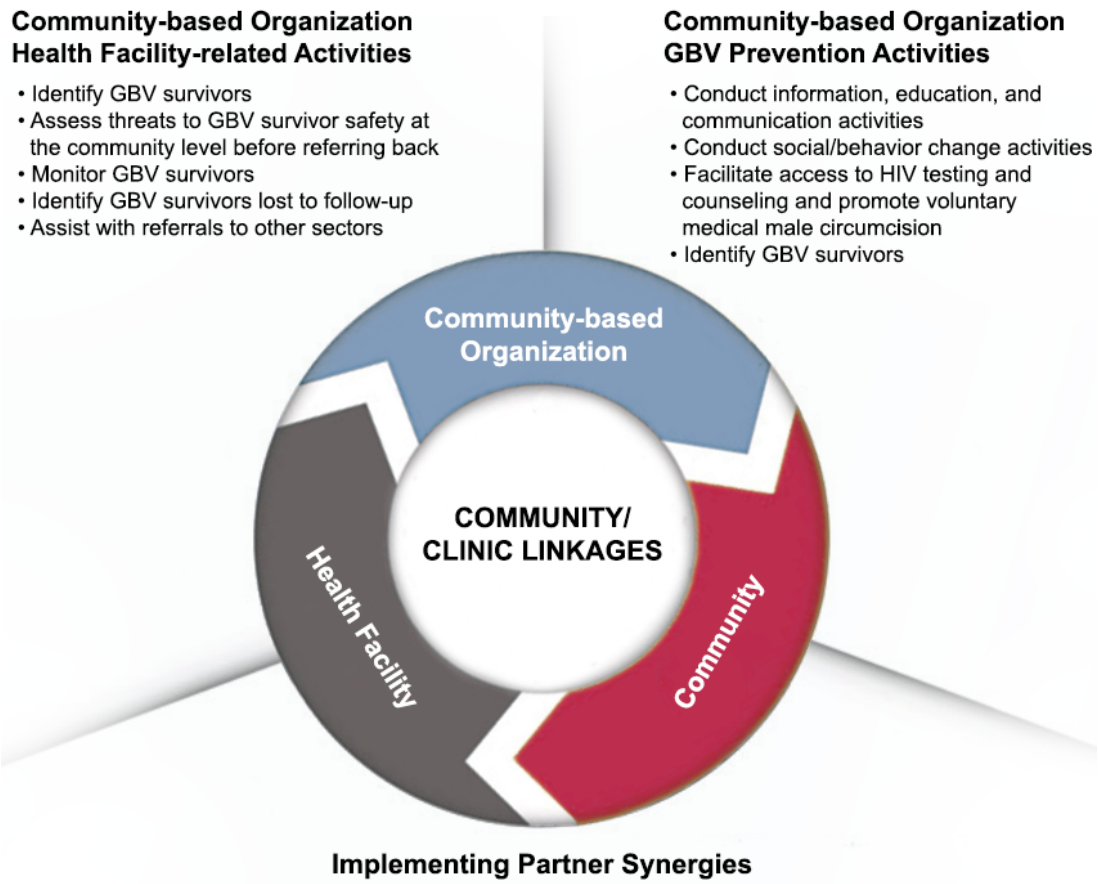
Community-based Screening

> "*Whenever there are issues there [at the community], they can identify survivors…The actual community counselors started to see that this was a serious issue in our country, and how violence is hidden… so this has been a very good experience for the implementers and for us.*"
> (Implementing partner)

When the GBVI first began there was limited demand for post-GBV services for several reasons including fear and stigma, sociocultural barriers, and lack of knowledge of existing services. GBV

survivors often failed to seek services within 72 hours of an incident of sexual violence, and even fewer completed the full regimen of HIV PEP. The recognition of these challenges led to increased and innovative efforts to strengthen linkages between communities and health facilities. Many lessons on how to encourage these connections came from GBVI partner field visits to the Centro de Atendimento Integrado in Ndlavela.

Figure 4. Community/Clinic Linkages



A few GBVI community partners conducted screening activities to identify survivors in their communities. Facility-based screening had not been established at the time of this report, although a few respondents indicated that a facility-based screening pilot was being developed. While several partners developed screening tools for use at the community level, the GBVI did not have a standard tool for partners to use. Although community-based screening had not been conducted by all GBVI partners and could benefit from additional support, it is an approach with vast potential.

Many GBVI partners were knowledgeable about the need to conduct screening in a safe and ethical way, and took steps to ensure that the safety of community workers and survivors was not compromised. Screening activities were woven into existing community-based activities, such as home visitations for HIV prevention and testing and behavior change communication activities around gender norms and roles. The GBVI took time to discuss gender norms with community members to create an open environment and enable GBV screening, which differs greatly from screening for tuberculosis or

malaria, for which one can simply knock on doors and ask. The increased ability to identify survivors is reported to have resulted in a greater demand for post-GBV services.

While some GBVI partners demonstrated much enthusiasm for community screening and reported positive results, others seemed wary of the potential unintended consequences of this approach. Despite the precautions taken, there were still concerns about inadequate privacy and confidentiality in certain contexts and a limited ability to track survivors once they reach health facilities. Thus, one of the lessons learned from community screening is that this screening must be implemented according to ethical and safety guidelines and take into consideration the limitations of resource-poor settings.

