SCALING UP THE RESPONSE TO GENDER-BASED VIOLENCE IN PEPFAR

PEPFAR CONSULTATION ON GENDER-BASED VIOLENCE, WASHINGTON, DC, MAY 6-7, 2010

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

MAY 2011

This publication was produced by the AIDS Support and Technical Assistance Resources (AIDSTAR-One) Project, Sector 1, Task Order 1, USAID Contract # GHH-I-00-07-00059-00, funded January 31, 2008.

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AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) is funded by the U.S. Agency for International Development under contract no. GHH-I-00–07–00059–00, funded January 31, 2008. AIDSTAR-One is implemented by John Snow, Inc., in collaboration with Broad Reach Healthcare, Encompass, LLC, International Center for Research on Women, MAP International, Mothers 2 Mothers, Social and Scientific Systems, Inc., University of Alabama at Birmingham, the White Ribbon Alliance for Safe Motherhood, and World Education. The project provides technical assistance services to the Office of HIV/AIDS and USG country teams in knowledge management, technical leadership, program sustainability, strategic planning, and program implementation support.

Recommended Citation

Cornman, Helen and Kai Spratt. 2011. *Scaling Up the Response to Gender-based Violence in PEPFAR: PEPFAR Consultation on Gender-based Violence, Washington, DC, May 6-7, 2010*. Arlington, Va.: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Acknowledgments

AIDSTAR-One would like to thank the PEPFAR Gender Technical Working Group for their technical support for this meeting and expert presenters and panelists.

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CONTENTS

ACRONYMS

AED	Academy for Educational Development
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CSO	civil society organization
DHS	Demographic Health Survey
DOD	Department of Defense
DRC	Democratic Republic of Congo
FBO	faith-based organization
GBV	gender-based violence
GHI	Global Health Initiative
GOM	Government of Mozambique
GOT	Government of Tanzania
HHS	U.S. Department of Health and Human Services
ICRW	International Center for Research on Women
IPV	intimate partner violence
JSI	John Snow, Inc.
MCDGC	Ministry of Community Development, Gender and Children
MOH	Ministry of Health
NGO	nongovernmental organization
OGAC	Office of Global AIDS Coordinator
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RTI	Research Triangle Institute
SGBV	sexual- and gender-based violence
UNAIDS	Joint U.N. Programme on HIV/AIDS
UNDP	U.N. Development Programme
UNFPA	U.N. Population Fund
UNICEF	U.N. Children's Fund
USAID	U.S. Agency for International Development

USG	U.S. Government
WHO	World Health Organization

EXECUTIVE SUMMARY

Gender-based violence (GBV) continues to be a human rights issue with significant health implications. GBV continues to exacerbate the HIV epidemic. A fear of violence often stymies a woman's ability to access prevention, social support, and treatment for HIV. According to Ambassador Melanne Verveer, U.S. Ambassador-at-large for Global Women's Issues, "the Global Health Initiative's focus on women and girls [and gender equality], due to the disproportionate affect of HIV on younger women and girls (girls are 2.5 more likely than boys to contract HIV), is not just the right thing to do but the smart thing to do." As stated by Ambassador Goosby, U.S. Global AIDS Coordinator, the moment to address GBV within the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the State Department's Global Health Initiative (GHI) is now and there is "real anticipation for the future" amongst these agencies in addressing GBV and HIV.

> "Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm…It includes that violence which is perpetuated or condoned by the state. [United National Population Fund (UNFPA) Gender Theme Group]"
> *Source: IGWG of USAID 2008, p. 4*

To address this important issue, PEPFAR recently announced a three-year, U.S.$30 million initiative, including special funding, on scaling up GBV activities in three focus countries: Tanzania, Mozambique, and the Democratic Republic of Congo. To initiate discussion on the GBV platform, on May 6 and 7, 2010, the Office of Global AIDS Coordinator, in collaboration with GHI and the PEPFAR Gender Technical Working Group, brought together technical experts within the field of GBV alongside implementers and country-level national and U.S. Government representatives to discuss the most effective methods for scaling up the response to GBV in PEPFAR.

The objectives of the meeting were to provide support to PEPFAR and partner countries to scale-up GBV programming to:

- Share expertise related to GBV prevention and care needs, and interventions across multiple sectors and systems (health, education, legal, policy, and community)
- Identify research gaps and best practices for monitoring and evaluation.

Some key themes emerged from the two-day meeting, including the following.

GBV is a global pandemic that contributes to substantial morbidity and mortality by reducing women's access to medical and reproductive health services, contributes to poor birth outcomes, and exacerbates women's vulnerability to HIV. Studies from around the world also show that approximately 20 percent of women report having been sexually abused as children (WHO and International Society for Prevention of Child Abuse and Neglect 2006). According to a 10-country study conducted by the WHO between 29 to 62 percent of women have experienced physical or sexual violence, or both, by a husband or partner in their lifetime (WHO 2006). GBV and gender

inequality are important determinants of women's HIV risk due to increased rates of HIV among abusive men and a fear of affected women to seek out HIV prevention and treatment services.

Diverse partnerships and participatory methods are key to creating effective GBV programming. Lessons learned from HIV in terms of coordination and employing a multi-sectoral response must be carried over to address GBV in a comprehensive manner. The approach must involve multilateral, bilateral, and private sector donors with coordinated government leadership at the national, provincial, and district level. The Ministry of Health, alongside various ministries, must be employed at the national level while a diverse array of provincial/district government officials, nongovernmental organizations, communities, and individuals must be responsible for implementing programs and enforcing laws.

Rigorous monitoring and impact evaluations must drive programming. GBV experts should be "searchers" and emphasize low-tech, home-grown solutions with rigorous evaluations. Standardized indicators/milestones must be developed to create effective and quality programs. There is a clear need for continued data collection and evaluation of existing programs and yet the imperative to implement should not be held back by the lack of data. Impact evaluations are extremely important in examining the effectiveness of a program or the differential effect of how it is implemented (efficiency, effectiveness, and cost-effectiveness) and can be carried out at several different stages during programming.

Continue to identify HIV prevention efforts that work. More than 25 years into the HIV epidemic, programmers continue to look for proven prevention approaches. In 2007, for every individual that initiated antiretroviral therapy, five more became infected. Alongside providing clinical, legal, and psychosocial services to women and girls affected by GBV, prevention campaigns to mitigate the violence must be tested and implemented. All new programming should be evidence-based, relying on the most effective methods identified to date. Pathways for identifying and reaching potential victims of GBV must be identified and capitalized on to increase programmatic reach and depth.

Linking mass media campaigns to community- and individual-level programs create more behavior change than relying on mass media alone. The response to HIV has demonstrated through rigorous evaluations that mass media campaigns contribute more to behavior change when they are linked to individual- and community-led interventions. Understanding gender norms within the community is integral to addressing some of the root causes and possible behavior change solutions around GBV. Transformation of male norms and normative behavior surrounding GBV often requires "getting personal," with value-driven programming the most effective in mitigating risk.

Responses to GBV must include impunity. Although many countries have laws addressing GBV and/or gender inequities, there continues to be a lack of implementation of existing laws and enforcement at the individual and community levels. At times, the burden for forensic information stymies efforts to bring perpetrators to justice. Policy-level reform may be needed to ensure enforcement of existing laws or to reform ineffective policing and legal processes.

INTRODUCTION

Gender-based violence (GBV) continues to be a human rights issue with significant health implications.[1] It includes sexual, physical, emotional, and financial abuse; structural discrimination; state-sponsored violence; and trafficking (Gardsbane 2009). GBV contributes to substantial morbidity and mortality by reducing women's access to medical and reproductive health services, contributes to poor birth outcomes, and exacerbates women's vulnerability to HIV. Studies from around the world also show that approximately 20 percent of women report having been sexually abused as children (WHO and International Society for Prevention of Child Abuse and Neglect 2006). According to a 10-country study conducted by the WHO in 2006, between 29 to 62 percent of women report experiencing physical or sexual violence, or both, by a husband or partner in their lifetime. GBV is a global pandemic that continues to exacerbate the HIV epidemic. According to research from South Africa, abusive men are more likely to have HIV and impose risky sexual practices on partners (Dunkle et al. 2004). A fear of violence often stymies a woman's ability to access prevention, social support, and treatment for HIV.

To address this important issue, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) recently announced a three-year, U.S.$30 million initiative, including special funding, on scaling up GBV activities in three focus countries: Tanzania, Mozambique, and the Democratic Republic of Congo (DRC). It is expected that this initiative will bring PEPFAR closer to a coordinated and integrated response that relies on evidence-based approaches.

To begin working on this initiative, the Office of Global AIDS Coordinator (OGAC), in collaboration with the Global Health Initiative (GHI) and the PEPFAR Gender Technical Working Group, convened a meeting in Washington, D.C., from May 6 to 7, 2010. The meeting brought together technical experts within the field of GBV, alongside implementers and country-level national and U.S. Government (USG) representatives, to discuss the most effective methods for scaling up the response to GBV in PEPFAR through this special initiative. Although GBV can affect men, boys, and gender minority communities, the meeting was geared toward GBV amongst women.

