

Should peer HIV prevention workers screen for gender-based violence? Results from a pilot in female sex workers and adolescent girls and young women in Tanzania

Myra Betron

SVRI Forum 2019

Grace Munisi (1), Caterina Casalini (2), Yeronimo Mlawa (1), Abubakar Rehan (1), Maneno Luponya (2), Myra Betron (5), Erick Mlangi (3)

Affiliations: EngenderHealth Tanzania (1), Jhpiego Tanzania (2), USAID Tanzania (3), NACP Tanzania (4), Jhpiego USA (5)

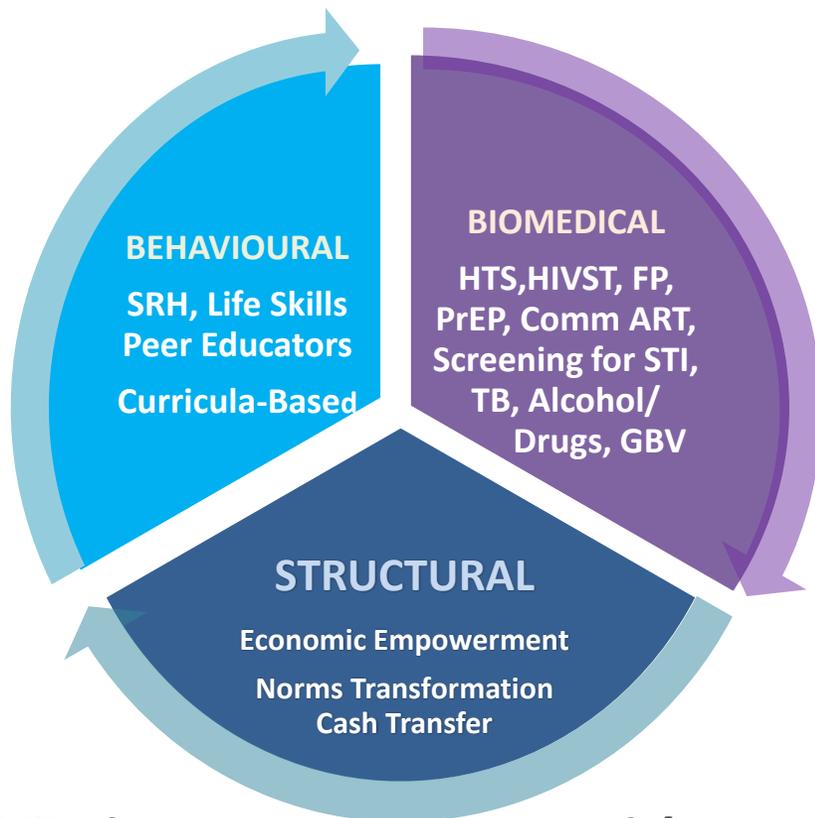


SAUTI PROJECT IN TANZANIA

GOAL: Contribute to improved health for all Tanzanians through sustained reduction in new HIV infections

Donor: USAID

Partners: Jhpiego (lead agency) with EngenderHealth, Pact and the NIMR – Mwanza



SAUTI PROJECT BENEFICIARIES

Key Populations (KPs)



FSW: Female ages 18 and above who exchange sex for cash/goods as primary source of income (>50%)



MSM: Male ages 15 and above who engage in sexual relations with other males regardless of the motivation

Vulnerable Populations (VPs)



