

Recognizing Gender-Based Violence as a Clinical and Multi-Sectoral Issue: A Case Study of Jhpiego's Support to the Ministry of Health in Mozambique



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This document is part of a series of case studies to showcase how gender can be integrated into Jhpiego's programs. It describes the integration of gender-based violence services with HIV testing and counseling services at the health facility and community levels in Mozambique.

Jhpiego is an international, nonprofit health organization affiliated with Johns Hopkins University. For more than 40 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world's most vulnerable populations.

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Abbreviations

CDC	Centers for Disease Control and Prevention
DHS	Demographic and Health Survey
GBV	Gender-Based Violence
GBVI	Gender-Based Violence Initiative
GDP	Gross Domestic Product
HTC	HIV Testing and Counseling
IPV	Intimate Partner Violence
MOH	Ministry of Health
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-to-Child Transmission of HIV
SBM-R®	Standards-Based Management and Recognition
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Summary of Key Results

Quality of gender-based violence (GBV) services at the health facility measurably improved. In less than a three-year period of intervention (2011–2014), five of the seven demonstration sites that received prioritized support achieved a score of 80% or more in the achievement of standards for quality comprehensive GBV services, up from 10% or less in most sites.

Access to post-exposure prophylaxis (PEP) for HIV by GBV survivors multiplied. From June 2011 to December 2014, a total of 3,818 survivors accessed GBV services in 42 health facilities supported by Jhpiego. Overall, access to PEP for sexual violence survivors increased to 81% in Year 4 (as of April 2014) of the initiative, up from 49% at baseline based on a retrospective analysis of data from 2005–2010.

A GBV recording and reporting system was established for the health sector. The GBV health reporting forms piloted by Jhpiego and partners have now been approved by the Ministry of Health (MOH) as the national tool for GBV case reporting in all health facilities.

Awareness and dialogue on GBV at the community level increased. Lay counselors reached some 27,366 men with GBV messages through voluntary male medical circumcision (VMMC) outreach activities and sensitized and screened 312,188 people for GBV, of which 76% were women. According to community leaders and lay counselors, dialogue about GBV in the community notably increased.

Community outreach resulted in increased uptake of GBV services. Service uptake consistently increased once Jhpiego-supported lay counselors and other U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Gender-Based Violence Initiative (GBVI) partners began to sensitize the community on GBV, identify cases, and make referrals starting in October 2012. Through Jhpiego community outreach, a total of 509 GBV cases were identified, and of these 84% reached the health facility.

In the peri-urban city of Ndlavela, a small city less than one hour from Maputo, Mozambique's capital, a young Jhpiego-trained doctor is leading the efforts to integrate comprehensive care for GBV survivors with services at the primary health facility. Despite the fact that there is just one health center and one health post that serve 169,000 inhabitants, making Ndlavela the most densely populated health catchment area in the country, Dr. Bachir Macuácuá, head doctor at the primary health facility, has made GBV survivors a priority. When initial data collected through HIV testing and counseling services at the household level showed a significant number of GBV cases, he took leadership in organizing and coordinating the GBV response in his health catchment area integrating efforts at the health facility and community levels. For example, when one particularly difficult case, which involved the sexual abuse of a young girl, was presented at the health facility, Dr. Bachir took it upon himself to visit her home to facilitate her removal from the situation to a safer environment. When asked if he faces resistance by those that he supervises, he said he simply tells them, "Today it may be someone else's daughter [who is raped]; tomorrow it may be yours."

Background

Mozambique is a young country located in sub-Saharan Africa that gained independence from Portugal in 1975. It has a population of 25,727,911, and its poverty and gender inequality indicators are among some of the lowest in the world. For example, the female-to-male ratio of education is .69.¹ Almost 65.5% of men and 35.9% of women can read or write Portuguese; and maternal mortality stands at 169/100,000 live births.² In Mozambique, 37% of women have experienced some kind of gender-based violence (GBV)³ in their lives, while 12% have been forced to have sex in their lives, and 7% in the last 12 months.⁴ Prevalence of HIV is also high at 11.5% of the general population, with prevalence among women—13.2%--higher than prevalence among men—9.8%.

Mozambique has a publicly funded health system providing health care for the majority of the population. The gross domestic product (GDP) per person is 1,100 USD and national expenditures in health are 6.2% of the GDP (2011).⁵ The system is based on the values and principles of providing universal primary health care to all. However, equity and universal access to health services is not yet a reality, despite strong commitments from the Ministry of Health (MOH). The major impediment to delivering essential interventions is the shortage of skilled health workers. With 64.5 medical doctors, nurses, and maternal and child health nurses per 100,000 population in 2011, Mozambique is below the global minimum acceptable health worker density threshold of 230/100,000, as recommended by the World Health Organization (WHO). The shortage is further

¹ <https://public.tableau.com/profile/mckinsey.analytics#/vizhome/MGIGenderParityandtheEconomyDashboards/MGIGenderParityandtheEconomy>

² <http://www.ine.gov.mz/estatisticas/estatisticas-demograficas-e-indicadores-sociais>.

³ GBV is any harm that is perpetrated against a person's will, and that results from power inequalities that are based on gender roles. It includes, but is not limited to, physical, sexual, and psychological harm (for example, slapping, hitting, kicking, punching, choking, sexual assault, verbal abuse, threats and coercion, etc.).

⁴ Ministério da Saúde (MISAU), Instituto Nacional de Estatística (INE) e ICF International (ICFI). Moçambique Inquérito Demográfico e de Saúde 2011. Calverton, Maryland, USA: MISAU, INE e ICFI.