The objectives of the meeting were to provide support to PEPFAR and partner countries to scale-up GBV programming to:

- Share expertise related to GBV prevention and care needs, and interventions across multiple sectors and systems (health, education, legal, policy, and community)
- Identify research gaps and promising practices for monitoring and evaluation.

One hundred and twelve participants attended the two-day consultation. The participants included a wide array of experts in GBV program implementation; research and program evaluation; national representatives from Mozambique, Tanzania, and the DRC; and key USG leadership. A full participant list is included as Appendix B. The meeting agenda is included as Appendix A.

[1] "Gender-based violence is violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm…It includes that violence which is perpetuated or condoned by the state. [United National Population Fund (UNFPA) Gender Theme Group]" (IGWG of USAID 2008, p. 4).

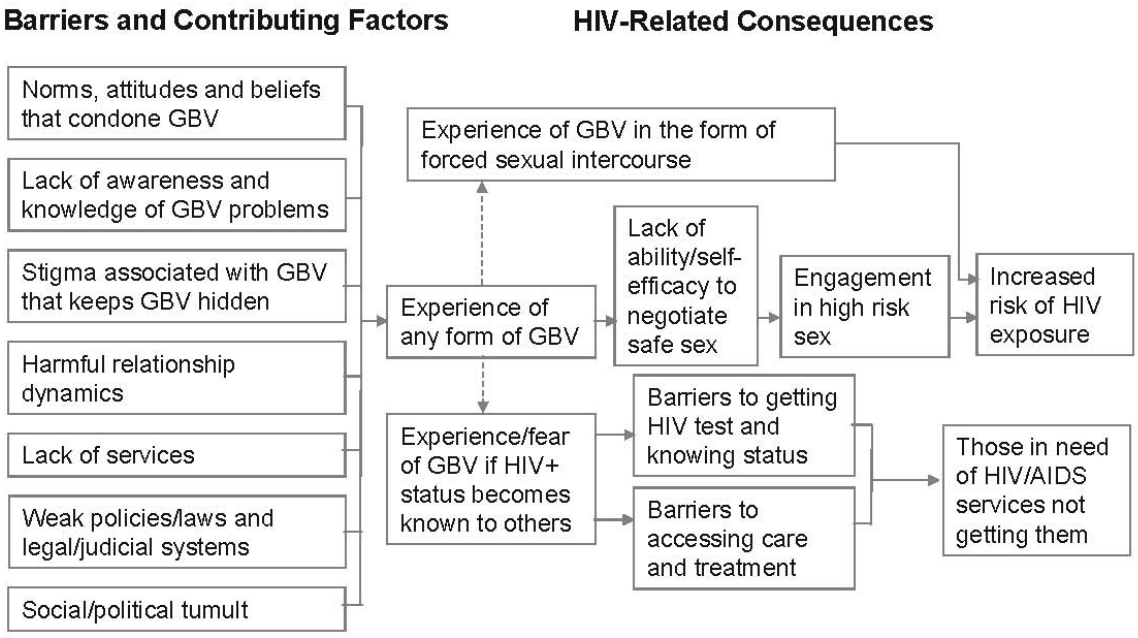
In the sections that follow, each presentation is summarized in the order in which it was given during the two-day meeting. All emphases are in original presentation text.

PEPFAR GENDER PROGRAMMING—PAST, PRESENT, AND FUTURE

Michele Moloney-Kitts, Former Assistant U.S. Global AIDS Coordinator, opened the meeting with a presentation on PEPFAR gender programming. She introduced the importance of addressing GBV within the context of HIV and provided a comprehensive description of the past, present, and future programming of PEPFAR on GBV prevention.

Moloney-Kitts opened her remarks with a description of the importance of GBV, emphasizing that women experiencing violence are exposed to a number of psychological and health implications including higher rates of unintended pregnancies, abortions, adverse pregnancies and neonatal and infant outcomes, sexually transmitted infections (including HIV), and mental disorders (such as depression, anxiety, sleep, and eating disorders). She described causal pathways between GBV and HIV (see Figure 1).

Figure 1. Causal Pathways Between GBV and HIV



Moloney-Kitts described the PEPFAR gender framework that was developed in 2006 following a consultation with more than 120 key partners, allies, and stakeholders. The strategy focuses on five-cross cutting areas, including:

- Increasing gender equity in HIV activities and services—including maternal and reproductive health
- Addressing male norms and behavior
- Reducing violence and coercion
- Increasing women's and girls' access to income and productive resources and education
- Increasing women's and girls' legal rights and protection.

Throughout this process, three key areas were identified that led to the development of three PEPFAR gender initiatives, including the Male Norms Initiative, the GBV Initiative, and the Vulnerable Girls Initiative. The following is a brief description of each of these initiatives.

MALE NORMS INITIATIVE

The centrally funded U.S.$1.8 million Male Norms Initiative was implemented in three PEPFAR countries: Namibia, Tanzania, and Ethiopia. The initiative sought to address harmful male norms and behavior, including GBV, that increase both men's and women's vulnerability to HIV by replicating best practices from existing successful programs implemented by EngenderHealth, Promundo, and PATH into new GBV prevention, care, and treatment programs. The programs, working with both older and younger men, have provided capacity development to key PEPFAR partners and local nongovernmental organizations (NGOs) to engage men and address GBV in HIV risk reduction. Results have demonstrated a decrease in men's likelihood in Ethiopia to support inequitable gender norms and a reported reduction in physical violence against their partners.

GENDER-BASED VIOLENCE INITIATIVE

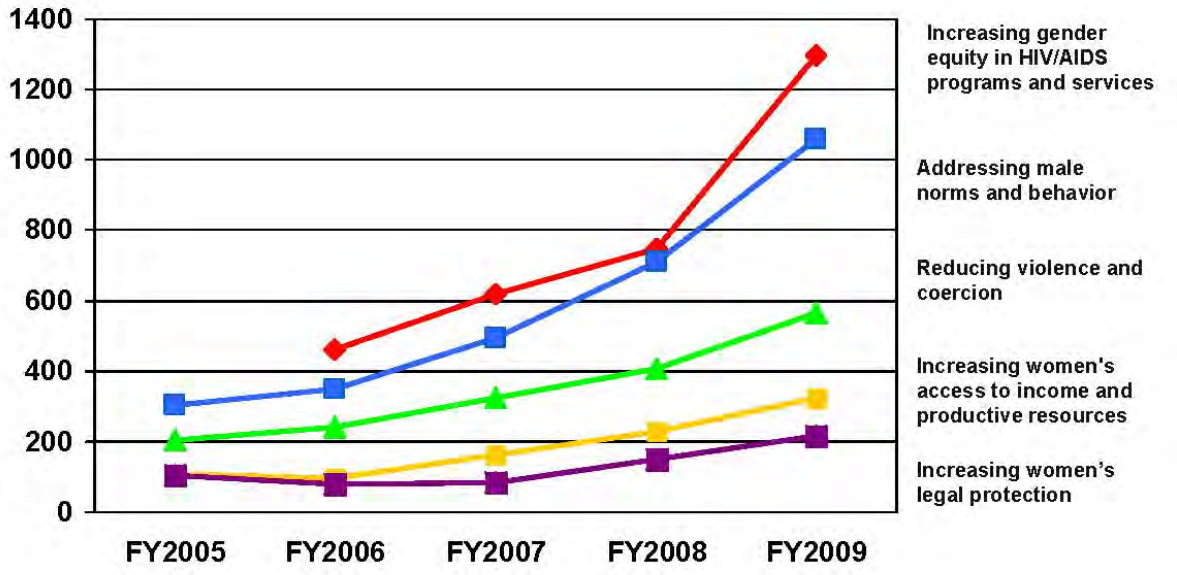
The U.S.$2.4 million GBV Initiative sought to strengthen comprehensive service provision to survivors of sexual violence, including postexposure prophylaxis. The initiative, aligned with the protocols of the Ministry of Health (MOH), was being implemented in Rwanda and Uganda through the Population Council and Futures Group/HPI from August 2007 to December 2010. It sought to increase the capacity of PEPFAR clinical providers and established a comprehensive monitoring and referral mechanism for cases of sexual violence. In January 2011, the project released a publication entitled *A Step-by-step Guide to Strengthening Sexual Violence Services in Public Health Facilities: Lessons and Tools from Sexual Violence Services in Africa*.

THE VULNERABLE GIRLS INITIATIVE

The U.S.$4.5 million Vulnerable Girls Initiative (Go Girls!), implemented from September 2007 to May 2011, seeks to reduce adolescent girls' risk of HIV infection by using interventions at multiple levels in Mozambique, Botswana, and Malawi. To date, the implementing organization, John's Hopkins University, has completed a community service mapping analysis, developed and tested a vulnerability index, and implemented a series of interventions at the structural, community, and family/peer/individual level. The multiple layers of interventions include in- and out-of-school life skills, adult-child communication, community mobilization, radio programs, and economic strengthening. The project aims to have a completed process evaluation and an adolescent girls' toolkit all of which will be available as of June 2011.