Most GBVI partners worked indirectly with communities through community-based organizations. Having both clinic- and community-based partners collaborating with community-based organizations helped bridge the distance between the communities and the clinics, thus facilitating a stronger connection between the two, as illustrated in Figure 4. While some partners took advantage of existing mechanisms such as community health workers, who were already formally linked to a clinic, others did not have a formal link to a clinic and partnered with other GBVI partners who did.

Community-based organizations, some of which had a cadre of activistas or peer educators, were trained by the GBVI on GBV prevention and response (consisting mostly of referrals). These organizations often had existing relationships with the communities and a personal rapport with community leaders, which facilitated GBVI partners' entry into the communities.

Raising awareness about existing services for GBV survivors comprised an integral part of GBV prevention activities and allowed partners to work on HIV and GBV prevention simultaneously, assist with demand creation for services, and increase health- seeking behaviors. GBV response activities enlisted activistas to help survivors access health facilities and identify survivors lost to follow-up in the communities.

The links between GBV prevention and GBV response activities differed by province, physical proximity, and funding streams. Collaboration between GBV prevention and GBV response was easier when partners were funded by the same PEPFAR agency.

Community-level Contributions

> *"Just providing information is not adequate. [You need] motivation, changing attitudes, also giving people skills. Work with men if you want to impact their aggressive behavior. They also need to have the skills to do something other than that."* (Implementing partner)

The GBVI saw significant successes in terms of expanding post-GBV care, but also focused on preventing violence from occurring in the first place. The pervasiveness of both GBV and HIV in Mozambique is the product of a complex interplay of risk factors at the individual, community, and societal levels. Preventing violence from occurring and removing the many barriers faced by survivors are not simple tasks.

The GBVI dedicated significant time to changing individual attitudes and behaviors, sociocultural customs, and gender norms that condone violence at the community level and enable GBV to be as widespread as it is in the country. Many GBVI activities followed a few key steps:

1. **Engaging community leaders** in activity design and community mobilization
2. **Recruiting and carefully selecting activistas** from the communities (or harnessing activistas where they already in place)
3. **Training activistas, community leaders, and/or community-based organizations** to lead and/or assist with activities such as discussion groups
4. **Developing or adapting training materials** to community needs.

The GBVI produced and adapted community and prevention materials including manuals based on participatory methodologies such as *Tchova Tchova*, *Stepping Stones*, *Go Girls!*, *Reflection and Action within Most at Risk Populations,* and *Where The River Flows*, used in Mozambique and other countries. Manuals were tailored to the needs and priorities of target communities. The GBVI applied innovative, theory-based behavior change activities such as narrative methodologies, edutainment, and peer education to target populations who often face additional barriers to accessing traditional services, such as sex workers, men who have sex with men, and drug users. For example, one partner used a video to inspire small groups of individuals at high risk of HIV to reflect on their own behaviors and commit to taking incremental steps to change with support from their group. Another used peer educators with strong rapport in the communities to distribute condoms and health information, and encourage their peers to test for HIV.

The GBVI partners used diverse strategies, methodologies, and approaches for addressing GBV and HIV prevention (see Box 5). For example, one GBVI partner targeted adolescent girls, one of the groups most vulnerable to HIV, through economic empowerment programs (such as Accumulated Savings and Credit Associations) combined with youth-focused life skills training. The GBVI also worked with community radio stations and journalists to properly cover reports on GBV survivors, including how to protect sources and what to do before, during, and after interviews with survivors.

The GBVI also provided technical assistance to a program designed to build the capacity of Mozambican nongovernmental organizations, community-based organizations, and faith-based organizations; and to include GBV prevention activities in their HIV prevention care and treatment programs. These efforts included carrying out formative research with community partners in their community to tailor social and behavioral communications materials accordingly, training activistas on how to conduct GBV prevention-related outreach activities, and overall institutional strengthening (e.g., grant-writing and organizational management) for sustainability. The GBVI's work with local partners necessarily differed according to the community context and to the organization's existing focus. For example, a faith-based organization focused on sensitizing communities about HIV and GBV through churches and religious leaders, while another worked primarily through high schools by engaging teachers and school principals.

Respondents suggested that GBVI community-level activities contributed to changes in knowledge of HIV prevention, care, and treatment, reduction in HIV-related stigma, and a greater willingness to discuss gender norms and harmful sociocultural traditions, such as marital rape and intimate partner violence to "discipline" women and children. The GBVI's efforts to involve community leaders (including religious) was seen as a key element of its success, because these individuals are opinion leaders and often a first point of contact for GBV survivors. Both implementing partners and community partners reported that real change was taking place in the communities, and that partners were able to integrate a relatively challenging topic into existing discussions on HIV prevention and gender norms.