⁵ http://www.aho.afro.who.int/profiles_information/index.php/Mozambique:Analytical_summary-_Health_financing_system/pt#cite_note-0 (WHO assumes that 6.2% of GDP was spent on health system, but the World Bank assumes that it was 5.7%).

compounded by an imbalanced distribution of personnel across regions and between urban and rural areas, resulting in poor coverage in many areas.⁶

GBV is a globally recognized public health problem. The findings from more than 100 international studies carried out in the last two decades paint a disturbing picture. They show that about one out of every three women globally has been raped, beaten, or otherwise mistreated, usually by a family member or intimate partner.⁷ The impact of this violence on the physical and mental health of women and girls is devastating and seriously limits their ability to participate fully and share in the benefits of development.⁸ GBV is not only a leading cause of injury and even homicide for women, but now a large body of evidence exists on its links to other health problems, including unintended pregnancy, low birth weight, lowered immune system, permanent disability, depression, suicide, and increased risk for HIV.

GBV puts women and girls at greater risk of HIV infection through multiple pathways. According to UNAIDS, women who have experienced violence are up to three times more likely to be infected with HIV than those who have not.⁹ Women who have been raped face an obvious risk of infection from their assailant through physical trauma and unprotected, coerced sex. However, women are often reluctant to report the crime because of the stigma associated with rape, concerns about secondary victimization,¹⁰ and a lack of confidence in the criminal justice system. Therefore, many GBV survivors do not receive any care or follow-up, including post-exposure prophylaxis (PEP) to prevent HIV infection where it is available. Women living with violent partners are less able to protect themselves from unsafe and coerced sex. Moreover, women who have experienced violence and child sexual abuse are more likely to practice high-risk behaviors that put them at risk for HIV, such as substance abuse and multiple concurrent partners.¹¹ At the same time, women living with HIV are more likely to suffer violence as a result of their status, from intimate partners as well as family and community members. Because of this, the fear of violence can keep women from seeking testing, care, and treatment, and, in some settings, may even discourage women from attending prenatal services to avoid testing and disclosure of their HIV status.¹²

Gender-Based Violence Policy Framework in Mozambique

⁶ Relatório Anual 2011, Ministry of Health, Directorate for Human Resources for Health.

⁷ Ellsberg M and Heise L. 2005. Researching Violence Against Women: A Practical Guide for Researchers and Activists. Washington, DC: World Health Organization, PATH.

⁸ For a comprehensive look at the prevalence, causes, costs, and consequences of violence against women, see: Nations. 2006. In-depth Study on All Forms of Violence against Women: Report of the Secretary General. Available at: <http://www.un.org/womenwatch/daw/vaw/violenceagainstwomenstudydoc.pdf>.

⁹ UNAIDS. 2010. Women, Girls and HIV Fact Sheet (Geneva: UNAIDS).

¹⁰ Secondary victimization refers to behaviors and attitudes of social service providers that are “victim-blaming” and insensitive, and that traumatize victims of violence who are being served by these agencies.

¹¹ Campbell JC et al. 2008. The Intersection of Intimate Partner Violence against Women and HIV/AIDS: A Review. *Int J Inj Contr Saf Promot* 15(4):221–31.

¹² Ibid.

Despite constrained resources, Mozambique has been mobilizing to promote gender equality and to address GBV, as per the Beijing Platform of Action,¹³ as early as 1995. Fórum Mulher, an umbrella group of civil society organizations promoting women's rights in Mozambique, had long been advocating for a law against domestic GBV before its passage in 2009 by Parliament. The passage of Law 29/2009 is a major milestone among the initiatives to address GBV in Mozambique. Although the final law is still considered to have many gaps¹⁴ by the national women's movement, its value is undeniable as the first mechanism to demonstrate official legal and political recognition of the issue, as well as to establish an important framework for mobilizing a response to GBV in the country. The law's stated aim is to:

“...prevent, punish offenders and provide victims of domestic violence the necessary protection, guarantee and introduce measures to provide state agencies with the necessary tools for the elimination of domestic violence.”¹⁵

As a result of these same efforts led by the women's movement, in 2008 to 2012, the government released the National Plan of Action for the Prevention and Combatting of Violence against Women. This National Plan put forth a series of actions for the government and its partners to take to reduce GBV, such as raising awareness; increasing advocacy; training various public and educational institutions on their roles and responsibilities in responding to GBV; and establishing medical, psychological and legal services; as well as multi-sectoral coordination mechanisms. Additionally, in January 2009, the Strategy for Integrating Gender across the Health Sector, which recognized GBV as a key issue, was approved by the Minister of Health and disseminated for use through the leadership and persistent efforts of the MOH Gender Advisor, Dr. Francelina Romão.

In 2012, the government, under the leadership of the Ministry of Gender, Children and Social Affairs¹⁶ and in collaboration with civil society, developed the *Integrated Mechanism for the Care of Victims of Violence* to define more specific roles and responsibilities of various government entities, including the Ministries of Health, Gender, Children and Social Affairs, Justice, and the Interior, as related to services to respond to violence, including GBV. The ultimate goal of this mechanism was to promote integrated services by outlining general guidance for:

- Improving quality of services to GBV survivors, from the definition of basic procedures of care through the development of guidelines and service delivery protocols for all professionals involved in a GBV response;
- Coordinating actors in the GBV response to better address the comprehensive needs of GBV survivors; and

¹³ The Beijing Platform for Action was the key outcome of the Fourth World Conference on Women in Beijing, China in 1995 and is an agenda for women's empowerment. It covers, among other topics, women's education, human rights, poverty, and violence against women. For more information: <http://www.un.org/womenwatch/daw/beijing/platform/>.

¹⁴ Gaps cited included lack of recognition gender inequality as a root cause of violence against women, limited responsibility on the State to prevent GBV and limited stipulations around victim assistance.

¹⁵ Assembleia da República de Moçambique Lei N.29/2009 Sobre a Violence Domestica Praticada Contra a Mulher.

¹⁶ Prior to 2015, this Ministry was named the Ministry of Women and Social Action.

- Institutionalizing monitoring and evaluation data collection and analysis, based on standardized forms and indicators developed by each sector.

Each sector was expected to create specific protocols and guidelines, as the mechanism promoted the development of service delivery protocols, including protocols for medical and psychological care, the medico-legal exam (forensic evidence collection), and the protocol for treatment of sexual violence survivors.¹⁷

¹⁷ At the time of writing, the Government was working on the revision of the document to improve specific clauses, for example, the guidance that survivors should first go to the police rather than to health services.

