USAID FROM THE AMERICAN PEOPLE

PEPFAR U.S. President's Emergency Plan for AIDS Relief

AIDSTAR-One | CASE STUDY SERIES January 2012

Public Sector Response to Gender-based Violence in Vietnam

Kai Spratt

Vietnam Duc Giang General Hospital

Nguyen Thi Ahn first learned about the Women's Counseling Center for Health three years ago. She had come to the Duc Giang General Hospital (DGGH) hospital for treatment of her arm, which she feared her husband had broken during a beating. She had suffered verbal and physical abuse from her husband and, at times, from her mother-in-law, for almost 20 years; both had threatened to throw her out of the house and keep her from her children. Though she worked hard to earn more money and tried to be a good wife and homemaker, her husband and mother-in-law continued to insult or beat her. She felt hopeless and depressed.

She was very surprised when the nurse asked whether the injury might be due to abuse at home, but she answered shyly that yes, her husband had done it. A short time later, the nurse accompanied her to a quiet room on the third floor called the "Women's Counseling Center for Health," where a counselor politely asked about her arm and what was happening at home. For the first time ever, Thi talked about her problems without being blamed. The counselor said she was experiencing "gender-based violence," which was illegal and which she did not have to tolerate. They talked about her alternatives—she felt she did not have the option of leaving her husband, and she could not bear the thought of leaving her children. Thi went home with the counselor's phone number. A week later, she called back and made another appointment. With the counselor, she made a plan to be safe if her husband and mother-in-law abused her again. Over time, she returned every few months for further counseling. The Women's Counseling Center for Health had become her lifeline.

By Kai Spratt and Thi Thu Trang

AIDSTAR-One
John Snow, Inc.
1616 North Ft. Myer Drive, 11th Floor
Arlington, VA 22209 USA
Tel.: +1 703-528-7474
Fax: +1 703-528-7480
www.aidstar-one.com

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.

Disclaimer: The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

The women's counseling center, which provides women with a safe space to discuss the violence in their lives, is a central part of the Improving Health Care Response to Gender-based Violence project. The project, implemented from 2002 to 2009 in two Hanoi hospitals by the Hanoi Department of Health and the Population Council, is an example of a public sector intervention that builds on a medical model and links survivors to ongoing counseling and support. Based on findings from the pilot project, the Vietnamese Government has approved the scale-up of this model to primary care hospitals throughout the country.

Background

Gender-based violence (GBV) is under-reported and under-researched in Vietnam (Gardsbane et al. 2010). Several small-scale studies revealed that the prevalence of GBV in Vietnam ranges widely from 16 to 37 percent for physical violence, and 19 to 55 percent for emotional violence, while sexual violence and sexual harassment are rarely reported (Jonzon et al. 2007; Nguyen 2006; Vu et al. 1999). A 2006 national survey with 9,300 households reported that in the preceding 12 months, 21.2 percent of families had reported at least one of the three forms of violence (physical, verbal, coerced sex); husbands were the most frequent perpetrators (Huong 2008). In everyday life, verbal abuse, slapping, and coerced or forced sex are often not considered violence in Vietnam (United Nations Population Fund [UNFPA] 2007).

Cultural norms (some might argue based on Confucian philosophy) position Vietnamese women as subservient to their father, husband, or eldest son (after the husband's death). It is acceptable for a man to use violence to "teach his wife" if he deems she has made a mistake, though wives cannot similarly punish a husband's mistake. There is shame and secrecy associated with GBV, which is viewed as a private family issue and is explained as resulting from poverty, alcohol or drug abuse, or stress among family members.

> ***"When I began to work on this project I thought doctors' responsibility was just to cure disease, but now I realize that as human beings we cannot refuse to help women; many women are in difficult situations. I definitely needed the training to help increase my communication skills with my colleagues and I became involved in many other activities…I also supported a colleague experiencing gender-based violence; she left her abusive husband, has remarried and is very happy now."***
>
> ***–Doctor, Hanoi Department of Health Services***

Communities are not well equipped to address or change attitudes about GBV. When conflicts occur in families or between neighbors, they are often brought to Reconciliation Committees,[1] government-mandated bodies whose members are drawn from local communes,[2] and mass organizations such as the Women's Union, Students' Union, and Farmers' Union. Members are generally not trained on general counseling skills, GBV, or legal rights and laws. Women or men experiencing GBV may seek divorce under the Marriage and Family Law, but

[1] These committees were formalized through the Ordinance on the Organization and Activities of Reconciliation at the Grassroots Level (Socialist Republic of Vietnam 1998).
[2] An administrative unit below the district level.

reconciliation is the culturally preferred and legally required solution; divorce is sought only when violence is intolerable (UNFPA 2007).

GBV and HIV: The link between GBV and HIV is not well documented in Vietnam, and women seeking services for GBV-related injuries or illnesses are rarely offered HIV testing. Women who request HIV testing, prevention of mother-to-child HIV transmission services, antiretroviral therapy, or care and support services at U.S. Government-funded programs are not routinely screened for GBV.