After describing these initiatives, Moloney-Kitts pointed to the "incredible opportunity for integration, services, systems, and communication." Although there are some areas where funding is lower, such as the legal and regulatory front, as a whole the level of investment from the field teams has been rising dramatically in the area of gender programming, as shown in Figure 2.

Figure 2. Trends in Gender Programming



GENDER IN PEPFAR REAUTHORIZATION AND THE GLOBAL HEALTH INITIATIVE

The PEPFAR reauthorization legislation included a renewed emphasis on addressing the underlying social, cultural, and economic factors that put women and girls at risk (Lantos and Hyde 2008). In the 2009 PEPFAR Reauthorization bill, there was a call for expanded program monitoring, impact evaluation research and analysis, and operations research. Some of the directed GBV activities included the following:

- Link HIV programming with programs addressing GBV
- Prevent and respond to GBV
- Promote the integration of screening and assessment for GBV with HIV programming
- Promote appropriate HIV counseling, testing, and treatment in GBV programs
- Support civil society organizations (CSOs) to create networks for psychological, legal, economic, or other support services
- Address the structural drivers of the epidemic.

In addition to the PEPFAR reauthorization bill, a focus on women, girls, and gender equality is a guiding principle for GHI. This approach requires that all USG-supported programs conduct a

gender analysis with a specific focus on the comprehensive needs of women. Additionally, it requires programs to work with partner governments to support gender equity and support a more integrated approach, with a particular focus on adolescent girls. It calls on programs to improve monitoring, evaluation, and research on gender-related programming, and involve women and men in program design, evaluation, and monitoring.

PEPFAR GENDER-BASED VIOLENCE PROGRAMMING

OGAC has implemented a number of strategies to increase the focus on gender within PEPFAR.[2] The 2010 country operational plan guidance has requested reporting on funding to GBV as a cross-cutting priority. Some of the activities that have been identified include but are not limited to:

- Comprehensive approach to rape care including the provision of post-exposure prophylaxis
- Prevention activities about GBV through interpersonal communication, community mobilization, and mass media
- Programs to address society and community norms discouraging GBV, promote gender equality, and build conflict resolution skills.

With the new GBV initiative, PEPFAR hopes to move beyond the GBV pilots and gender-based activities to significant scale-up in select PEPFAR countries where national programs are dedicated to GBV. Screening and counseling for GBV within HIV prevention, care, and treatment programs will be encouraged. PEPFAR will support comprehensive GBV response packages for victims of violence at all health facilities (legal services, psychological support, pre-exposure prophylaxis, etc.) and work across sectors (education, police, judiciary, and social services) to address the underlying causes of violence. There will be a focus on addressing policy and structural barriers, and an increased focus on monitoring and evaluation. Moreover, there will also be an increased focus on national leaders to establish, implement, and enforce laws on GBV.

A number of questions followed Moloney-Kitts' presentation, ranging from the timeline of the initiative, the content of the primary focus, and how to involve private sector, to the relationship of GBV within PEPFAR Partnership Frameworks.[3] Moloney-Kitts reiterated that the primary focus will be on the most effective methods surrounding prevention, treatment, and care of GBV with an eye toward integration. She stressed that GBV programming must learn from HIV to reach beyond vertical programming and involve more than just the MOH to address the problem. At the national level, several ministries must be involved in addition to the MOH, such as the Ministry of Social Affairs, Finance, etc. She repeated her vision that women should be reached with GBV messaging through the same pathways that bring them into services for HIV. For example, health providers could discuss GBV with women entering their clinic for other services. In terms of the Partnership Frameworks, participants were reminded that this must come from the countries and that in reviewing the Partnership Frameworks at headquarters, some of these important issues around GBV can be scanned for and asked for if not present. Although no specific timeline for the initiative was

[2] The five PEPFAR strategies are increasing gender equity in HIV programs and services, reducing violence and coercion, addressing male norms and behaviors, increasing women's legal protection, and increasing women's access to income and productive resources.

[3] Partnership Frameworks provide a five-year joint strategic framework for cooperation between the U.S. Government, the partner government, and other partners to combat HIV/AIDS in the host country through service delivery, policy reform, and coordinated financial commitments.

offered, Moloney-Kitts noted that funding for the three countries would be available shortly. It was explained that the "how" for this programming still has not been determined due to the expectation that it will be a country-driven process incorporating monitoring and evaluation from the start to determine best practices. Finally, Moloney-Kitts stressed that PEPFAR is committed to strengthening the government response to GBV through technical assistance at both the national and district levels.

CREATING CHANGE AND FINDING COMMON GROUND IN THE RESPONSE TO GENDER-BASED VIOLENCE

The first panel on day one represented a number of implementers and researchers currently working on GBV research and field projects. The moderator for this session, Susan Brems, Deputy Assistant Administrator, Global Health Bureau, U.S. Agency for International Development (USAID), opened the panel with remarks on the importance of following the research and programmatic experience conducted to date on GBV. The first panelist, Gary Barker, International Center for Research on Women (ICRW), provided an overview of what experience, research, and programming have offered about responding to GBV.

According to Barker, there has been a tremendous amount of research on prevalence and factors associated with GBV in the past 10 years, including a WHO multicountry study and several other studies on programmatic experience. Researchers have increasingly begun to ask questions about the driving forces of use of GBV and factors associated with women's victimization (Garcia-Moreno et al. 2005). Research has identified some of the factors associated with men's use of GBV, including witnessing or experiencing violence (in home of origin or community context), belief/acceptance of rigid gender norms, lack of social controls and impunity, adversarial views toward women, low empathy/remorse, men's economic stress, and substance/alcohol use. Based on research from the IMAGES study in South Africa, men who are economically stressed report higher rates of physical intimate partner violence (IPV): 24.3 percent versus 16.3 percent; higher rates of sexual violence (IPV and stranger rape): 26.6 percent versus 13.9 percent; higher rates of alcohol use: 49 percent versus 29.4 percent; and lower rates of condom use. Some of the factors associated with women's victimization from IPV include witnessing or experiencing violence as a child, age (younger women often have less access to social support networks), age at first marriage (younger than 15 years of age), high parity, low education (less than secondary school), marital status (e.g., living together, separated), and access to independent income (access to microcredit has demonstrated both a reduction and, in some cases, an increase of violence) (Pronyk et al. 2006).

In terms of impunity, Barker highlighted the beginnings of a normative framework in terms of the response to GBV in several countries. Many new laws on GBV have recently been enacted with significant variations in terms of implementation and follow-up, and some research has begun to document implementation and follow-up of these laws. According to Barker, the initial attention on survivor services is now transitioning toward primary prevention and a particular focus on reaching youth at younger ages.

Barker also discussed the complexity of GBV in disaster and conflict settings. Conflict, economic stress, and disaster situations exacerbate GBV, and in many cases changing social sanctions, emasculation of men's roles, weakening social institutions, and increasing stigma create new contexts

for GBV. In these situations, the multiple roles of men as victims, witnesses, agents of change, and perpetrators of GBV are important to recognize and integrate into any prevention efforts.

Barker ended his presentation by endorsing a gold standard community-based integrated approach to GBV that includes several components:

- End impunity
- Survivor services
- Legal and economic empowerment of women
- Primary prevention, including activities targeting men and boys and women and girls in the community, school, mass media, workplace, and sports
- Complementary public security measures such as control of alcohol sales, gun control, and making public spaces violence-free for women and girls
- Policies that engage men and women in achieving gender equality, including policies related to equal sharing of care burden, political empowerment of women, livelihoods, and health.

He endorsed five areas that should be considered to advance the field of addressing GBV at this time:

- **Scale-up evidence-based participatory group education via schools** that promotes critical reflections about gender norms.
- **Reinforce messages with well designed community and mass media campaigns** in which men and women participate in the design, and that present positive messages and paths to change.
- **Train service providers within the health and justice sectors.**
- **Support women's economic empowerment,** particularly when combined with social support and workshops with men.
- **Engage women's rights groups and the growing movement of men and boys** to work for policy change and implementation on issues of gender justice.

He stressed an increasing need for operations research to provide more in-depth evidence based on these approaches.

TRANSFORMING THEORY INTO PRACTICE

The next panelist, Rachel Jewkes, Medical Research Council, South Africa, provided some insight into the programmatic experience of transforming theory into practice from the Stepping Stones project in South Africa. (Please note that the next set of presentations are only brief summaries. All of the PowerPoint presentations are posted on AIDSTAR-One's website at www.aidstar-one.com/focus_areas/gender/resources/technical_consultation_materials.)

Jewkes outlined a number of pathways where GBV may lead to increased risk of HIV. She outlined data from an upcoming article in *The Lancet* that highlights how GBV and gender inequity in relationships increases South African women's risk of HIV acquisition. Through this data, she demonstrated that South African adult men, particularly younger men, who perpetrate GBV are

much more likely to be living with HIV (e.g., men who are violent are two times more likely to have HIV).

She stressed that some of the key messages must include a willingness to discuss masculinity and femininity and move away from an exclusive focus on changing violent behavior.