Box 5. Select GBVI-supported Community-level Achievements

Sample Activities

- **Small group debates on specific topics identified by CBOs through formative research.** The 8–12 sessions usually started with a short film or theatrical sketch on topics such as peer pressure, gender norms, intergenerational sex, multiple concurrent partners, living with HIV, and HIV counseling and testing
- **Workshops with activistas in the community** about what to do in cases of violence against women
- **Programs to stimulate open discussions about masculinity** called Homem na Cozinha (Men in the Kitchen) and Conversa de Homens (Men's Talk), Sexta-feira Dia de Homen (Friday is Man's Day)
- **Community-based HIV testing and counseling** and referrals to clinic-based testing
- **Integration of male norms and behaviors** into discussions to promote voluntary medical male circumcision activities
- **GBV screening** as part of home visitation and behavior change communication activities
- **Establishment of men and women's groups** by some community and clinical partners as part of their HIV and GBV prevention strategy which provides a safe space for men to discuss a number of issues
- **Establishment of male peer educators in the military** to promote discussions around HIV and GBV.

Training Manuals

- **Tchova Tchova Histórias de Vida:** emphasizes the transformation of gender norms and male involvement in lowering risky sexual behaviors, reducing victimization/blaming of women, increasing uptake and adherence of ART and PMTCT, and reducing barriers that prevent disclosure and access to health services
- **Reflection and Action within Most at Risk Populations:** behavior change communication for drug users
- **Development of Conversa com Homens:** to engage men in discussions about health, alcohol, gender norms and roles and the acceptability of violence
- **Manuals to facilitate radio programs about GBV:** as part of a broader program called Tua Cena.

IEC Materials

- **Informational pamphlets** on the 29/2009 GBV law, human rights, and child rights
- Development of a series of brochures on the importance of survivors seeking GBV services and PEP within 72 hours
- **A popular TV show** "Homen que e Homem" (Men Who Are Men)
- **Communications packages to facilitate discussion**, printed audiovisual materials including pamphlets, posters, radio, and TV spots
- **A series of training videos** Breaking Barriers (Quebrando Barreiras) to stimulate community debate on HIV prevention and topics such as multiple partners, intergenerational and transactional sex, and GBV
- **A magazine on GBV** translated into local languages.

Successful Models/Approaches

Participatory and Gender-Transformative Approaches

> *"At first there was a focus on women, then a focus on men, but in fact both need to be involved."* (Implementing partner)

Several successful models and approaches came from the GBVI's community-level work, including participatory and gender-transformative approaches. While there were many types of methodologies and techniques used to encourage behavior change and transform sociocultural norms related to GBV and HIV behaviors, there were commonalities among successful approaches:

1. **Active engagement of opinion leaders at all levels and within all stakeholder groups**
2. **Participatory, engaging activities that use creative methods (such as video or theater) to encourage self-reflection and discussion over time**
3. **Involving men and boys as part of the solution.**

An important aspect of these successful approaches was engaging leadership at all levels, including USG agencies, ministries, institutions, and communities. Truly changing the culture and mentality of an organization or community first requires endorsement of leaders, who set the tone for how the rest of the group will respond to GBV, how seriously the issue will be taken, and how successful the activity will be. The GBVI's engagement took many forms, from workshops, training, and simply taking the time to work closely with partners (positive role modeling) to lead them to question their socialization and gradually accept new ideas. In some cases, men decided to become activistas or join a discussion group after seeing another man carry out tasks traditionally delegated to women, such as fetching water.

The GBVI used several behavior change communication methods that were seen as successful and well-received:

- *Edutainment*: A combination of education and entertainment that embeds messages in stories, like novelas, dramas, small videos, and short messages.
- *Social media*: Using Facebook data metrics to assess age profiles and see engagement and dialogue and conversations among youth.
- *Slogan campaign*: Soldiers participated in a competition to develop a campaign slogan.
- *Small group discussions*: Several partners used group discussions that spanned several weeks and focused on questioning gender socialization and encouraging incremental behavior change. Respondents believed the GBVI was successful in working with boys and men to promote gender-equitable attitudes and behaviors. Discussions on gender norms and roles always preceded any conversations about violence. The GBVI used men's groups to discuss male socialization, including parenting and household chores, leading to conversations about GBV. The GBVI engaged men on the domestic violence law and how it pertains to them, and was seen to have contributed to greater numbers of men involved in antenatal care, improved communication between serodiscordant couples, and increased willingness to test for HIV through its "Father to Father" group and other activities.

Multisectoral and Partner Synergies

> *"It was a great meeting because we were able to share best practices as well as talk about gaps and challenges in implementation, and to develop strategies based on the lessons learned of different provinces… the meeting made it so that people understand GBV, the importance of it, and take it more seriously."* (Government representative)

> *"It's a challenge. We understand that the connection between clinical and community is not aligned, but with improved coordination, in theory this can work. In practice, this doesn't function well. Referral works, but the rest is very complex and difficult to monitor…"* (USG agency)

The GBVI was designed to generate synergies across sectors and programs. Respondents believed that regular meetings with different partners and sectors facilitated collaboration. In particular, GBVI partners consistently met with representatives responsible for the Ministry of Health GBV portfolio, which enabled a strong, working relationship. Respondents frequently mentioned the importance of having a capable leader within the GBVI to facilitate such meetings. Although many types of meetings took place, three kinds stood out to respondents: 1) the USG-organized partner meetings, 2) the first-ever national-level GBV multisectoral meeting (held in May 2015) organized by the Ministry of Health, and 3) multisectoral meetings at the provincial and district levels.