Jhpiego's Support to Gender-Based Violence Initiatives in Mozambique

Against this political backdrop and a favorable donor environment, Jhpiego assisted the MOH in making significant strides to establishing a formal response to GBV in the country, in particular, in the development of health service delivery protocols and training materials for GBV. Jhpiego, under the auspices of the President's Emergency Plan for AIDS Relief (PEPFAR) and the Centers for Disease Control and Prevention (CDC) grant "Strengthening Safe Hospitals and Clinics in HIV/AIDS Prevention,"¹⁸ had been helping the MOH to promote HIV testing and counseling (HTC) and to provide PEP, primarily for occupational exposure to HIV. Under this program, Jhpiego worked with the MOH to draft the health service protocols and training materials that would become the official MOH protocols and the standard training package used by all PEPFAR partners conducting GBV health service training in Mozambique. Additionally, Jhpiego provided technical support to the MOH to integrate GBV with national health data collection tools.

With a new three-year PEPFAR GBV Initiative (GBVI)¹⁹ that brought additional funding from the United States Office of the Global AIDS Coordinator, Jhpiego was one of 23 US Government partners called upon to expand its work, particularly the expansion of PEP services to GBV survivors through capacity-building and technical support. This initiative included integration of GBV services with HTC activities, GBV education in outreach, and services for voluntary medical male circumcision (VMMC) at both the facility and community levels. Jhpiego also provided technical assistance on GBV health services to all (CDC and the United States Agency for International Development [USAID]) clinical partners across the country.

Under the CDC grant to scale up non-occupational PEP, Jhpiego undertook the following activities starting in 2011:



In-service training on GBV for nurses and medical technicians at Pemba Provincial Hospital.

¹⁸ Objectives of this program included capacity-building and technical support in palliative care and infection control in Tuberculosis (TB-IC), HIV counseling and testing, health systems strengthening/human capacity development, and voluntary medical male circumcision.

¹⁹ In 2011, PEPFAR launched a \$55 million, three-year GBVI in response to the global body of research showing a strong and complex set of linkages between GBV and HIV infection, with violence being both a risk factor for HIV acquisition, and a consequence of being HIV infected. The Democratic Republic of Congo, Mozambique, and Tanzania were tasked with integrating GBV prevention, care, and treatment interventions into their HIV platform. The GBVI was the first of its kind, where simultaneous prevention and response activities were conducted such as combining GBV interventions at the individual, community, and clinical levels.

In Mozambique, this inter-agency effort integrated GBV into existing HIV programs at community, health facility, and national policy levels through 23 implementing community and clinical partners of the CDC and USAID, plus the Ministries of Health, Interior, and Gender, Children and Social Action. The GBVI was designed to: 1. Expand and improve GBV prevention coordination and effectiveness; 2. Improve GBV-responsive policy implementation; and 3. Improve the quality and availability of GBV services.

- An assessment of 10 health facilities to inform a strategy and develop guidelines for the health sector response;
- Development of guidelines, training materials, and quality assurance tools for GBV services in the health sector; and
- Training and technical support to health care providers across 42 health facilities across the country.

Under the GBVI, Jhpiego initially planned to scale up its community counseling and testing work to include the identification and referral of GBV cases through community- and household-based outreach and conduct follow-up of survivors by reinforcing linkages among community and health care services. Later, in the GBVI and based on the commitment of health facility staff, Jhpiego also supported:

- Infrastructure upgrades were made to demonstration sites for integrated, one-stop centers for GBV services;
- Integration of GBV sensitization in community outreach and door-to-door HTC activities; and
- Multi-sectoral coordination for an integrated response with police, justice, and social affairs.

These activities and related achievements are further described below.

Assessment of health facility responses to GBV. In order to mount a more holistic response to GBV that includes quality care and support at the health facility, Jhpiego, in coordination with the MOH, conducted an assessment in 10 health facilities to identify the profile of GBV survivors and perpetrators, strengths and weaknesses of the institutional response, and opportunities to improve it.²⁰ Key findings of the assessment were:

- 69% of GBV survivors reporting to facilities are minors (aged 17 or younger);
- GBV survivors mostly report to the police first and are referred to the health facility by the police, as per the national protocols; and
- Of those sexual violence survivors who access health services, almost 31% arrive too late for PEP,²¹ putting them at risk for HIV infection as a result of the assault.

Development of guidelines and training materials. Thanks to its close working relationship with the MOH, Jhpiego was



Health Sector Guidelines and Training Curriculum

²⁰ C:\Users\Ana Baptista\AppData\Local\Temp\AIDS 2012 Abstract - Sexual violence in Mozambique the first profile at Mozambique's largest hospital.htm.

²¹ Ibid.

tapped to develop the health sector guidelines and training materials for care for GBV survivors. Dr. Francelina Romão, who at the time was the gender advisor within the MOH, relied heavily on Jhpiego to lead the development of a “Guide for Integrated Care for Victims of Gender-Based Violence” (2012) and a “Manual for Integrated Care for Victims of Gender-Based Violence” (2012). In coordination with the MOH, Jhpiego supported the development of “Guidelines for Post-Exposure Prophylaxis and Care for Gender-Based Violence” (2011). Jhpiego was one of the lead authors of the materials and facilitated consultations with a multi-sectoral technical working group, which included the WHO and other PEPFAR-funded organizations, to write the documents. Drawing on this manual, Jhpiego is also working with the MOH to integrate a GBV module into pre-service training for nurses. In addition, Jhpiego also led the fine-tuning of a protocol and corresponding job aid demonstrating the clinical care steps on providing care for GBV survivors from intake to the provision of PEP and emergency contraception.