AGYW: Female out of school, sexually active ages 15-24



PFSW: Sexual Partners of female sex workers



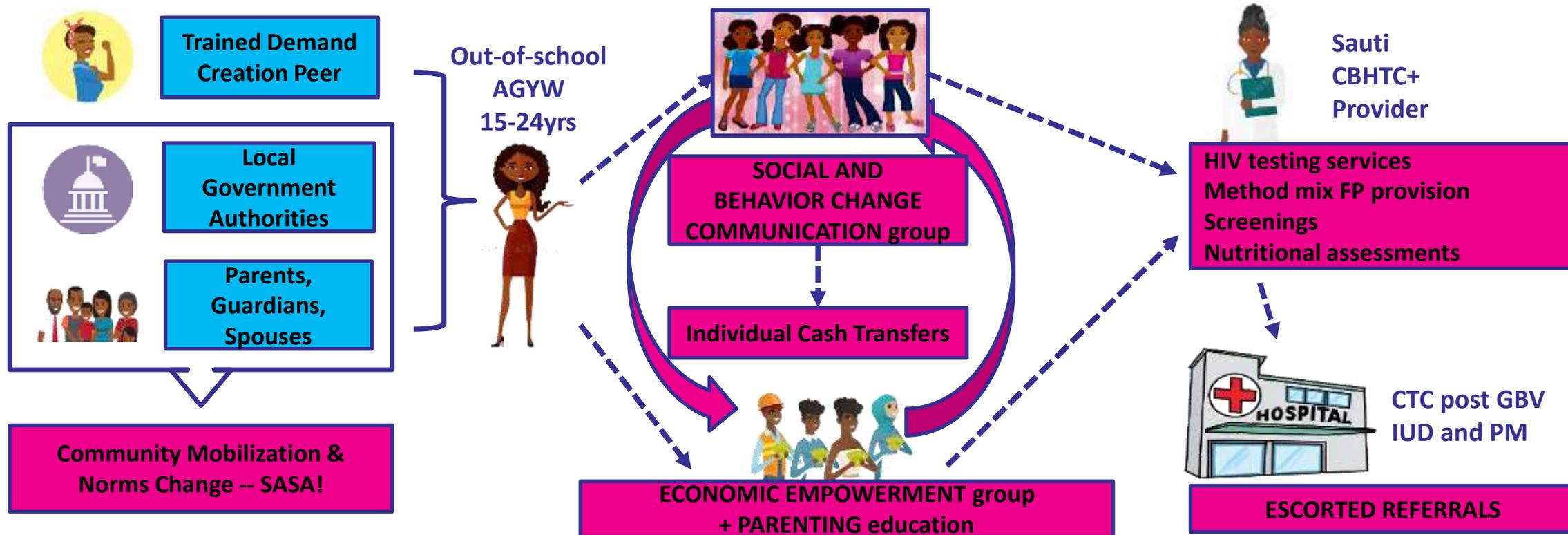
OHSP: Other Hotspot Populations (e.g. men in mobile occupations, mine workers, fishermen, truck drivers, female in transactional sex, etc.)

AIM: To Saturate 80% of KVPs in coverage areas with a core package of combined biomedical, structural & behavioural interventions by 2020

TIMELINE: 2015-2020

DREAMS INITIATIVE INTERVENTIONS UNDER SAUTI PROJECT

IDENTIFICATION IN THE COMMUNITY GROUP-BASED EDUCATION @ SAFE SPACES BIOMEDICAL SERVICES PROVISION



OBJECTIVES: Empower AGYW and Reduce Risk | Mobilize Communities for Change | Strengthen Families | Reduce Risk of Sex Partners



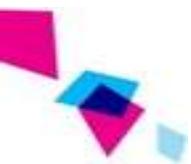
REGIONS
Dar es Salaam
Shinyanga
Mbeya



ANNUAL TARGET: ~30,000

- *Out of school*
- *15-19yrs who are sexually active*
- *20-24yrs involved in transactional sex*





GBV Screening and Support in Sauti

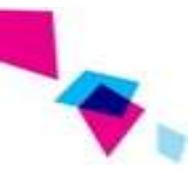
- Trained health providers on GBV screening and first-line response (LIVES)
- Providers screened, after obtaining consent, in community-based HIV testing sites (test, drop-in centers) as part of larger health screening
- Screened for physical, sexual and emotional violence using modified, abbreviated questions about actual acts (Conflict Tactics Scale);
- Included danger risk assessment
- Provided escorted referral to all GBV survivors needing medical, legal or psychosocial support



Challenges in GBV Screening & Support

- Took time to convince providers of its importance
- Integration during biomedical services (HTS, FP) difficult: long queues of clients
- Very low percentage of clients reporting GBV compared to vulnerability assessments





Our Pilot Study

Overall study question: Should peer HIV prevention workers screen for gender-based violence?

- **Objective 1** - Compare the GBV survivor identification by biomedical providers (nurses/clinicians), peer educators (PEs) and empowerment workers (EW).
- **Objective 2** - Determine the barriers and enablers for GBV screening from the beneficiaries and biomedical provider (nurses/clinicians), PEs' and EWs' perspectives.