The GBVI, alongside members of the US-based Interagency Gender Working Group, convened partner meetings that included all implementing partners and other US government partners working on GBV that were not funded under the GBVI. Depending on the agenda, sub-partners, government representatives, civil society organizations, and nongovernmental organizations were also invited to attend. The partner meetings encouraged collaboration, allowing participants to identify areas of mutual interest and complementary expertise, and to share research findings, methodologies, materials, and tools. The GBVI identified and mapped complementary partners, making synergy easier to establish at provincial and district levels. Most partners responded favorably to collaborating and saw it as a logical solution that enhanced their activities. Partner collaborations were facilitated by geographic proximity and similar funding streams.

The GBVI also convened provincial-level partner meetings in Gaza and Zambezia provinces, where there were many implementing partners. The purpose of these meetings was to introduce the GBVI to provincial health staff and ensure collaboration and transparency through mapping activities to avoid duplication of efforts. After the initial meeting, partners continued to meet on a monthly or quarterly basis and included law enforcement and other stakeholders in the group. An excellent example of this collaboration was in Gaza province in 2014, where all partners and stakeholders conducted an extended (through the month of December), provincial-level 16 Days of Activism Against GBV campaign to coincide with the return of miners from South Africa for the Christmas holiday.

In 2015, the Ministry of Health convened the first national multisectoral meeting on GBV, supported by GBVI partners and involving all four sectors included in the Multisectoral Mechanism, as well as multilateral agencies, civil society organizations, faith-based organizations, traditional medicine

practitioners, and service providers from various levels. The national-level multisectoral meeting provided a forum for discussions on data, knowledge exchange, and lessons learned among provinces on working multisectorally. Additionally, it boosted morale and ownership, and conveyed the message that GBV is important.

Multisectoral meetings and joint trainings with different sectors and partners occurred more frequently at provincial and district levels due to geographic proximity, motivated gender focal points, and technical assistance and support provided by partners. Multisectoral collaboration involved joint trainings and meetings to discuss referral networks for GBV survivors and troubleshooting follow-up issues.

Although there were challenges in partner synergies, in most cases, partners were able to acknowledge and respond to them in a solution-oriented manner. Challenges did not prevent partners from moving forward with programs and plans. Where there were barriers to synergistic relationships between partners they were usually due to two key factors:

1. **Lack of coordination/communication** resulting in duplicated efforts, lack of human resources or partners available with the desired skill sets to accomplish tasks, and confusion between clinical and community partners about who should be responsible for leading in areas where linkages were possible
2. **Differing objectives and priorities** due to USG agency-specific mandates, agendas, manner of executing, and levels of understanding/buy-in related to GBV prevention and response.

Quality and Scale-up

> *"There was a lot of waste in terms of rolling out everything from the beginning instead of phasing in. There was pressure to keep expanding, keep expanding, why would you expand and invest in all of that, when the cost per person is ridiculous, since you only see five people… Start small, figure out what works, what the assembly blocks are and why, then think about expansion."* (USG agency representative)

> *"It's always like this. Quality and expansion don't walk hand in hand. First we increase access. First quantity, then quality. It's not possible to do both at the same time. If you want to increase quantity, you compromise quality to some extent. This isn't unique to GBV."* (Implementing partner)

Initially, scaling up GBVI activities met a set of challenges that seemed to affect GBV response more than prevention. Prior to the GBVI there were limited GBV prevention and response activities in the country. Most GBVI efforts were dedicated to establishing awareness-raising activities, and operationalizing basic services. While many GBVI activities were scaled up with varying levels of success, community partners found that GBV fit naturally with their programs and agenda. Clinical partners, however, found that quality was often lost when activities expanded too quickly.

Many of these challenges were largely outside of the GBVI's control, such as a shortage of trained psychologists and the absence of post-GBV care clinical algorithms for children earlier in the initiative. Although the GBVI and local governments are still attempting to fill some of the gaps in post-GBV care, there has been a remarkable scale-up of health facilities offering these services. As one US government respondent remarked, "it has gone from next to nothing to over 250 clinics providing post-GBV care. For example… they did a great job scaling up something that didn't even exist at a national level."

The GBVI's experiences with scaling up clinical activities differed slightly depending on the length of time working with the health facilities, existence of trained resources, and the province. In some cases, GBV was not fully integrated within the organization, or appropriate staff were not sufficiently involved. In other cases, the inclusion of GBV worked quite well. In one province, for example, the team was already trained and doing PEP monitoring and supervision in health facilities, so GBV was easily integrated in existing channels. In this case GBV was not something that was started from scratch; it was like a second step, an additional set of services. Demonstration sites that used one-stop models, such as Ndlavela and Dondo, were scaled up from two to seven and then to fourteen sites. This process was conducted by the GBVI through quality control measures. The one-stop sites qualified based on their achievement of 80 percent of the verification criteria for GBV performance standards. The use of one-stop models positively affected other partners who attempted to employ the same model.

Scaling up allowed partners to learn lessons about implementation and refine their strategies. For example, the one GBVI partner identified the need to involve both men and women in prevention activities, while another decided to hire an expert to assist with their behavior change strategy. The expansion process led to insights in technical gaps and challenges not previously available to them.