Jewkes outlined Stepping Stones, a gender transformative program for HIV prevention that aims to improve sexual health through building stronger, more gender equitable relationships. The program, provided for large numbers of people (500,000 in Mozambique between 1999 and 2003) in over 40 countries, has been translated into at least 13 languages; focuses on skills building, gender, communication, and empowerment; and employs a flexible, participatory learning approach. Gender is streamlined throughout the program with a focus on women's lives and empowerment. Stepping Stones was adapted for use in South Africa in 1998 with an additional focus on sexual and reproductive health as well as HIV. In its most recent 2010 third edition, 13 three-hour long sessions are held over six to eight weeks with an additional three peer group meetings for a total of 50 hours of intervention. Through a randomized control trial, Stepping Stones, South Africa, found a reduction in incidents of sexually transmitted infections in male and female study participants (33 percent reduction of herpes), and a reduction of male perpetration of IPV (38 percent reduction) was sustained up to 24 months following the intervention (Jewkes et al. 2008). Behavior changes were also noted, including less transactional sex with casual partners, less substance use, and some evidence of fewer overall partners in men. Because Stepping Stones is the only behavioral intervention in Africa to demonstrate a biological outcome and impact on male perpetration of violence, Jewkes advocates the roll-out of Stepping Stones as a viable evidence-based program to address GBV.

THE PRIVATE SECTOR'S CONTRIBUTION

Gary Cohen, Becton, Dickinson and Company, followed with a discussion on a potential role for the private sector.

Cohen opened with additional background data on GBV (150 million girls are affected) and offered potential roles of the private sector in addressing global health issues such as providing funding, training, and capacity development on employer standards/codes of conducts, and positive incentives and disincentives in dealing with employees. He stressed that donors must pressure high profile companies to lead in projects addressing GBV in the workplace and the communities where they are operating.

Cohen described Becton, Dickinson and Company's current project on addressing GBV that has a number of collaborating partners including WHO, the U.N. Entity for Gender Equality and the Empowerment of Women, and OGAC. The primary pillars of the project include the following:

- Collecting national data on sexual violence experienced by girls in Swaziland, Tanzania, and Kenya
- Providing a comprehensive package of interventions in courts, schools, etc.
- Developing mass communication campaigns.

PRACTICAL EXAMPLES FROM THE FIELD

Nduku Kilonzo, Liverpool VCT, Care and Treatment, Kenya, followed with a presentation on the Liverpool VCT, Care and Treatment GBV/Post-Rape Care service project based in Kenya.

Kilonzo described how the health care system in Kenya, as in much of sub-Saharan Africa, is premised on health sector reforms and international paradigms with dual horizontal and vertical approaches. The horizontal approach often provides decentralized management, a focus on public health, use of the health care system, and relies on limited infrastructure and capacity development. The vertical approach manages from the center; relies on single purpose mechanisms in terms of facilities, human resources, etc.; and focuses on specific issues such as HIV.

Kilonzo described that through research and programmatic experiences in HIV and other programming, the following components are key to effective rape care and GBV service delivery and research:

- Provide one-stop services (this is feasible for high populations but is challenging for scale-up in limited resource rural settings where rape is prevalent and health systems are weak).
- Provide integrated services based on existing systems—allow for scale-up as part of integrated health care systems with rigorous accountability indicators.
- Integrate GBV research into national reproductive health research and continue to develop more in-depth research on children and males reporting sexual violence.
- Provide sustained funding and capacity development for ongoing operations research (testing and evaluation) on GBV and costing research on service scale-up.

In terms of national policy on post-rape care and GBV, Kilonzo advocated for national standards and plans led by a national agency that develops training guidelines on value-based gender and preservice training. The medical and legal sectors must become more integrated with common indicators, referral pathways, and information and training approaches. In terms of systems, minimum quality assurance and minimum planning indicators should be developed. Any organization that considers the addition of post-rape care kits, both at the commercial and locally assembled level, must consider the cost to the supply management chain, potential for stockouts, and perception of providers. Pre-exposure prophylaxis must also be considered standard in terms of post-rape care as a portal for long-term HIV prevention, and improving adherence issues of pre-exposure prophylaxis must be a focal point. Finally, to create a clearer GBV advocacy agenda, a functional network for CSOs must be developed applying lessons learned from the voluntary counseling and testing and HIV movement in Kenya.

Following all of the presentations, a range of questions were asked regarding issues such as the lack of evidence of community-based interventions, the optimal time to start working with men and boys, scale-up needed for engaging communities, the need for hotlines and shelters, and how to work with policymakers who are perpetrators. The answers addressed the high cost of rigorous randomized control trials, the need for giving people/communities tools, and the fact that mass media campaigns are much less effective than smaller based interventions in addressing behavior change. In terms of the hotline, one panelist stressed the need to develop effective referral mechanisms and standards in addition to hotlines and safe places. Policymakers should be encouraged to bring the behavior to the forefront and acknowledge that GBV may be seen as normalized behavior by some lawmakers. It was also stressed that value-based training must continue to be implemented for clinical providers and lawmakers.

GENDER-BASED VIOLENCE RESPONSE PORTFOLIOS WITHIN TANZANIA, MOZAMBIQUE, AND THE DEMOCRATIC REPUBLIC OF CONGO

Deborah Birx, Director, Division of Global HIV/AIDS, Centers for Disease Control and Prevention (CDC), moderated this session. Representatives from all three countries presented data on country responses to date on GBV.

TANZANIA

According to a WHO study, 41 percent of ever-partnered women in Dar es Salaam and 56 percent in Mbeya have experienced physical/sexual violence; 17 percent of these women in Dar es Salaam and 25 percent of these women in Mbeya experienced severe physical violence (Garcia-Moreno et al. 2005). A total of 23 percent and 31 percent of ever-partnered women in Dar es Salaam and Mbeya, respectively, have experienced sexual violence, with 1 in 10 respondents reporting sexual abuse before the age of 15 years. Women who experienced physical or sexual partner violence were more likely to report current health problems, while 60 percent who experienced physical partner violence have never gone to any formal service or person of authority for help. Several other studies were referenced on GBV in Tanzania from the USAID/Health Policy Initiative, Demographic Health Survey (DHS), and the U.N. Children's Fund (UNICEF).

The GBV-related policies that were referenced included:

- The Women and Gender Development Policy of 2000 that provides more focused prevention and eradication efforts on GBV
- The Land Act No. 5 and Village Land Act No. 4 of 1999 that provide the right of land ownership for both men and women
- The National Development Vision 2025, recently passed by the government, that provides for formulation and reviewing of macro and sectoral policies, plans, and strategies with gender perspectives.

The Government of Tanzania (GOT) has also adopted a number of international and regional instruments aimed at achieving gender equality including the Committee on the Elimination of Discrimination against Women; the Southern African Development Community declaration on

Gender and Development addendum; the Ministry of Community Development, Gender and Children (MCDGC) National Plan of Action for the Prevention and Eradication of Violence against Women and Children 2001-2015; and the Sexual Offenses Special Provisions Act that has redefined rape, lowered requirement for biological evidence, increased severity of penalties, and criminalized female genital mutilation/cutting and human trafficking. Recent GOT national multi-sectoral prevention frameworks have a strong emphasis on gender and GBV, and recent gender and HIV operational plans recognize the need to expand efforts to address GBV. Gender desks have been established in ministries, independent departments, and institutions for the purpose of enhancing gender equality. Some of the most recent activities include the development of Ministry of Health and Social Welfare GBV guidelines.

Despite all of these efforts, several challenges still exist in terms of the requirement for proof of penetration, lack of stiff sentencing, and the fact that rape cases are still treated as private matters. Moreover, the National Plan of Action for the Prevention and Eradication of Violence against Women and Children 2001-2015 has been ineffective due to lack of coordinated implementation. While the Law of Marriage Act of 1971 sets the minimum age of marriage for girls at 14 years, this is in conflict with the international and national definition of a child as any person younger than 18 years of age.

USG-led initiatives in Tanzania are also beginning to address this issue. PEPFAR recently developed a GBV technical working group, and PEPFAR implementing partners working in Tanzania have developed their own working group. PEPFAR partners within Tanzania have been implementing several activities including the following:

- GBV coalition/collaboration with GOT
- Community mobilization and interpersonal communication (integrated with HIV prevention and alcohol)
- "Safe schools" pilot
- Integration of GBV into the helpline
- Police training on GBV issues
- Capacity development with journalists
- Local NGOs/forums strengthening
- Needs assessments on GBV issues
- Legal and human rights awareness and education programs, including providing free legal aid services to men and women.

Still, several program gaps exist in terms of periodic GBV surveillance, screening and counseling for GBV, referrals for HIV/health/GBV services, standardized pre-exposure prophylaxis/GBV guidelines, coordinated behavior change campaigns, and coordination between health/social/legal sectors. Significant work also remains in the policy/advocacy arena, particularly in developing legal/judiciary frameworks in raising awareness and behavior change, and women's empowerment, including economic empowerment. Sustained strategies must be aimed at transforming unequal relations of power that perpetuate GBV.