Piloting GBV Screening in Economic Empowerment and Behavior Change Groups



- Dates: April- September 2017
- Coverage: 14 wards in Kahama, Shinyanga
- All PEs and EWs participated in a three-day gender, sexuality and GBV LIVES training
- All received a one-day orientation on GBV screening tool and process
- Selective screening only one person was screened per meeting after awareness session on GBV
- Follow-up support and referrals offered



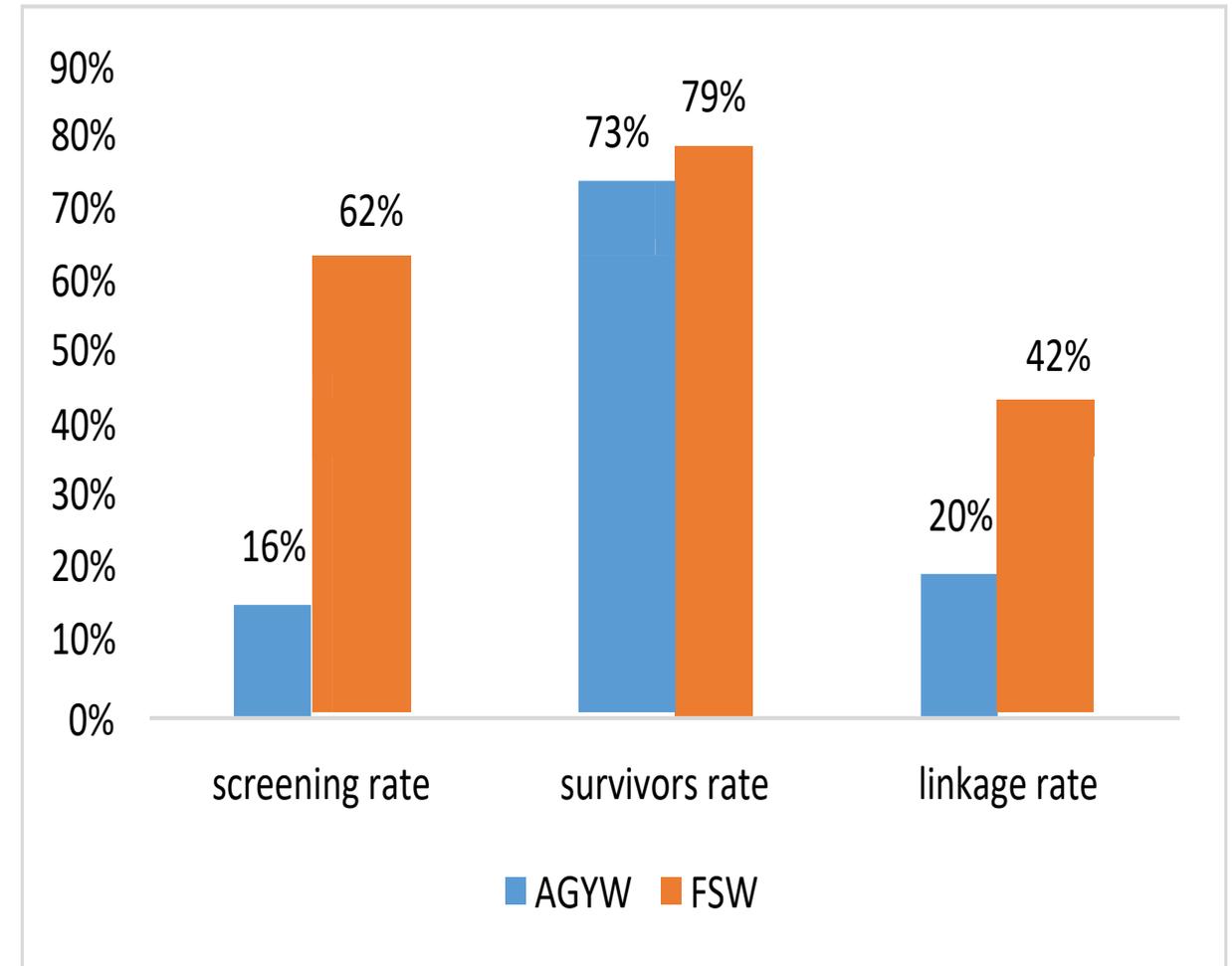
Our Methods

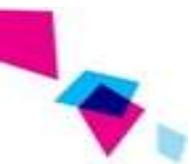
- 3 focus group discussions, 2 groups with EWs and PEs (n=18); 1 group with FSWs and AGYW (n=10) in October 2017
- GBV screening data collected from April 2017 to September 2017
- KIIs with PEs (n=17), EWs (8), biomedical providers (n=15) in August 2019
- Additional provider and client surveys conducted but data not yet cleaned