In several cases where respondents believed that implementation had already yielded successful results, the GBVI funding allowed expansion of activities based on current approaches. While this was true primarily for partners working in GBV prevention, one GBV response partner was able to expand activities based on the success of smaller research studies and pilots. One government respondent credited the GBVI with enabling the significant scale-up of medico-legal services and an increase in the number of doctors trained in forensic pathology; there are now seven provinces with such specialists, up from three specialists prior to the GBVI.

In terms of GBV prevention activities, there has been an increase in the demand for GBVI materials and GBV prevention strategies at the community level. As one respondent mentioned, "There was a lot of demand. [They wanted to know] how can they themselves use that capacity building layout, that approach…they were using our models."

The GBVI was designed to incorporate a focus on the quality of services and quality improvement. GBV care has improved since the GBVI started, since no formal post-GBV care services existed prior to the initiative. Post-exposure prophylaxis, rape kits, health care worker training, and quality assessment tools were scaled up and are now part of the clinical routine and Ministry of Health structure.

GBVI partners recognized the need to assess and monitor quality in clinical settings. One partner used the Standards-Based Management and Recognition approach to rate each health facility from 0 to 100

percent. Those that rate 80 percent and above are recognized as "model" sites. This methodology, accepted by the Ministry of Health, has led to healthy competition between sites and is used by provincial-level government monitoring teams. Although the use of this approach varied by province it enabled the GBVI to scale up while maintaining quality. Although the tools mentioned are evidence of important GBVI achievements, there is room for improvement. For example, there are no government-level indicators in the performance assessment framework (a document produced during a joint annual review, which the government gives donors and partners to demonstrate its accomplishments).

Building the Evidence Base (Monitoring and Evaluation)

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

The GBVI was designed to promote national and project-specific data collection. This included piloting three GBV indicators and developing knowledge about specific outcomes related to programmatic approaches and multicomponent models. When the GBVI started in Mozambique, there was no GBV monitoring and evaluation system; nor was GBV part of the existing health information system. The entire program needed to be implemented from the ground up.

The GBVI pilot indicators for all three GBVI countries were as follows:

1. Number of people reached by an individual, small group, or community-level interventions or services that explicitly addresses GBV and coercion.
2. Number of GBV service encounters at a health facility.
3. Percentage of health facilities with post-GBV services available.

Respondents reported that the indicators changed several times to better reflect and capture results.

During the GBVI, implementing partners recognized that their activities could not take place in isolation, and required linkages with communities and health facilities. They began reporting on indicators that were originally intended for either community or clinical implementing partners. Another complex dynamic involved frequent duplication of monitoring and evaluation activities by (mostly clinical) implementing partners and the government. The GBVI experience with monitoring and evaluation reflects the interconnected and multifaceted nature of GBV prevention and response.

Tools and Instruments

Although there were few existing data collection mechanisms or systems in place, GBVI partners were expected to report activities shortly after the GBVI began. In response, clinical partners rapidly developed their own data collection forms on post-GBV care to ensure that they could capture activity results. Although the Ministry of Health had existing data collection forms and registers, especially for HIV care and treatment, these did not fulfill PEPFAR reporting requirements for GBV.

One GBVI partner worked with the Ministry of Health to develop a universal data collection sheet on post-GBV care, which led to two main issues. First, obtaining formal government approval and officially instituting the data collection sheet proved to be a lengthy process. (It is expected that the sole GBV/PEP data collection sheet will be approved in 2016, along with the 2015-2020 GBV Plan for the Ministry of Health.) Second, the sheet was not shared with other GBVI partners before Ministry of Health approval, resulting in a perceived lack of buy-in from other partners. These difficulties were compounded by the perceived "ever-changing" indicators and the increasing rigor and specificity of the data requested by PEPFAR.

As a result of these circumstances, throughout the GBVI, some clinical implementing partners used a "pilot" data collection sheet that was both pending approval and periodically changing. Other partners developed and used their own data collection mechanisms. The profusion of forms reflected the lack of harmonized data collection tools and instruments among partners and the Ministry of Health. As a result of the lack of standardized, institutionalized instruments, and the existence of seemingly parallel systems, implementing partners received more GBV data than the Ministry of Health, efforts were duplicated, and the data collected failed to match.

Despite the duplication of data collection instruments, GBVI partners worked arduously with the government to develop tools and instruments such as a national data collection sheet and register book. That these will be approved in 2016 is no small accomplishment. Emerging GBV data from partners suggest that the epidemic is pervasive in the country, and legitimizes the need for continued GBV prevention and response activities.

Another positive outcome is the development of a clinical site monitoring tool developed by GBVI to use during partner visits to health facilities. The tool covers a wide array of essential post-GBV care topics, including staff knowledge and capacity; the availability of guides, materials, and job aids; patient flow and procedures; the minimum package of post-GBV care; and data flow. Developing the site monitoring tool was an important way to help partners improve the quality of post-GBV services and identify facilities requiring additional support.

GBVI Indicators

The perception of GBVI partners was that the GBVI indicators changed several times over the three years, making it difficult to track changes or trends or report concretely on scale-up. In 2014, reporting transitioned from the three GBVI pilot indicators to two new PEPFAR-wide standardized indicators. Changes included adding more specific and rigorous definitions. For example, to qualify for one of the indicators, a community intervention needed to span at least 10 hours, in line with emerging evidence that longer behavior change interventions are more effective at producing change than one-off activities. Because of these changes, GBVI partners were often unclear which indicators were required and which were optional at any given point, and confused by operational definitions such as "GBV service encounter."