MOZAMBIQUE

In Mozambique the concept of "gender" is viewed as pertaining to women. Men are invited to gender-related activities and trainings and often exclude themselves from participating. GBV tends to be rooted in cultural values that assign an inferior socioeconomic status to women as compared to men. GBV is seen by society as a result of poverty and deprivation rather than a result of patriarchal values and underlying gender inequality. Most women do not report or seek support as it is considered a "private" issue. Violence is more common among married and low-income women where it is associated with partner jealously, suspicions of infidelity, and controlling behavior. A national Law against Domestic Violence was passed in September 2009 and went into full effect in March 2010. The Government of Mozambique (GOM) had 180 days to disseminate information and explain the law before it went into full effect in March 2010. Very few ministries disseminated the information. To date, no national system, guidance, or protocols exist on how to refer, counsel, and/or treat victims of GBV. There is a lack of integrated, systematic procedures and guidelines for addressing GBV. The majority of medical records related to cases of GBV do not report violence as a related cause of an illness. The few shelters/*casa de refugios* that do operate lack standardized protocols and guidelines. Only 10 percent of all cases of violence are reported to the police, with research showing that offenses perpetrated by non-partners are much more likely to be reported than those committed by partners. Sex for grades at both the secondary and tertiary level of schools, and sex for protection with armed forces is common. A 2003 Ministry of Education Decree on sexual abuse in schools is currently under review.

There are several policies and legal frameworks in place that address gender and GBV, including several articles under the constitution, a 2009 Domestic Violence Act Against Women, the 2008 Law Against Human Trafficking and Children's Rights Act, the 2004 Family Law Act, and the 1997 Land Law.

The GOM has implemented several activities to address GBV including the following.

- Activities implemented by MOH:
  - New comprehensive clinical and psychosocial care and referral services
  - Training of health care providers in Maputo to identify victims of GBV for counseling and referrals to other medical or police services
  - Regional trainers will continue to scale-up at the provincial level.
- Activities implemented by the Ministry for Women and Social Action:
  - Training of activists in human rights
  - Capacity development and technical assistance to local organizations working on GBV
  - Income generation assistance program for victims.
- Multi-sectoral responses by the Ministry of Interior:
  - National telephone hotline for reporting and prosecuting abuse against women and children
  - Victim services sections located within 215 police stations at the provincial and district levels

  - Twenty victim support units housed separately from the police stations and located primarily in provincial capitals and surrounding districts
  - New preservice and in-service training programs for police on human rights, gender, and violence.

- Activities implemented by the Ministry of Education:
  - Literature review on sexual abuse in schools
  - Inventory on experience in prevention and combating sexual abuse in schools
  - Joint education and policy and campaigns against violence in schools with teachers' unions, the National Union for Educational Development, and UNICEF.

Civil society community mobilization has been the most active in addressing the issue through the development of a coordinating body to provide capacity development and assistance on issues related to GBV. National trainings for activists, paralegals, and magistrates have been conducted on gender and GBV. Lobbying and advocacy activities are being conducted to revise legislation, policies, and programs that impact women, and community awareness campaigns continue to be conducted on gender, GBV, and violence against girls in schools. Maputo has seen the development and establishment in 2009 of a male engagement program, *Homens pela Mudança*, which is part of MenEngage. Pathfinder conducts the country-wide White Ribbon Campaign of 16 days of activism.

Despite these efforts, several opportunities remain untapped, including incorporating GBV screening into national clinical-based health programming, scaling up preservice and in-service training for health care providers, developing guidelines for preventing and addressing GBV in emergency situations, and improving forensic services and facilities. Trainings must be conducted across sectors, such as health care facilities; the police, justice, and education departments; and social services. GBV awareness and prevention programs must focus on cultural and traditional practices and their impact on men, women, GBV, and HIV. Civil society and community members may work with faith-based organizations (FBOs)/community-based organizations (CBOs) on GBV awareness, alcohol abuse, cultural and traditional practices, and their impact on GBV and HIV. There also exist opportunities to incorporate GBV into armed forces training, especially for new recruits who are most vulnerable. Military units in general are also an opportunity for GBV awareness programs considering that the troops stationed there are away from their loved ones and they interact with surrounding communities on a daily basis. Other specific programs can be directed to the Mozambican peacekeeping force considering their involvement in some operations around Africa. In terms of research and evaluation, an expanded amount of information is needed, including baseline data on current usage of existing services; expanded forensic services; development of clear protocols, and guidelines and indicators for monitoring; program development; and evaluation.

DEMOCRATIC REPUBLIC OF CONGO

According to 2007 data from the DHS, 71 percent of partnered, divorced, separated, or widowed women have experienced emotional, physical, or sexual partner violence in the DRC (Democratic Republic of the Congo 2007). Of these, 36 percent have experienced physical or sexual violence more than five times in the past 12 months. Nine percent of women have had sex under duress, while 16 percent have been forced to have sex against their will. Sixty-four percent of women have experienced domestic violence since age 15, of which 49 percent experienced domestic violence in

the past 12 months. Twelve percent of women who have been pregnant have experienced violence during pregnancy. Almost 50 percent of the 17,500 cases reported in 2009 were children aged 10 to 17 years. Another 9 percent were children under the age of 10 years.

Qualitative data on cultural norms and attitudes related to GBV in the DRC has demonstrated that survivors are often blamed for violence while early marriage may be a contributing factor to GBV (Ray and Heller 2009). While people in uniform perpetrated over 50 percent of the cases reported in the Kivus, in other provinces up to 94 percent were by civilians. Of all of the reported cases in South Kivu, only two percent sought any type of judicial support. There is a national strategy to combat GBV, a U.N.-led Comprehensive Strategy in the Fight Against Sexual Violence in the DRC, and a 2006 anti-GBV law. Yet despite these policies, there continues to be a lack of impunity and enforcement of current laws and policies. According to Margot Wallstrom, a U.N. official based in the DRC, "if women continue to suffer sexual violence, it is not because the law is inadequate to protect them, but because it is inadequately enforced."

Civil society–led community-wide campaigns, primary school education, support networks, economic empowerment, and reintegration of rape survivors are currently being provided across the country, although overall coverage of GBV services continues to be low, particularly in rural locations. Men are affected as well as women, and women can also be the perpetrators. Since 2002, PEPFAR and other USG programs have provided care and treatment services for well over 100,000 sexual- and GBV (SGBV) survivors, including access to medical care, counseling, and family mediation. Human rights, legal services, NGO capacity building, justice, and law enforcement sectors, as well as the media and services for internally displaced persons and refugees, are all part of the multi-sectoral response. The State Department provides training and capacity development for DRC's military justice system, and the U.S. Embassy in Kinshasa provides small grants to local organizations that provide economic and legal support to GBV survivors.

In addition to all of these current activities, some of the potential opportunities identified include:

- Scaling up SGBV clinical training packages for health care workers to respond to SGBV.
- Building SGBV referrals and counseling into the anonymous hotline for HIV.
- Building SGBV questions into already existing research activities and conduct research on prevention and best practices for treatment of children.
- Encouraging the U.N. Population Fund (UNFPA) and Office for the Coordination of Humanitarian Affairs to synthesize GBV data into a mapping format, and ensure that relevant GBV indicators are included in PEPFAR funded data monitoring systems.
- Ensuring harmonization of reporting and monitoring systems for sexual violence.
- Strengthening community outreach and capacity for community-level referral and changing male norms.

Civil society must continue to be empowered to coordinate a mass media toolkit; strengthen other CBOs, FBOs, women's networks, and community leaders to respond to and promote economic strengthening activities; as well as transform male norms correlated with SGBV at the community level. Other activities that still must be carried out by either multi-sectoral and/or civil society involve increasing intergovernmental coordination; training and sensitization of teachers, military, and police; and strengthening of parent-teacher associations', as well as schools', connections with the legal system. Additionally, the military and criminal justice systems must be strengthened.

In terms of evaluation, it was urged that activities must include assessing feasibility, including cost, and implementing a longitudinal cohort study. Baseline and effectiveness studies are needed on testing and costing of SGBV basic packages.

Most of the questions focused on coordination within the countries and as a region. Michele Moloney-Kitts stated that PEPFAR is working with the interagency technical working group on gender and also with the State Department's Office of Global Women's Issues.

AFTERNOON BREAKOUT SESSIONS

Participants spent the afternoon in one of seven concurrent breakout groups. The topics for small groups included behavior change communications/community mobilization, economic empowerment/income generation, the education sector, health services, the legal sector, policy/advocacy, and the social services sector/psychological support. Each group spent approximately 90 minutes discussing their topics and addressing three areas in their report, including key challenges, key interventions, and overarching recommendations. The following is a compilation of the report notes and does not include all of the individual group discussions.

BEHAVIOR CHANGE COMMUNICATIONS/COMMUNITY MOBILIZATION

KEY STRATEGIES/INTERVENTIONS

Objective: Transforming norms and building appropriate relationships between men and women, students and teachers, parents and children, etc.

1. Coordinate efforts from all stakeholders from the top to the bottom.
2. Depending on local context, implement a multi-strategy approach including but not limited to the following:
    a. Small group interventions (e.g., Stepping Stones)
    b. Community mobilization
    c. Edutainment
    d. School-based curricula
    e. Parenting interventions.