GBV screening data in Pilot Sites, Apr-Sep 2017

- 166 FSW and 561 AGYW were screened for GBV
- Identification of only physical abuse was FSW – 48%; AGYW 52%
- Identification of only sexual abuse FSW – 3%; AGYW - 11%
- 20% of AGYW and 42% of FSW were linked to GBV services





Acceptability of screening

- Most providers, PEs and EWs saw screening as important opportunity to help GBV survivors
- Most said screening was accepted by clients
- Beneficiaries appreciated that PEs and EWs responded like friends
- A few clients of clinical providers were perceived as not trusting or fearful the process

*There is a lot we can do to support our fellow girls who are the victims of GBV. We cannot keep ourselves silent or get tired in supporting our fellow; since GBV seem to be part of our lives”
-CBHS provider*

“I feel very good and safe been screen by madam (EW) because she takes enough time to listen to me; and she always use very polite language when responding back” - AGYW

“She was shocked and felt that their information was being taken to be misused” – Nurse.



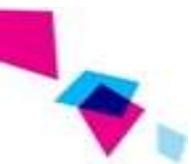
Issues of privacy, confidentiality and safety in behavior change and economic empowerment groups

- Privacy and confidentiality was possible most of the time.
- PEs and EWs went beyond meeting times and locations to conduct screening (**30 min to 1 hour process**)
- Sometimes, parents, guardians or landlords tried to interfere in the screening
- Being threatened by perpetrators. (PEs and EWs only)

“I always find a private place that is comfortable for conducting GBV screening. That being the case, sometimes we go beyond the meeting point so that I can be able to listen to my clients appropriately.” -Empowerment worker

“Our life is in danger and more badly when the perpetrator(s) realize that we are the ones who initiated those cases to the police. That makes us afraid and do lead to sometimes giving up”....

- Empowerment Worker



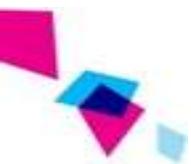
Barriers to seeking follow-up support

- GBV being seen as normal in the community (all)
- Minority of survivors willing to report the perpetrator due to financial dependence
- Lack of 'safe spaces' while awaiting referral services
- Survivor's not having financial resources needed

"We are poor, and we depend a lot from our parents/guardians and/or sexual partners. GBV has been part of my day-to-day life conducted by close relative. I cannot attempt to report him/her to police as my life will be miserable"
- AGYW

"There are many GBV survivors in the community, but they cannot accept referrals to the Police. Due to some of the Police Officers being rude, hence making them fear to further expose themselves. The environment is hostile" – FSW

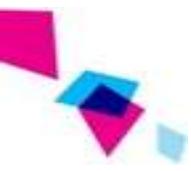




Overall takeaways

- GBV screening by **trained community-based health and economic empowerment facilitators** *may* identify more survivors than providers in biomedical sites.
- **Rapport-building, trust and time** necessary for screening and support seem to be key.
- However, **privacy, confidentiality and safety** related to GBV screening in community-based settings is a challenge. Clear guidelines are needed.
- Programs need to understand the **social acceptance of GBV and fear of perpetrators as barriers** to seeking follow-up support.
- Additional **integration of medical, social and legal services** is needed to facilitate comprehensive care for community-based GBV screening and first-line support.





Limitations and Areas for Further Study

- Very small sample of clients participated in discussions
 - Further exploration needed on why and how peers can identify and support GBV survivors fr. survivor perspectives
- What is “privacy and confidentiality”:
 - In communities where such concepts are not the norm?
 - Where community mobilization leads to speaking out?
 - Where survivors feel that speaking to peers is more confidential?
- What minimum role can peers, lay counselors and community health volunteers play in the GBV response?





**Asanteni Sana!
Thank you!**

**Myra Betron
Myra.Betron@Jhpiego.org**