Collecting increasingly specific information required higher data quality and changing indicators meant that implementing partners had to modify existing data collection systems and develop new data collection sheets. Some partners found the indicators too clinical in nature, or failed to capture the complexity of the work. Others struggled to understand the rationale behind the indicator changes.

Other partners found the indicators well-developed and clear, and attributed difficulties to excessive demands by PEPFAR and unrealistic expectations in the Mozambique context. They felt there was a struggle between "nice to know" and "need to know" information and that it was important to stick with "need to know" to draw conclusions, measure impact, and plan what really needed to be done. There was a sense that it was important not to collect additional indicators until the current ones were "under control and working well."

Some implementing partners found it difficult to interpret and operationalize the indicators. Despite PEPFAR headquarters and USG staff efforts to explain the indicators, partners' frustration with the indicators suggests that discussion about them could have been of higher quality. Although the need for data collection and reporting was understood, implementing partners believed that timing, context, and local realities should have been more carefully considered.

Performance and Implementation

When the GBVI started, all clinical implementing partners were providing HIV care and treatment services, which allowed GBV to be integrated into the HIV clinical structure. Partners expressed frustration at the start-up of GBV activities, but soon found it to be a natural fit. Partners were proud of their ability to overcome monitoring obstacles in creative ways to ensure that they could effectively provide services and report to PEPFAR.

GBVI partners noted that GBV survivors entered the health facility at different points, such as the maternal and child health department, the emergency department, or police and informal community referrals. The ability to track a patient around a health facility has improved, as has the creation of formal links between sectors. However, a harmonized, integrated data system does not yet exist. The government does not have a unified database that can register all GBV cases and types of violence that occur across the country. Each ministry, such as the Ministry of Health and the Ministry of the Interior, has its own database and set of indicators.

Data Quality

Obtaining high-quality data is not simple. It requires a robust monitoring and evaluation system, strategic planning, consensus on the purposes and means of data collection, coordination, and clear lines of communication at all levels and among all parties involved. Mozambique has system-wide monitoring and evaluation challenges that are not unique to HIV or GBV. These difficulties at the central level were reflected in the health facilities where the data are generated, and problems with data management and excessive reporting requirements compromise data quality. This includes poorly filled out forms, limited follow-up reporting, and misfiled forms.

The majority of health facilities run by the Ministry of Health are paper-based, adding to poor data quality and compilation. Although there is limited capacity on the part of the government, some respondents reported that GBVI partners had overburdened health care workers and placed unreasonable demands on health facilities and the system as a whole.

While there will always be room for improvement in monitoring and evaluation systems, the GBVI sparked a renewed discussion on an important topic, brought some challenges to the fore, and established GBV data collection mechanisms where there were none.

GBVI Sustainability

> *"…We have mobile vehicles and CAIs [Centro de Atendimento Integrado, or one-stop model] that are new, but in general it is not a cost-heavy thing to integrate into existing systems funded by the government. With regard to costs of GBV, there's no reason why it wouldn't continue because it is not expensive…"* (Implementing partner)

> *"Organizations want to know how these activities can continue without money. But they have their own knowledge. We will identify activities that can continue more or less without funding or help. It will depend on the facilitator element, the attitude to do so… they will need a person who can pull people together. They will need to be motivated to continue."* (Implementing partner)

Many of the GBVI activities have been institutionalized within government structures and included in government plans, strategies, and budgets. For example, GBV is now included in Mozambique's five-year development strategy and health, social, and economic plans; GBV modules are part of the pre-service curricula of nurses, physician assistants, and police officers; and both training and funding for forensic pathology are included in health sector plans.

GBV prevention and response have been fairly well integrated into community activities and clinical services. Post-GBV care within health facilities is expected to continue because these services are now part of government protocol. However, health facilities will still require supportive supervision, training, and materials for optimal functioning, as will community and GBV prevention activities. A disadvantage of these activities is that while they have become part of GBVI implementing partner activities, many have not been included in government protocols or funding structures. GBVI partners emphasized the commitment and dedication of community-based and nongovernmental organizations that are now trained and will continue this work to the extent possible.

The greatest threat to the sustainability of GBVI activities is lack of funding across the board. Yet GBVI partners remained optimistic, certain that enough progress has been made in GBV that regardless of the financial outcome, residual community activities and basic post-GBV care services will remain available.

CONCLUSIONS

The findings summarized in this report were based on feedback from a diverse group of stakeholders, including government representatives, US government agencies, PEPFAR implementing partners, and peer educators, to name a few. While many different stories and perspectives were shared, several key contributions of the GBVI became clear. Firstly, while Mozambique had already recognized GBV as an important issue when the GBVI was first established, the initiative strengthened existing efforts tremendously. This included raising the profile of GBV as a priority—particularly in HIV prevention, care, and treatment—and ensuring that GBV prevention and response were highlighted in policy agendas. The visibility of GBV as a public health and human rights issue increased and reached all corners of the country, from US government offices to rural clinics.