KEY BARRIERS/SOLUTIONS

1. Notions of equity—must reflect on own biases and allow community to speak.
2. Messages are negative—must reframe message to more positive messaging (e.g., healthy relationships).
3. One size does not fit all.

ECONOMIC EMPOWERMENT/INCOME GENERATION

KEY STRATEGIES/INTERVENTIONS

1. Combined economic/gender approaches; linked activities but not necessarily one implementer.
2. Multi-sectoral strategies based on formative research to understand context-specific constraints and realities.
3. Change norms simultaneously with women's empowerment.

KEY BARRIERS/SOLUTIONS

1. Limited data on how GBV links with income generation solution—increased funds for gender analysis and a real need for indicators.
2. Unintended consequences (increased transactional sex, backlash)—operations research to document and respond to unintended consequences (e.g., Shaz!).

EDUCATION SECTOR

KEY STRATEGIES/INTERVENTIONS

1. Social development programs within school settings (students/teachers/communities); integrating with other health programs, including HIV.
2. School-community linkages (for safer school environments, NGOs, parent-teacher associations, parenting programs, safe spaces, after-school opportunities).
3. Post-secondary professional and paraprofessional training for service providers (community workers, health workers, social workers, police, judicial staff).

KEY BARRIERS/SOLUTIONS

1. Vertical funding sources—incorporate various stakeholders to address HIV, GBV, and other cross-cutting issues in all scale-up planning and country level work within USG teams.
2. Lack of rigorous evaluations of programs located in low-income settings—provide a commitment to ensure that monitoring and evaluation is an integral part of program design and scale-up, and incorporate the necessary resources (financial, human, etc.) to conduct evaluations.

HEALTH SERVICES

KEY STRATEGIES/INTERVENTIONS

1. Identify key existing data, gaps, and relevant use of GBV data.
2. Ensure service providers understand health implications of GBV and the tools (commodities) for responding; ensure there are adequate resources and policies (e.g., requirements in budgets, guidance, etc.).
3. Ensure a clear understanding of available linkages (legal, mental health, etc.).

4. Encourage utilization of non-HIV health services for GBV response.
5. Encourage role and use of community and linkages to health services.
6. Create entry points to reach men and children.

KEY BARRIERS/SOLUTIONS

1. Stigma and gender inequity.
2. Lack of strong health systems.
3. Bringing in new providers.
4. Understanding of the importance of GBV.
5. Limited scope of this initiative.

LEGAL SECTOR

KEY STRATEGIES/INTERVENTIONS

1. Capacity development for legal sector with regard to proper understanding and application of laws as related to GBV.
2. Support harmonization of conflicting laws and support efforts in making and implementing laws where they do not exist.
3. Multi-sectoral collaboration: link the legal sector to other sectors (medical, community, etc.)

KEY BARRIERS/SOLUTIONS

1. Cultural norms and practices—advocacy of individual rights (including legal rights) and behavior change communication at the grassroots level.
2. Bureaucracy—advocacy at policymaking level and streamlining of laws and procedures.
3. Lack of coordination among different community actors—look to other specialty areas for expertise and best practices in multi-sectoral and multiagency collaboration (e.g., humanitarian reform).

POLICY AND ADVOCACY

KEY STRATEGIES/INTERVENTIONS

1. Central role of CSOs: capacity development; advocacy agenda; involvement in design, implementation, and enforcement; networks.
2. Build political leadership: cultivate champions and capacity; bring in key stakeholders (across government and other sectors); utilize mechanism such as Partnership Frameworks to leverage; accountability.
3. Build efforts toward national coordinating mechanism with adequate mandate and resources: create local demand (through CSOs and FBOs) coupled with USG/multilateral pressure/support and work with government.

KEY BARRIERS/SOLUTIONS

1. Procurement processes—open opportunities for CSOs/indigenous organizations to access USG funds and/or mandate partnership and capacity development in NGO scope; and address humanitarian/postconflict timelines.
2. GBV not sufficiently linked to HIV within PEPFAR structure or operationalized in existing policies and services—review existing national plans and PEPFAR guidance and set expectation/support for USG teams and partners to integrate GBV (staff, resources).

SOCIAL SERVICES AND PSYCHOSOCIAL SUPPORT

KEY STRATEGIES/INTERVENTIONS

1. Build capacity for psychosocial support at the community level (nonprofessional), at the basic service delivery sites, and for more sophisticated psychological therapy.
2. Ensure security: safe spaces, hotlines, shelters, etc.
3. Address stigma and discrimination at all levels (community, family, medical providers, teachers, etc.).

KEY BARRIERS/SOLUTIONS

1. Quality of care available—culturally appropriate techniques and models training and support.
2. Lack of techniques and strategies to engage men in strategies of intervention—working with influential community leaders to suggest appropriate solutions.

Roxanna Rogers, Health Office Director, USAID/Southern Africa, concluded with some remarks on themes common to the day's presentations. She stated that uniformly there is impunity for perpetrators and lack of enforcement of existing laws in all of the countries and communities discussed. Rogers stressed that addressing impunity may be a critical piece of the solution to comprehensively address GBV.

Rogers also highlighted that linking and coordination is an important theme that every country needs to address. Lessons learned from HIV in terms of coordination and employing a multi-sectoral response must be carried over to GBV and HIV. There is also a clear need for continued data collection and evaluation of existing programs. Finally, Rogers concluded that understanding gender norms within the community is integral to addressing some of the root causes and possible behavior change solutions around GBV.

MEASURING GENDER-BASED VIOLENCE PROGRAMS AND OUTCOMES: INDICATORS AND A RESEARCH AGENDA

Day Two opened with a panel discussion on the importance of assessment, lessons learned, and how the health sector may respond to GBV issues. Sunita Kishor, ORC Macro/MEASURE DHS, moderated the panel. The first panelist, Sajeda Amin, Population Council, provided an overview of assessing output and outcomes of GBV prevention and services based on lessons learned from the Population Council's work on SGBV. She also provided some examples of indicators and research strategies to address GBV. The following are brief summaries of the extended presentation. For full access to the presentation, see the slides posted for each presenter on the AIDSTAR-One website at www.aidstar-one.com/focus_areas/gender/resources/technical_consultation_materials/scaling_up_response_to_gbv#presentationsection

The African regional GBV network, operated by the Population Council, the Canadian International Development Agency-Gender Equity Support Project, and the Swedish-Norwegian HIV/AIDS team, involves nine countries and more than 20 partners (www.popcouncil.org/projects/128_AfricaRegSex.asp). Through analysis of data from this project and other Population Council research programs on poverty, gender, and youth, Amin reported that about half of all reported cases of sexual violence occur with children younger than 19 years of age.

In the Copperbelt region of Zambia, of the 612 survivors reporting to the police, 49 percent were under the age of 14 and 85 percent were under the age of 19. In Malawi, a national study found that 50 percent of child sexual assault cases were with children aged 2 to 13 years. In South Africa, police records indicate that 41 percent of all reported cases of rape are against children.

Although the majority of survivors reporting sexual assault across many countries are children or adolescents, services are commonly designed for adults.

There are a number of considerations in creating effective SGBV services, such as the most appropriate place to locate services (health facility, police, social service agency, etc.), and strategies for linking services and who "owns" the services (police/justice departments, which emphasize forensic components, and/or the health sector, which emphasizes the clinical services). Amin reported that most victims who report to the police do not report to the health facility due to the fact that health services may be non-existent, inaccessible, and/or unknown. The guardian may see the incident as legal rather than a health issue, particularly when no medical symptoms are present. Delayed reporting may be due to repeated violations, lack of symptoms, inaccessibility, and/or that a family member is the perpetrator.

As identified by Amin, a framework for comprehensive care must include both immediate- and longer-term response components that provide the following:

- Medical management of sexual violence at point of first contact
- Psychological counseling of the survivor
  - Sensitive approaches to child survivors of sexual violence (of both sexes)
  - Encourage and enable presentation by male survivors.
- Collection of forensic evidence
  - At health facility during medical management and/or at police station
  - Create a chain of evidence that can be used during prosecution.
- Strong links between police and health facility
  - Enable incidents to be referred to initiate prosecution
  - Ensure prosecutions are sustained through the judiciary.
- Prevention in health setting
- Screening for signs/symptoms during routine health communications.

Amin also outlined the PEPFAR special initiative currently being implemented by seven PEPFAR partners in Rwanda and Uganda. The initiative calls for a strengthening of GBV health services, referrals from health facilities to other services, and linkages between clinical services and other stakeholder groups to facilitate increased victims' access to health services. She outlined a number of service and referral indicators. She also reported on prevention programs for vulnerable poor, orphaned, and/or socially isolated girls. Amin reported that poorer girls are more likely to experience sexual debut earlier, and those with fewer social connections are more likely to experience forced sex. Orphans, particularly adolescents, have more economically motivated sexual encounters.

In conclusion, Amin outlined some program indicators corresponding to vulnerability/safety, attitudes toward violence, and incidence/prevalence of SGBV, and acknowledged the challenge of no objective indicators. She outlined some research design considerations such as selection issues for the control and non-control groups. Amin urged that program indicators be tailored to the nature of the intervention and most vulnerable groups (setting matters as well as demographics, particularly age). She also stressed that "who" (as in, who comes to the program) matters more than the setting.