Standards of performance and quality for GBV services. Jhpiego also developed a set of standards for GBV health facility services in Mozambique through the Standards-Based Management and Recognition (SBM-R[®]) process. Jhpiego’s approach to performance and quality improvement, which it has applied across the range of health areas in which it works. This process entails assessing each facility to determine whether it meets a key set of quality standards and then giving each facility a score at various points in the technical assistance process. For GBV, this includes the following seven categories: leadership, multi-sectoral coordination, availability of physical resources and materials, human resources, flow of patients for GBV services, immediate GBV care, clinical and psychological care of survivors, and recording and follow-up of cases. In total, the SBM-R[®] for GBV has 43 standards in the seven areas, which are now being used by the MOH and other partners to monitor and improve the quality of GBV services across the country. Prior to trainings, participating facilities assessed themselves with these GBV standards to develop a facility improvement plan at the end of their training. Jhpiego provided supervision and validation of the assessments. Progress was measured by facilities assessing themselves against the standards every six months thereafter. The SMB-R[®] standards developed for Mozambique are now being turned into a global tool that can be applied in other countries.

Training and ongoing technical support to health care providers. From June 2011 to December 2014, Jhpiego trained 2,367 health care providers, including, doctors, nurses, medical technicians, psychologists, and social workers in GBV clinical care. Jhpiego trained an initial core set of master trainers in both the content and training skills so that these master trainers could then cascade the trainings to others in their respective provinces across 42 sites of varying capacity and levels of the health system. Three-day trainings for health care providers covered: sensitization on gender and gender norms; definitions, types, nature, health consequences of GBV; legal framework on GBV; provision of clinical care, including PEP for GBV survivors; psychosocial support; medico-legal aspects, such as forensic evidence collection; the importance of integrated care; referral systems; data recording and information systems; and follow-up of survivors. An additional two days of training included planning and coordination with other sectors.

The establishment of demonstration sites for integrated GBV care. After non-occupational PEP had been scaled up in the 42 health facilities, Jhpiego met with CDC staff and the PEPFAR Gender Advisor

to identify additional activities. The GBVI had identified five priority provinces based on a number of factors, including high HIV rates and low contraceptive prevalence, where providers had been trained. Based on priorities of the *Integrated Mechanism for the Care of Victims of Violence*, the group decided that Jhpiego should identify one site in each of the priority provinces to serve as a demonstration site for best practices in integrated post-GBV care and follow-up. This way, partners and other facilities could learn from Jhpiego's experience, especially given that Jhpiego would take on the clinical technical assistance role around post-GBV and treatment. In 2012, the idea of a centrally located demonstration site, where a survivor could access police, psychosocial, and medical services for GBV, was agreed upon. Jhpiego was then responsible for initially establishing five demonstration sites: Xai-Xai Provincial Hospital in Gaza province; Dondo Health Center in Sofala province; Pemba Provincial Hospital in Pemba province; Ndlavela Health center in Maputo provinces, and General Hospital José Macamo in Maputo city. These sites qualified based on their high achievement ratings as per the standards of performance for GBV, as well as strong leadership and committed staff. As such, investments were made in infrastructure upgrades, furniture and toys for children, and beds for an overnight stay for survivors who could not return home safely. Although no new structures were built, mainly to minimize costs, the health facilities were able to identify a secure and safe space to provide post-GBV services. An additional two demonstration sites were added in 2013 in Gaza province (Chokwe Rural Hospital) and Maputo City (Xipamanine Health Center) given their standard of performance.

Integration of GBV care into general health services. Jhpiego supported the integration of GBV care and support at 35 health facilities of varying capacity and levels of the health system, from hospital to health post, through the training and SBM-R® process described above. Providers were trained to give care as described above. Screening for GBV, however, is routinely done only in Ndlavela, where comprehensive services (legal, psychosocial, etc.) beyond the health facility are available. The decision to avoid routine or universal screening was based on a WHO recommendation,²² which found that routine screening increases the identification of survivors of intimate partner violence (IPV), but does not lead to a reduction in IPV. Furthermore, women may find repeated inquiry difficult, particularly if no action is taken due to a limited capacity of responding to women identified through screening. Where demonstration sites exist, providers at other facilities in the area refer survivors to those centers for further care.

Inclusion of GBV in the national health data recording. The MOH, with support from Jhpiego, also piloted and established a national standard reporting form and information system for each health facility to record GBV cases, allowing the MOH to compile, analyze, and compare data in one national registry. Jhpiego has been providing technical assistance at the facility level on the recording of GBV data. At the community level, data collection forms and a database include information for



Primary register forms for post-GBV care implemented

²² WHO. 2012. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. p. 17–18.

GBV screening, referrals, and follow-up of survivors. Innovative approaches have included the development and implementation of a computerized data entry form that can also be accessed and used on a smartphone. Once data are entered, the information can be quickly sent to the MOH national database.

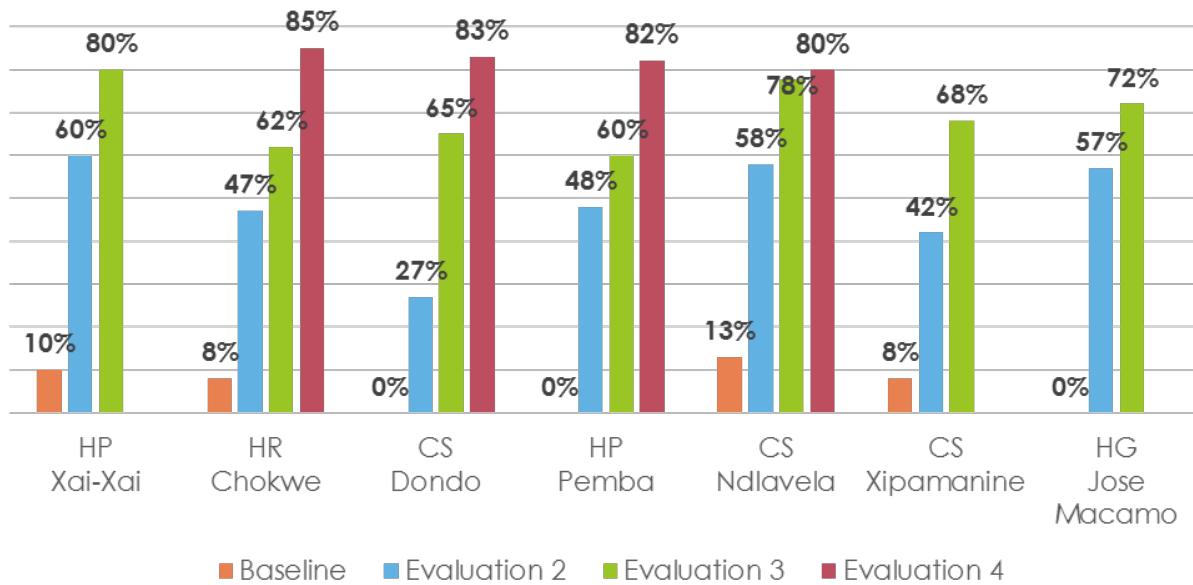
Increasing access to justice through standardizing medico-legal reports. Jhpiego also provided technical inputs into the development of a tool to document medical forensic evidence for GBV. These tools are being tested in coordination with the police and legal system to ensure quality of medico-legal evidence and reports for GBV, and ultimately, improve access to justice for GBV survivors.