Secondly, the GBVI expended considerable effort partnering with government to produce sustainable, long-term strategies and plans to help guide GBV prevention and response long after the GBVI is gone. GBV is now integrated in national and health sector plans with dedicated budgets. As a result of GBVI support, the country now has protocols and guidelines for responding to GBV survivors at many health facilities, and a cadre of committed, trained health care providers throughout the country. GBV survivors are now able to access HIV post-exposure prophylaxis and a host of vital services, where previously there were few. In several provinces, survivors are now spared potential re-victimization by being able to access many services, such as the police and psychosocial support, in a one-stop facility.

Thirdly, a unique contribution of the GBVI, and one of the first of its kind, was the multisectoral and multilevel approach that the initiative employed. The GBVI worked with various other sectors to ensure that GBV survivors were able to access other services on the referral pathway, such as psychosocial and legal support. To this end, the GBVI brought together several ministries, including the Ministry of Health, the Ministry of the Interior, the Ministry of Gender, Children, and Social Affairs, and other important stakeholders, and involved them in GBV prevention and response activities. At the provincial and district levels, this collaboration was reflected in multisectoral trainings and meetings with health care workers, police, judges, and other service providers, who often sat in the same room to discuss referral pathways and follow up on specific cases of GBV survivors. The GBVI also involved actors not traditionally involved in GBV prevention and response, such as the military. For example, with GBVI support, the Armed Forces of Mozambique included GBV within their efforts to prevent HIV among their personnel, and enthusiastically participated in a slogan campaign on GBV prevention.

Finally, throughout the activities described above, the GBVI also tackled one of the hardest issues to address within GBV prevention and response: attitude and behavior change. At the root of GBV prevention lie unequal gender and sociocultural norms that condone violence. These norms permeate all levels of society, from high-level officials to fishermen. Through interactions with the numerous stakeholders involved in the initiative, the GBVI raised awareness of GBV as an important issue, and helped to elucidate the linkages among harmful gender norms and attitudes, GBV, and HIV. A significant proportion of GBV prevention and behavior change activities were dedicated to the

community level, and included strategies as diverse as the needs and priorities of the communities. One strategy the behavior change activities had in common was the desire to change communities from within, by sparking difficult discussions around gender and GBV, where perhaps none had ever taken place. The skill and dedication required to carry out such endeavors should not be underestimated.

Despite the countless barriers and challenges in Mozambique, the combined contribution of all the GBVI partners is commendable: every single respondent interviewed emphasized the improvements they had seen in the country in terms of GBV prevention and response. These improvements are too numerous to mention, but suffice it to say they provide staunch confirmation that the GBVI was certainly a worthwhile endeavor.

LESSONS LEARNED

The purpose of this report is to document what was learned by the GBVI in Mozambique for the benefit of others seeking to integrate GBV prevention and response into the cascade of HIV services. These lessons and the recommendations that stem from them are presented below.

Overall, **use a phased approach.** Many of the lessons learned below result from too many activities being carried out at once without adequate time to develop each one. Funding should allow for planning and piloting materials (year 1), implementation with assigned targets (year 2) and so forth.

1. **Create a strategic master plan and central leadership**. Prior to implementation, work collaboratively to create a plan that sets clear roles and responsibilities for all parties involved (donor and host-government actors, civil society, clinic and community partners), and maps out all partner locations, activities, and resources to avoid duplication and increase efficiency. Include an overall leader or manager to facilitate collaboration among and between all partners, as well as focal points within each partner and, in the PEPFAR context, within USG agencies.
   Similarly, it is important that government partners know which partners are responsible for which activities. For example, for the GBVI in Mozambique a lot of time was spent duplicating efforts and defining roles and responsibilities of each partner, specifically for areas outside the purview of either clinical or community implementing partners such as community-clinic linkages. In the GBVI/Mozambique experience, synergies were facilitated when there were a multiple number of community and clinical counterparts in the same province who committed to regular meetings/coordination.
2. **Harmonize materials and communication.** Before implementation, have in place all necessary evidence-based protocols, guidelines, training manuals, information, education, and communication materials and any other materials that may be needed. Taking the time to develop materials and messaging beforehand can facilitate involvement and buy-in by government agencies and other stakeholders, and ensure that all partners and stakeholders have the same definitions and understanding of GBV. In cases where development of materials is part of the implementation, create a system for sharing these documents across partners to ensure consistent utilization and implementation. For example, in the GBVI/Mozambique experience respondents believed there was duplication of training manuals, and different information, education and communication materials, data collection instruments, logos, and mass media campaigns.
3. **Schedule regular coordination meetings at all levels** (national, provincial, and district) to share lessons learned and collaborate, and to make plans, define targets, monitor progress, and evaluate results based on the indicators. Harmonized efforts through the same messages result in a greater impact, as the 16 Days of Activism Against GBV showed in Mozambique. Taking the time to develop materials and messaging beforehand can facilitate government involvement and buy-in and ensure that all partners and stakeholders share the same definition and understanding of GBV.