MOBILIZING COMMUNITIES TO PREVENT GENDER-BASED VIOLENCE AND HIV: LEARNING LESSONS FROM SASA!

Lori Michau, Raising Voices, followed with a description of how Raising Voices has moved from more program-based work to implementing impact evaluations alongside programming. Raising Voices attempts to build bridges between program implementers and researchers by developing new tools to assist organizations to move beyond counting activities to more outcome and impact

evaluations. Michau outlined a range of community mobilization principles, such as getting personnel to use multiple strategies and activities over time. She introduced "Start, Awareness, Support, and Action" (SASA!) as a community mobilization approach to preventing GBV and HIV organized into these four phases to influence community norms. Michau also discussed some of the challenges in monitoring and evaluation for community mobilization, including the following:

- Few tools exist
- Must move beyond counting activities
- Lack of capacity for NGOs to conduct population-based studies
- Lack of capacity of NGOs to analyze qualitative data
- Difficulty in identifying essential milestone/indicators along the continuum of prevention
- Randomized control trial design is less conducive to social diffusion models.

Michau outlined the SASA! Evaluation Study, a collaboration between the Gender Violence and Heath Center at the London School of Hygiene and Tropical Medicine, Raising Voices, the Center for Domestic Violence Prevention, and Makerere University (Watts 2008). A cluster randomized trial with two cross-sectional surveys is being conducted in eight sites, in addition to a costing study and evaluation of qualitative components. Indicators have been developed for each phase of the project that are tracked with simple tools (activity report form, outcome tracking tool measuring change in knowledge and attitude, and a rapid assessment survey) designed to provide essential feedback on the program design.

Through the basic research to date, Michau identified some programmatic and monitoring scale-up considerations, including the need for specific GBV content, clarity around goals/strategies, investment in operations research, and reliance on already existing data and lessons learned. Partnerships between research institutions and NGOs can assist in monitoring and evaluation, and possibly guard against overstretching staff. Michau stressed the importance of remembering that transformation requires programs that work at the community level to help people think critically about gender inequity, that must "get personal" about each person's role in perpetrating or condoning GBV, and that all programming must strive to be value-driven and maintain reasonable quality. However, to create vast change, projects must move away from the project mindset and more toward social change.

In conclusion, Michau encouraged participants to access the GBV network to share information and resources, and continue to build the movement (see www.preventgbvafrica.org).

DEVELOPMENT AND USE OF PROGRAMMATIC AND POPULATION-BASED GENDER-BASED VIOLENCE INDICATORS

Shelah Bloom, University of North Carolina/MEASURE Evaluation, followed with a discussion on the compendium of indicators developed for GBV and the international movement to develop harmonized gender and HIV indicators. According to Bloom, the compendium grew out of multiple donors', including USG and the Joint U.N. Programme on HIV/AIDS (UNAIDS), needs for standardized programmatic and monitoring indicators, rigorous impact evaluations, and best practice

recommendations. Through a collaborative process in 2007 and 2008, including the development of a technical advisory group, an agreed on set of quantitative monitoring and evaluation indicators were developed for program managers, NGOs, and policymakers working to address GBV. The indicators were designed to measure short- and long-term progress, evaluate achievement, and demonstrate country- and regional-level outcomes. A range of areas were covered by the indicators including the following:

- Magnitude and characteristics of different forms of GBV (e.g., skewed sex ratios, IPV, child marriage, etc.)
- Sector-based programs (e.g., health, education, justice and security, and social welfare)
- Underdocumented forms of GBV and emerging areas (e.g., humanitarian emergencies)
- Prevention of GBV (e.g., working with youth, men, and boys).

Bloom outlined areas not covered by the indicators, including those best assessed by qualitative methods, emergent areas such as stalking, emotional abuse, and national-level and policy-based indicators such as surveillance systems. She provided some examples of indicators within the compendium and described in depth how one indicator might be measured. The following is one example.

Program Sector—Health

- Percent of GBV survivors who received appropriate care
  - **Numerator:** Number of women/girls who reported violence during a specific time period and who received appropriate care, defined as:
    - Sexually transmitted infection screening and treatment
    - HIV counseling and treatment
    - Emergency contraception (rape survivors presenting within 72 hours)
    - Access to safe abortion
    - Psychosocial counseling
    - Referrals to legal and other community (safe shelter) services.
  - **Denominator:** Number of women/girls who reported violence during same time period.

Bloom concluded by describing the process for creating harmonized indicators within the context of gender and HIV. She stated that there is currently a push to develop at least one or two indicators that can be implemented at the national/U.N. General Assembly Special Session level with a longer menu of programmatic level indicators.

POTENTIAL GENDER-BASED VIOLENCE RESEARCH AGENDA

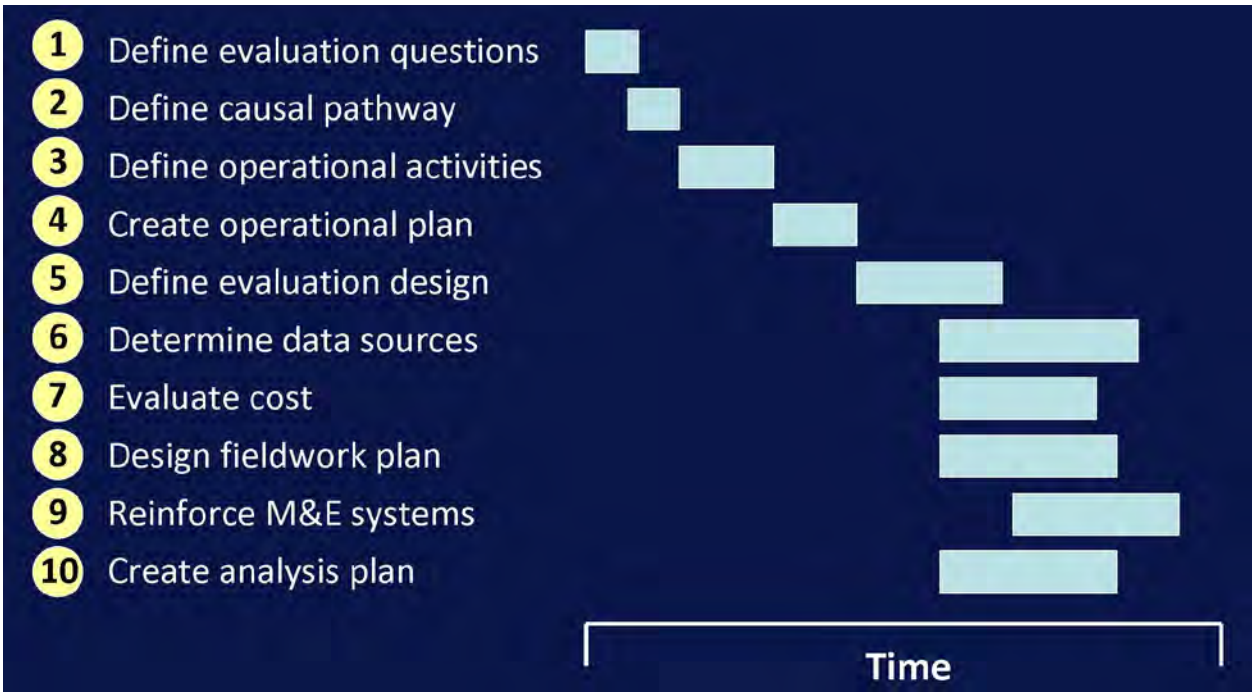
Nancy Padian, Public Health Advisory to OGAC, followed with a discussion on the future research agenda by outlining some key unanswered questions on GBV and linkages with HIV in

programming and service delivery. Padian stressed that it is imperative to balance need with evidence. Evidence-based choices must be implemented from the start to avoid replication of the mistakes made in HIV. She cautioned participants to not let mitigation and care efforts dwarf prevention efforts. However, she also acknowledged that the imperative to implement should not be held back by the lack of data. Although impact evaluations are extremely important, a checklist of indicators does not equal impact.

Padian outlined some criteria for choosing a program including feasibility/acceptability, affordability, scalability, replicability, and whether the causal pathway makes sense; there are measurable outcomes at each step. She stressed that GBV experts should be "searchers" and emphasized low-tech, home-grown solutions with rigorous evidence-based evaluations. She implored the participants to consider innovative strategies for delivery/implementation, such as conditional cash transfers, cash delivery, pay for performance, cash/prize on delivery, and variability in terms of recipients of incentives (e.g., females/males/families/institutions).

Padian outlined some actions to define programs depicted in Figure 3.

Figure 3. "Preliminary" Actions to Define the Program



Padian also provided an example of a causal pathway or logic model and outlined evaluation challenges and solutions including the following:

- Challenges:
  - Reporting bias.
  - Capturing social mobilization and changes in social norms in difficult and unpredictable situations.
  - Long time horizon.
  - Prevention more challenging than mitigation and care.