Community outreach through lay counselors and community leaders. In October 2012, Jhpiego integrated GBV with outreach by lay counselors who were already conducting household visits to promote HTC and other health services, such as VMMC and TB testing. Lay counselors received a two-week training for HTC, which included theory and practice and ongoing supportive supervision by Jhpiego staff on GBV awareness-raising, identification, referral, and follow-up. Moreover, community leaders were also engaged to facilitate access to services and to speak out against GBV. After a series of household visits and discussions about other health issues and risk behaviors for HIV, such as forced sex, lay counselors opened up discussions about violence and provided information to household members about Mozambique's law against GBV, Law 29/2009. During private consultations about HIV, the counselors inquired about any acts of violence the client faced, or, when addressing children in the household, if they experienced any inappropriate touching, and then referred them to the nearest one-stop center or health facility offering GBV services. If the survivor desired, lay counselors accompanied them to the facility to help link them to services, and, when available, a peer navigator at the facility helped orient the survivor through care and treatment services. Households visited by lay counselors were recorded and mapped.

Key Results

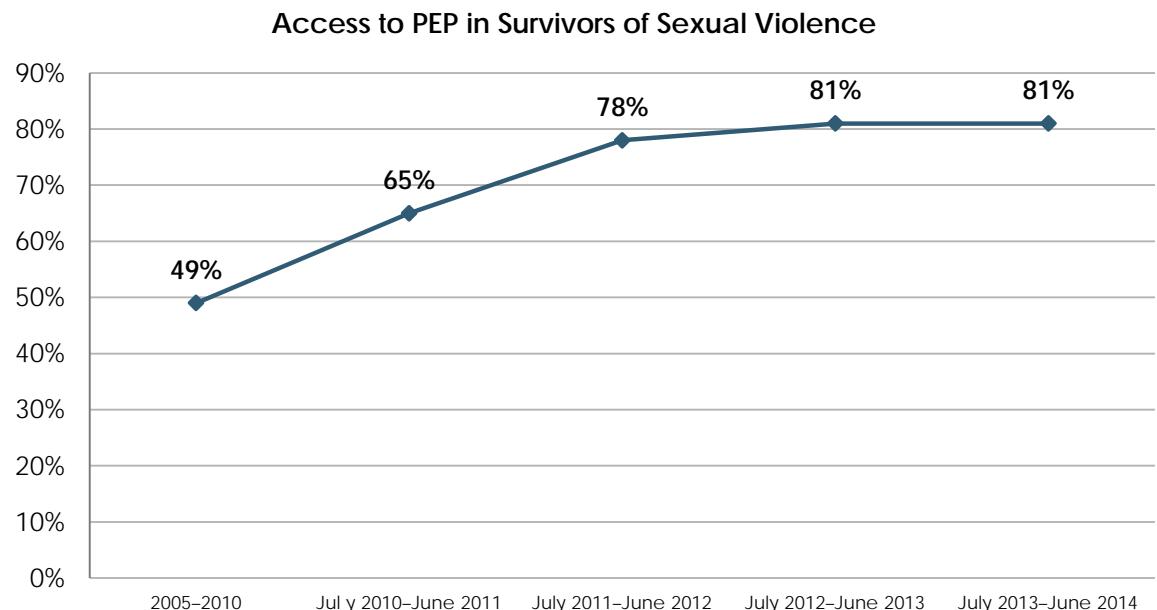
Quality of GBV services at the health facility measurably improved. In less than a three-year period of intervention (2011–2014), five of the seven demonstration sites that received prioritized support achieved a score of 80% or more in the achievement of standards for quality comprehensive GBV services. In comparison, at baseline, most of these sites had met only 10% or less of the standards. See Figure 1 below. Still, there are several areas for improvement. Use of data forms to report GBV cases is still new and requires ongoing technical support and supervision to ensure quality. Moreover, most facilities (not including demonstration sites) do not have the materials needed. For example, often the physical space available for counseling and treatment does not allow for privacy and confidentiality. Additionally, there are stock-outs of pediatric antiretroviral drugs and antibiotics to treat syphilis. The biggest challenge is the follow-up of survivors after PEP. For instance, in Ndlavela, only 70% of survivors returned on day 30, 30% on month 3, and less than 10% in 6 months.

Figure 1. Achievement of Standards of Quality for GBV Services in Demonstration Sites



Access to PEP for HIV by GBV survivors multiplied. From June 2011 to December 2014, a total of 3,818 survivors reached GBV services in 42 health facilities supported by Jhpiego. Overall, access to PEP for sexual violence survivors increased to 81% in Year 4 (as of April 2014) of the initiative, up from 49% at baseline based on a retrospective analysis of data from 2005–2010. See Figure 2 below for the increasing trend in access to PEP by survivors over the four-year initiative. Both strategies of community outreach and the one-stop integrated approach to services increased access to and uptake of GBV services and, ultimately, PEP.