4. **Collaborate with partners from the beginning.** Engage government, community- based organizations, and clinics from the beginning. This is particularly important for encouraging ownership and buy-in, achieving sustainability, and establishing good will. Government partners should have a continuous role in program planning, design, and implementation, as well as in the development of all materials related to GBV prevention and response. For example, the GBVI in Mozambique made efforts to involve government representatives and other partners from the start, but many factors contributed to limited participation and involvement of different actors, including bureaucratic processes at the central level (which often delayed partner activities); government staff turnover (in particular, the key GBV champion at the Ministry of Health left at an inopportune time); weak technical capacity in some partners and limited interest or availability in others; and pressure to complete activities and achieve time-sensitive targets. Partnerships that worked well featured strong champions and leaders, open and consistent communication, and well-established rapport. It is crucial to recognize that policy-level change takes time, as does building capacity and achieving buy-in for new ideas.
5. **Create and foster multisectoral synergies**. GBVI laid the foundation for multisectoral synergy, which is critical to GBV integration, as is investment in civil society organizations, use of champions, and continued integration across technical sectors. Pushing the GBV prevention and response agenda forward requires strong, dedicated leaders and robust civil society. Specific tips include the following:
   - Invest in gender officers and focal points within different ministries, such as the Ministry of Health, Ministry of the Interior, Ministry of Justice, and Ministry of Education.
   - Support existing and emerging champions dedicated to GBV.
   - Encourage frequent meetings with partners and other actors across sectors at national, regional, and local levels to coordinate efforts, share tools and lessons learned, and ensure alignment with government strategies, such as nascent GBV strategies and policies.
     It is also important to integrate GBV prevention and response into other areas of health and HIV, such as sexual and reproductive health and prevention of mother-to-child transmission of HIV. Establishing a partner forum or technical group that is not housed within a specific ministry, but is instead an independent entity that brings together relevant activists, stakeholders, and partners, can help foster coordination and synergies across sectors. There is wide scope for using creative strategies to further involve other sectors, such as forging new links through health fairs in high schools, parent committees, agricultural groups, women involved in rites of passage, and traditional healers.
6. **Build capacity and awareness.** Partners, service providers, and government representatives at provincial and district levels need consistent and continuous GBV training and sensitization. This includes multidisciplinary training for all relevant members of the health facility and police, as well as USG partners and government representatives, because levels of understanding and buy-in for GBV prevention and response vary. Training should include GBV sensitization and awareness, post-GBV care, and proper referral services and processes. Trainings should emphasize GBV integration

into the cascade of HIV services and within family planning and sexual and reproductive health. Adequately trained health care workers are critical, especially in countries like Mozambique that have high health facility staff turnover. Training and capacity building needs to extend beyond technical and clinical aspects to behavior change communication and sensitization, because service providers often have the same harmful gender attitudes as the rest of the population. Support to service providers should also include self-care measures and psychosocial support to avoid vicarious trauma and address providers' own experiences with GBV.

7. **Engage communities and males.** Preventing GBV begins with the community. Sociocultural norms dictate much of what happens to GBV survivors within communities, whether they seek services in time to receive post-exposure prophylaxis, or are able to seek justice. Behavior change, especially within the context of GBV prevention and response, is a long-term endeavor that requires deep community involvement and continued efforts. Make community and local leaders the focus of programs to build leadership capacity at the community level and transform harmful gender norms. It is critical to involve *both* men and women in activities to change sociocultural norms and reduce GBV.
8. **Ensure clarity in referrals and linking survivors across sectors.** Commit resources to one-stop centers such as the Centros de Atendimento Integrado, caseworkers, or a dedicated liaison linking community and clinics. It is essential to establish consistent coordination across service providers within the referral pathway. This includes clear roles and responsibilities for actors within each sector, a clearly-defined system for referrals to other services, a harmonized data system, and a community liaison/case worker. Part of a well-functioning referral system also includes trained and sensitized service providers in other sectors, such as the police. In the absence of a one-stop center, health facilities should conduct multidisciplinary training so that all personnel know where to refer survivors both inside and beyond the facility.
9. **Plan for sustainability and country ownership.** Government ownership, GBV integration across government sectors, and a capable and willing civil society are crucial for sustainability once funding ends. Many activities do not require a lot of funding, but do need to be integrated into government structures and strategies. Encourage governments or other initiatives to work directly with nongovernmental and civil society organizations, particularly those that have the capacity and willingness to work on GBV prevention and response, Ensure that government ownership of activities is encouraged from the start, and that implementing partners have well-developed exit strategies.
10. **Develop simple and focused monitoring and evaluation plans.** Consistent, targeted, realistic, and focused indicators that are synchronized and aligned with the government, donor, and implementing partners are critical to monitoring and evaluation. Simple, consistent, monitoring and evaluation plans are critical for providing evidence of effectiveness prior to scale-up. Efforts to measure quality, along with frequent evaluations, help to ensure effective programs. Such measures also allow for learning and adapting over time. Activities for measuring quality indicators should focus on survivor follow-up, completion of post-exposure prophylaxis regimens, and HIV cases

averted. Other indicators could trace survivors in schools and in communities, and measure the dissemination of messages promoting GBV prevention and response.

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ANNEX 1.
LIST OF IMPLEMENTING PARTNERS

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

Elizabeth Glaser Pediatric AIDS Foundation

FHI 360

Global Health Communication Gorongosa Restoration Project

I-Tech

International Center for AIDS Care and Treatment Programs

International Centre for Reproductive Health

IREX Jhpiego

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Mozambique Ministry of Health

N'weti

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