- Solutions:
  - Build in interim outcomes and examine trends in ultimate impact early on.
  - Choose methods that consider multiple programs and use interim analyses to tweak and drop programs.
  - Measure complete array of health outcomes (a matrix of key indicators will be developed under the Global Health Initiative).

Padian outlined the main themes of conducting an impact evaluation as gaining causal attribution (effect of program on outcomes), understanding impact on beneficiaries, and a comparison of what actually happened to what would have happened without the program. Padian discussed in depth the effectiveness of an impact evaluation on implementation. Essentially, the fundamental premise of an impact evaluation is to examine the effectiveness of a program or the differential effect of how it is implemented (efficiency, effectiveness, and cost-effectiveness). An impact evaluation can be carried out at several different times during program development, such as at program initiation, when scaling up a program (often the most effective time to carry out an impact evaluation), and even when a program is at a "steady state," although this may be the most challenging time.

Padian offered some immediate recommendations for scaling up GBV programming. She encouraged participants to integrate HIV/GBV and reproductive health programs, and to consider multi-sectoral responses that address gender equality and empowerment, including social welfare and development programs such as food security and agriculture. She stressed the importance of requiring measurements in all domains of programming, incorporating transparency, external peer review, and dissemination of all evaluation findings. Padian concluded her discussion by describing some of her research to date on lessons learned and the challenges of three interventions designed to address gender, GBV, and HIV: IMAGE, South Africa; SASA!, Uganda; International Rescue Committee/Men's Resources International, Côte d'Ivoire.

Padian reported that small cluster randomized trials are currently being conducted in all three sites with quantitative surveys being implemented at baseline and following the intervention. Ongoing qualitative research with participants, project staff, community members, and key stakeholders is also being conducted along with costing studies in the IMAGE project, South Africa, and SASA!, Uganda.

CONCLUSION: THE WAY FORWARD

Michele Moloney-Kitts concluded the public portion of the meeting by summarizing what was discussed during the previous two days and by identifying common themes and potential avenues for moving forward. She opened with a review of an ICRW article discussing essential key elements to create social change over time. Moloney-Kitts discussed the "core levers" outlined in the article and related them to the discussion on GBV. The following are some of the "levers" as well as Moloney-Kitts's analyses of how they relate to GBV.

- Breaking boundaries for strategic partnership—cross-sectoral models (e.g., Country Coordinating Mechanisms, National AIDS Control Agencies)
  - Integration model—must consider how the GBV issue can be mainstreamed and how related issues such as child protection can be integrated.
  - Create alliances for effective use of resources.
  - Increase use of networks.
- Engaging men and women in design and diffusion
  - Must include children—importance of children's rights issues, and the inclusion of children may yield more momentum and leverage.
  - Must not ignore men and masculinities as core to prevention.
  - Safety issues should be considered throughout the program.
- Cultivating champions
  - Must identify local and national leaders.
  - Collect data on effective interventions and cost.
  - Support government and civil society to create attention and implement integrated approaches.
  - Clear punitive responses must be part of the equation.
  - Cultivate role of advocates (e.g., Mozambique advocacy on GBV during elections).
- Create a buzz and make it stick
  - Community mobilization imperative.
  - Support media communication and behavior change communication messaging on GBV.
  - Engage providers (e.g., teachers to reduce violence in schools).

- Capitalize
  - Utilize different sectors at the country level.
  - Clearly define what are the "must haves" in programming and advocacy, and identify low-hanging fruit.
- Target efforts
  - Create clear and effective criteria (e.g., economic status might not be as important with GBV).
  - Identify the populations who are most vulnerable.
  - Develop a skill set among communities and individuals.
- Synergize top-down approach
  - Policies, particularly around punitive laws, must be endorsed at the country leadership level.

Moloney-Kitts concluded with a description of some follow-on next steps, including a report from the meeting, a live open chat, and the need to identify gaps and compile tools, models, and programmatic ideas for filling those gaps. She reminded participants that addressing GBV must ultimately become a social movement that promotes the safety of all women and girls, and that future interventions must be value and quality driven.

Friday afternoon was dedicated to USG-only sessions at which no notes were taken by AIDSTAR-One staff. Sessions included the following:

- Recap and setting the stage
  - Overall goals and objectives of the GBV scale-up program.
  - Planning process.
  - Open discussions and questions from country teams..
- Monitoring and evaluation and research discussion
  - Common indicators across countries.
  - Expectations in terms of measurement.
  - What evaluation and/or research needs to happen outside of the countries or through central funding.
- Independent work by country on an outline for country plan including the following:
  - Key content areas the plan should address.
  - Process for developing the plan.
  - How will the plan be reviewed and validated.
  - Country time-line for having a plan ready.
- Report published and discussion.

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RESOURCES

Stepping Stones – South African edition, 2010 third edition, is distributed by the South Africa Medical Research Council Gender & Health Research Unit; please contact Monalisa Hela at mhela@mrc.ac.za

*African Regional Gender Based Violence Network (*Population Council)—www.popcouncil.org/projects/128_AfricaRegSex.asp

GBV Prevention Network—www.preventgbvafrica.org

APPENDIX A: AGENDA

CONSULTATION ON SCALING UP THE RESPONSE TO GENDER-BASED VIOLENCE IN PEPFAR

MAY 6 & 7, 2010, RENAISSANCE DUPONT HOTEL, 1143 NEW HAMPSHIRE AVENUE, WASHINGTON, D.C.

Objective: Provide support to PEPFAR and partner countries to scale up gender-based violence (GBV) programs to:

1. Share expertise related to GBV prevention and care needs, and interventions across multiple sectors and systems (health; education; legal; policy; community); and
2. Identify research gaps and best practices for monitoring and evaluation.

Participants: (1) Experts in GBV program implementation; (2) Experts in GBV research/program evaluation; (3) Representatives from countries selected for GBV program scale-up; and (4) Key USG leadership and members of PEPFAR.

Day 1:

8:30 am	Breakfast
9:00–9:15 am	Opening Remarks: **Ambassador Eric Goosby,** U.S. Global AIDS Coordinator; **Ambassador Melanne Verveer,** U.S. Ambassador-at-large for Global Women's Issues
9:15–10:00 am	PEPFAR Gender Programming—Past, Present and Future: **Michele Moloney-Kitts**, Assistant U.S. Global AIDS Coordinator
10:00–10:15 am	Break
10:15–12:00 pm	Panel Discussion: Creating change and finding common ground in the response to GBV– What works? What doesn't work? How do we move forward?

	Moderator: **Susan Brems,** Deputy Assistant Administrator, Global Health Bureau, USAID
	Panelists:
	Gary Barker, International Center for Research on Women; What experience, research and programming have taught us about responding to GBV: An overview
	Rachel Jewkes, Medical Research Council, South Africa; Transforming theory into practice: The Stepping Stones experience
	Gary Cohen, Becton, Dickinson and Company; The private sector's contribution
	Nduku Kilonzo, Liverpool VCT, Care & Treatment, Kenya; Practical examples from the field
12:00–1:00 pm	Lunch
1:00–2:30 pm	Panel Discussion: Country Presentations of GBV Response Portfolio—**Tanzania**, **Mozambique**, and **The Democratic Republic of Congo**
	Moderator: Deborah Birx, Director, Division of Global HIV/AIDS, CDC
2:30–4:00 pm	Break-out Groups by Sector (each to prepare a 5 min report using templates provided)
	Areas for Small Groups and Facilitators -Policy/Advocacy (Diana Prieto, USAID) -Health Services (Clint Liveoak, CDC) -Legal Sector (Hormazd Sethna, DOD) -Education Sector (Daniela Ligiero, OGAC) -Social Services Sector/Psychological Support (Nina Hasen, OGAC) -Behavior Change Communications/Community Mobilization (Meghan Donahue, Peace Corps) -Economic Empowerment/Income Generation (Kimberly Coleman, DOD)
4:00–5:30 pm	Report Out and Plenary Discussion
	Moderator: Roxana Rogers, Health Office Director, USAID/Southern Africa
All day/afternoon:	Marketplace of Ideas and Programs (a place where organizations and countries can showcase their work, materials, resources, etc. related to GBV)
6:00–7:00 pm	Welcome Reception, Circle Bistro, 1 Washington Circle NW
Day 2	
8:30 am	Breakfast
9:00–11:00 am	Panel Discussion: Measuring GBV Programs and Outcomes: Indicators and a Research Agenda
	Moderator: Sunita Kishor, ORC Macro/Measure DHS

	Panelists:
	Sajeda Amin, Population Council; Measurement of GBV prevention and services: assessing output and outcomes
	Lori Michau, Raising Voices; Monitoring and evaluation of GBV community mobilization programs: Lessons from the field
	Shelah Bloom, University of North Carolina/Measure Evaluation; Development and use of programmatic and population-based GBV indicators
	Nancy Padian, Public Health Advisor to OGAC; Defining the research agenda for the future: key unanswered questions on GBV and linkages with HIV in programming and service delivery
11:00–12:00 pm	Next Steps with advocacy and HIV/AIDS Communities and Closing: **Michele Moloney-Kitts**, Assistant U.S. Global AIDS Coordinator

APPENDIX B:

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