Figure 2. Increased Access to PEP for Survivors Accessing Services at Demonstration Sites

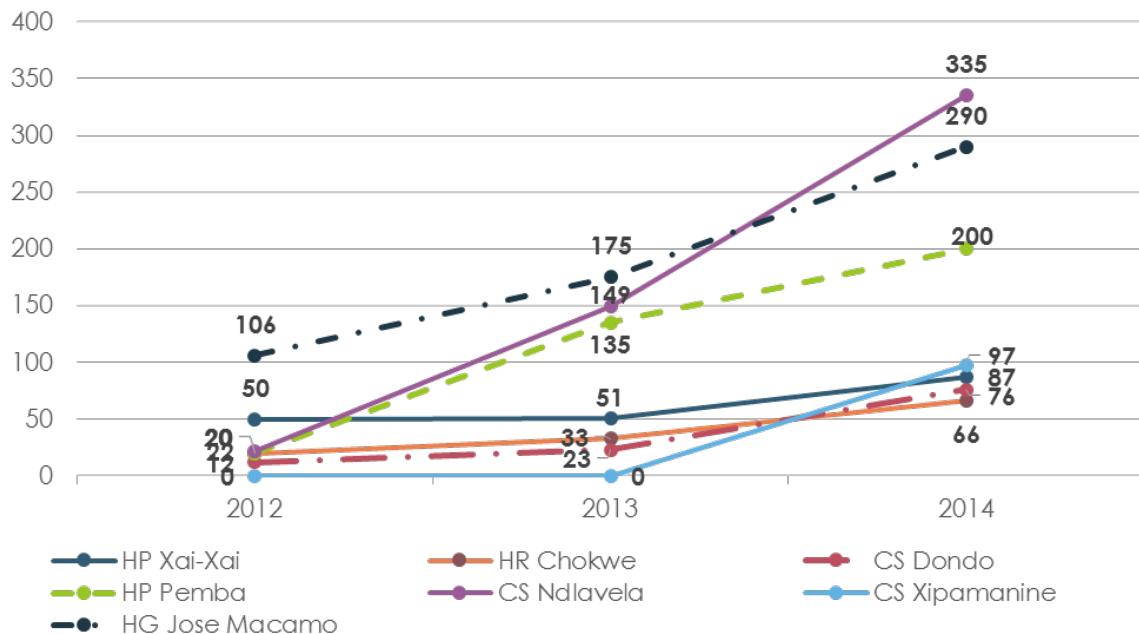


A GBV recording and reporting system was established for the health sector. The GBV health reporting forms piloted by Jhpiego and partners have now been approved by the MOH as the national tool for GBV case reporting in all health facilities. Training and supportive supervision for providers to use these forms continues. Data collected through these forms will allow the Ministry to identify needs for GBV supplies, human resources, differences in service provision between regions and between urban rural areas, and other ongoing training and technical assistance needs.

Awareness and dialogue on GBV at the community level increased. Lay counselors reached some 27,366 men with GBV messages through VMMC outreach activities and sensitized and screened 312,188 people for GBV, of which 76% were women. According to community leaders and lay counselors, dialogue about GBV in the community notably increased, as well as reports of GBV to authorities. Leaders also independently initiated discussions within their communities about GBV and available services.

Community outreach resulted in increased uptake of GBV services. Service uptake consistently increased once Jhpiego-supported lay counselors, as well as other PEPFAR GBVI partners, began to sensitize the community on GBV, identify cases, and make referrals starting in October 2012. Whether in hospital or health facility, once lay counselors and other PEPFAR partners began community outreach on GBV, the number of cases received at the demonstration sites steadily increased. Through Jhpiego community outreach, 509 GBV cases were identified, and, of these, 84% reached the health facility. Global experiences of referral of GBV cases typically result in low turnout, although tracking GBV cases is also often difficult. Thus, this high percentage indicates the successful role of lay counselors in facilitating utilization of GBV services.

Figure 3. Number of Cases Received at Demonstration Sites



Dashed lines represent hospitals with high demand and referrals. Continuous lines represent health centers and show a similar increase that seems to be, at least in part, thanks to the intervention of lay counselors.

Best Practices and Lessons Learned

Leadership and champions at all levels facilitate the process. From Dr. Francelina Romão in the MOH national office to Dr. Bachir Macuacua in Ndlavela primary health facilities to community leaders who facilitated the work of lay counselors in the community, a champion at each level has been key to effectively mobilizing the GBV response in Mozambique. As is the case when building a response to any new issue, leadership by well-respected individuals is essential. For GBV, a topic that is still very taboo and not spoken of or acknowledged widely in Mozambique, such leadership is perhaps even more essential. With national leadership as an example, champions at the district and sub-district health administrative levels conducted GBV performance assessments and shared experiences among provinces. Their networks were supported at the provincial directorate by a GBV supervisor and at the national level by the current GBV authorities.

Partnerships, coordination, and teamwork among multi-sectoral stakeholders are essential ingredients to mobilize a response to GBV. GBV is a cross-cutting, multi-sectoral issue, meaning it should be everybody's issue; but this also means it could have been nobody's issue. Coordination, not only among sectors, but even within sectors, is important for building a systematic, consistent response to the problem. However, coordination does not happen on its own. Assigning an individual, or individuals responsible for coordination, in line with international best practices, facilitates multi-sectoral coordination. At the provincial level in Maputo, the GBV coordinator in the Directorate of Provincial Health Services convenes monthly coordination meetings with other sectors. In Jhpiego-supported demonstration sites, coordination among sectors occurs through regular meetings, usually monthly, to review challenges in achieving GBV service standards, as per the SBM-R® process. Within Jhpiego, a staff member was assigned the responsibility of coordinating GBV activities within the organization and with the MOH. In addition, the PEPFAR Gender Advisor convened USG-partner GBV working groups in provinces with a large number of partners. In Gaza province, for example, there were four community partners and one clinical partner in addition to Jhpiego. Partners were able to share experiences, avoid the duplication of efforts, and work collaboratively with the provincial health department. On the flip side, GBV, as a relatively unique multi-sectoral issue, has bred partnership and collaboration among various institutions that do not normally collaborate so regularly; this alone has promoted a sense of pride and teamwork, according to some informants.

The use of simple screening tools and discussion guides are important to support health care providers and lay counselors to effectively assess for and educate about GBV. Screening tools and discussion guides aided providers in the implementation of screening and GBV awareness-raising. An important lesson for the design of these guides is that they must use simple, straightforward language that can be understood by the general community. The language of GBV is not necessarily familiar or understood by lay people, especially in a context where some violent acts are not generally considered

violent or abusive.²³ Thus, as researchers conducting surveys have found in the past and as lay counselors found in their work, using language to describe specific acts rather than the term “violence,” is much more effective in identifying GBV. Likewise, pictorial discussion guides can facilitate discussions about violence, but must be careful not to convey pictures or messages that may be confused or reinforce patriarchal or violent norms, or negative images of violence that cause people to turn away or disassociate themselves from the scenarios.

The service delivery standards and the quality assurance process through SBM-R® facilitated concrete actions that actors needed to take to improve their response to GBV. The SBM-R® process not only gave health care providers and lay counselors a concrete tool to guide and improve the quality of their work on GBV, but it also gave them objectives that they could aspire to and plan their work around. The assessment results achieved by each facility created healthy competition between sites, increasing motivation to implement GBV activities.

Psychosocial care is a key aspect of services. Providers at demonstration sites have indicated the key role psychologists play in helping survivors feel comfortable to talk about their experiences and deal with ongoing trauma that impacts other aspects of care, such as PEP adherence. Psychologists or social workers are not available at all health facilities, and clinical providers may not have the capacity to provide even basic counseling, a skill essential for treating GBV survivors. Hence, training providers in basic counseling is also important.

Community members and GBV survivors should participate in the design of interventions and communication materials to prevent and respond to GBV. The development of screening questions, communication aids, posters, and any other materials to be used with the general community needs to be tested with the population to which messages or questions will be conveyed. The language of GBV is not common to the wider community; many people do not even consider many acts that they experience as violence or may frame it in different terms. Thus, messages must be crafted with understanding of community perceptions related to GBV. In addition, service design must also engage the community from the start. In the words of one doctor interviewed, without community involvement, “it’s not complete.”

The community component is essential for raising awareness about GBV, increasing uptake of GBV services, and improving services. As providers were trained and services were rolled out, it became evident that there were obstacles for women and girls to get to health services to receive PEP. This was supported with the findings from the health facility assessments that Jhpiego also conducted, which found that survivors would go to the police to report GBV, as was more commonly known in the community as the first-line response for GBV, but often never made it to the health facility to receive care and treatment. In some cases involving adolescent girls, parents would engage the community courts to negotiate a fine with a perpetrator and then consider the issue resolved.

²³ The **conflict tactics scale**, for example, created by Murray A. Straus in 1979, asks about specific acts of aggression, such as shouting, hitting, yelling, throwing, and deliberately excludes attitudes, emotions, and cognitive appraisal of the behaviors measured. This is because many victims of IPV do not see themselves as suffering abuse, and, as such, their cognitive appraisal of their situation can affect the measurements.

Engaging the community not only means making them aware of GBV services, it also requires a process of sensitizing community members about what GBV is, that domestic violence and sexual abuse of minors is against the law and a violation of their human rights, and that it leads to negative health consequences.

This is an iterative process that requires community outreach, not simply at the health facility level, given that many GBV survivors are not likely to access services. Through the outreach work by lay counselors, with support from community leaders, it became evident that many community members did not see GBV as an issue that demands attention from authorities and professionals. In addition, outreach through lay counselors from also helped identify community needs with respect to GBV, namely better understanding that GBV is against the law and has severe impacts. Outreach to the community also proved to be best done by peers and community leaders using simple and participatory dialogues that first seek to understand their perceptions about GBV, rather than by service providers who tend to use more technical language gained from training.

A process of sensitization and transformation about personal attitudes about GBV for service providers and lay counselors is a critical first step. Service providers and counselors come from the same communities and culture as beneficiaries of services, and, therefore, we cannot assume that they understand what constitutes GBV and that they will not perpetuate existing beliefs and attitudes that deem GBV as acceptable. This requires a process of transformation that does not happen overnight or in a two- or three-day training; rather, continual reflection and discussion are needed among providers and lay counselors. Although this is generally common knowledge and well-established in the literature and field of GBV programming and social and behavior change communication, it is all too easily forgotten or overlooked in the context of short timelines and limited funding.

Maintaining confidentiality is also critical in such small communities. In small, tight-knit communities where information spreads quickly and privacy is not a common concept, maintaining confidentiality can be challenging. Still, because GBV is considered a sensitive or stigmatizing issue, often to be kept within the family, training lay counselors and providers on the importance of discretion and confidentiality is also very important.

Discussions on GBV should be introduced after a series of discussions on other health issues. Because GBV is a highly sensitive topic, lay counselors and health care providers may need to build rapport with community members before they can effectively discuss GBV. Lay counselors introduced discussions on GBV with community members after discussing other health issues such as water, sanitation and hygiene, nutrition, and HIV, where GBV is addressed as part of the risk behavior for HIV. This helped with “breaking the ice” and building trust.

HIV and GBV are strongly linked, and thus, we must justify the need to mainstream GBV into HIV services. The PEPFAR GBVI was founded on the understanding that there are pathways and linkages between GBV and HIV; yet the statistical evidence and gravity of these linkages vary according to global meta-analysis of the literature. Data collected from one of the demonstration sites in Mozambique, Ndhavela, between 2012 and 2014, indicate that twice as many women experiencing violence tested positive for HIV than those who did not disclose experiences of violence. In addition, national adult prevalence of HIV is 11.5% (13.8% in women and 9.2% in men); however, among GBV survivors (who are predominantly female) served through Jhpiego-supported sites, the

prevalence of HIV is 18%, supporting research findings that GBV increases HIV incidence. These data further substantiate the need to mainstream GBV identification and response through all HIV programs and services.

There is a need for specialized services for children, as most survivors are children. Data collected between 2012 and 2014 in 42 health facilities supported by Jhpiego also demonstrate that sexual violence is extremely high in children. In fact, the majority of cases, some 69%, reporting to demonstration sites are among those aged 24 and younger. In Xai-Xai Hospital, data show that 14% of sexual violence cases that presented at the demonstration site were between 0 and 4 years old. Clinicians still need training on PEPFAR's Technical Considerations for Post-rape Care for Minors, which was introduced under the GBVI but did not yet have a specific training package.

Demonstration sites or one-stop centers are a demand on human resources in a health system already constrained by a lack of human resources. Providers interviewed for this case study indicated that it is not always possible to have providers manning the one-stop centers 24 hours a day and on weekends. During these times, survivors would have to go through the main health facility and then be referred to return to the one-stop center when it is open. Yet, nights and weekends, when fewer providers are available, are times when violence may actually peak, as that is when families are home together.

Recommendations for Future Action

Take opportunities to integrate, monitor, and evaluate GBV sensitization as part of health education campaigns. As services develop and improve in quality, parallel work at the community level must be undertaken to make people aware that GBV is a health and human rights concern that warrants attention and that there are GBV services available. Without these efforts, highly sophisticated services for GBV survivors may be available, but underutilized, as the general population still sees GBV as a common and acceptable part of life in Mozambique. To fully understand community-level norms and behavior change on GBV and its impact on uptake of health services and health, it would also be essential to collect data on change in awareness and attitudes at the community level.

Further evaluate the feasibility and cost-effectiveness of scaling up GBV demonstration sites. Given the shortage of human resources in Mozambique, it is important to assess whether one-stop center models are cost-effective and sustainable before scaling them up. On one hand, the MOH may want to monitor and continuously consider whether dedicated staff is needed at all times, particularly for small health facilities. On the other hand, on or near-site availability of police and psychologists or social welfare officers at larger health facilities with strong referral systems may be an alternative model that would not require dedicated staff to physically sit in the separate one-stop facilities. Such a model would require strong leadership by someone at either the health facility or other local coordinating body, such as a community leader or social affairs office.

Integrate GBV case detection and first-line response with other existing services. Since many GBV survivors do not come forward to report their experiences of violence and abuse to authorities or

health care providers, and there is now strong global evidence that GBV is linked to a variety of clinical conditions and sexual and reproductive health outcomes, providers need to become more attuned to signs of GBV and to inquire about violence as a possible cause or aggravating factor when treating for clinical conditions. Jhpiego is currently piloting GBV detection and screening in the antenatal care and prevention of mother-to-child transmission of HIV (PMTCT) setting with support from PEPFAR. The WHO recommends this approach, as detailed in its clinical and policy guidelines, *Responding to intimate partner violence and sexual violence against women*.²⁴ In addition, the WHO recommends a first-line response to GBV detected through health services, including: empathetic listening, basic counseling, ensuring safety, providing comprehensive post-rape care for sexual assault survivors, inquiring about other needs, and providing referrals for other services. As noted above, basic counseling is key to effective care for survivors.

Develop and include a GBV module for pre-service training in medical schools. Currently, GBV is not included in pre-service training for all health care providers, just for maternal child health nurses, medical technicians, per Jhpiego-supported curricula, and for physician's assistants, per a module developed by I-TECH. However, the MOH aims to offer GBV services at a minimum in 526 health facilities across the country where PMTCT services are provided. By mid-2015, just 263 facilities were providing the MOH package of post-GBV care services and training. Moreover, there is constant turnover at health facilities. Thus, for longer-term sustainability and reach of the provision of skilled GBV care in health facilities, training for all health care providers should be provided and required pre-service.

Continually train and monitor health care providers and lay counselors to ensure that their delivery of GBV services prioritizes the needs, rights, and safety of the client. Health care providers and community outreach workers are influenced by the same societal attitudes and behaviors related to GBV as clients. Changing these attitudes and behaviors does not happen in a one-day or even one-week training. Health care providers and outreach workers must have continued opportunities to reflect on their values and behaviors that may condone GBV or prevent them from adequately taking action to respond to GBV.

Test the viability of support groups for GBV survivors similar to groups for people living with HIV/AIDS. GBV survivors also need continued care and support to mitigate the risks related to any ongoing experience of violence. Lay counselors and psychologists may not always be able to play that role, given resource constraints. Support groups, similar to those for people living with HIV/AIDS, may offer people a low-cost way to access continued social support for GBV. However, they must be tested and examined for potential barriers related to stigma, capacity, and risks related to re-victimization or other unforeseen issues.

²⁴ World Health Organization. 2012. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva.

Conclusion

GBV is a serious public health issue that warrants a clinical response and community-based and multi-sectoral efforts. Leadership on the part of the Government of Mozambique at national, district, and community levels has facilitated much progress to develop multi-sectoral policies, guidelines, capacity-building, and coordination on these fronts. In the health sector, Jhpiego's close relationship with the MOH allowed for an effective and efficient collaboration to: develop these tools and illustrate their use through seven demonstration sites; demonstrate how an improved GBV response through the health sector can increase uptake of services by survivors; provide support to survivors; ensure access to PEP by survivors; and initiate dialogue and reporting on GBV overall. To be sure, there is still much work to be done to scale up a comprehensive response to GBV in Mozambique, and prevent its occurrence in the first place, including adding GBV to pre-service training for all providers, integrating GBV detection and care into other women's health platforms, and expanding upon GBV sensitization campaigns, among other things. Still, there are a strong policy foundation and experiences upon which to build.



"16 days of activism against GBV" in Xai-Xai, Gaza Province