Until now, the risk of HIV for women has not been perceived as a priority. Vietnam's HIV epidemic is concentrated in most-at-risk populations, especially among people who inject drugs and sex workers. The 2009 national estimation and projection report for 2007–2012 showed that HIV prevalence among the general adult population (15 to 49 years of age) is expected to reach 0.31 percent during this period, stabilize at 30 percent among people who inject drugs, and increase to 9.7 percent among sex workers, remaining highest in urban centers. During this period, the ratio of infected men compared to infected women is expected to decrease to 2.6:1 as a result of increased transmission from infected men to their wives and regular sex partners (Ministry of Health 2009). Given the link between GBV and HIV risk in other countries, it is prudent for Vietnam to integrate HIV testing into GBV services and GBV screening into all HIV services.

Policy Environment

The 1959 Vietnam Constitution endorses equality between men and women in all aspects of political, economic, cultural, social, and family life. Adopted in November 2006, the Gender Equality Law promotes gender equality in all areas of social and family life, and mandates that all agencies, organizations, families, and individuals support equality, reject discrimination, and provide oversight, investigation, and response to violations of gender equality. This law targets several issues, from wage disparities between men and women to gender-based discrimination. Some provisions address GBV, physical damages, psychological counseling, and protection of legitimate rights. The law includes provisions for safe sex, especially protection against HIV, as well as actions that can be taken against perpetrators of violent acts. It also requires that gender be mainstreamed into law and policy development and into state bodies and organizations. The Ministry of Labor, Invalids and Social Affairs is responsible for implementing the Gender Equality Law and building the capacity of state organizations to enforce it.

In 2007, the government passed the Law on Domestic Violence Prevention and Control,[3] which defines domestic violence as "an act intentionally committed by a family member, which causes harm or possibly causes harm in physical, emotional, and economic terms to another family member" regardless of sex, age, or relationship to the victim(s) (Huong 2008, 39). The Ministry of Culture, Sports and Tourism is responsible for overall implementation of the law and is expected to collaborate with other ministries to develop and disseminate guidance for implementation. The law includes provisions for punishing perpetrators, establishing shelters for domestic violence survivors, intervening through community-based conciliation committees, expanding access to family-centered counseling, promoting "trusted addresses" in communities (homes where survivors can seek short-term protection or support), and regular monitoring and supervision of the law's implementation. The law is rather broad, covering any intentional act committed by a family member,

[3] The term "gender-based violence" was not acceptable to parliamentarians because it is viewed as a foreign concept (Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents 2010).

including divorced couples or common law couples (Huong 2008).

Vietnam's policies have evolved to reflect the rapidly changing social and economic situation in Vietnam, especially after 1986 when the country opened its markets and began to dismantle its centrally managed economy. However, the laws in and of themselves are not sufficient to begin the process of change; each ministry involved in implementing a policy must issue a decree before developing guidelines and funding implementation at all levels of state authority (UNFPA 2007). While several decrees and strategy documents have been issued, many are not backed by line-item budgets, staff training, or mechanisms to ensure the accountability of those responsible for implementation. As a result, implementation of these laws is nascent. Nevertheless, these laws mark a shift in the perception of GBV; once a private matter, it has become a public issue.

Gender-based Violence Services in Vietnam

Some services for GBV do exist in Vietnam. Years before the law on domestic violence was drafted, several government agencies and local and international nongovernmental organizations mobilized to address GBV and by late 2010 supported three nationwide GBV counseling hotlines and 11 counseling and "trusted" addresses in the Hanoi area. One of these organizations, the Center for Creative Initiatives in Health and Population (CCIHP), is conducting research through support from the Ford Foundation to build community capacity to address GBV and gender norms in the town of Cua Lo in Nghe An Province. CCIHP adapted training manuals produced by the U.K.-based organization Respect[4] for community training and established a counseling center with two professional, full-time counselors. UNFPA and the Reproductive and Family Health Institute, funded by the Swedish Cooperation, have projects targeting both survivors and abusers in other provinces. All of these programs are generally small in scale, scattered across the country, and focused primarily on physical violence (UNFPA 2007).

Many hospitals will keep GBV survivors for five to seven days, but after that there is no safe place for women to go. The first shelter for survivors of violence, established in Hanoi in March 2007 by the Center for Women's Development, houses up to 20 women and their children for a maximum of four weeks.

The Improving Health Care Response to Gender-based Violence Project

Hanoi Department of Health Services (HDH) data show that a significant number of women seek services for "in-house accidents" at several hospitals under its supervision. Statistics from DGGH from 1997 to 2001 indicate 14,035 accident cases, with 28 percent caused by interpersonal conflicts; of these, women comprised 44 percent of survivors. Of the 57 accidents registered in the obstetrics and gynecology department, over half (31) were rape cases. Twenty-six accidents during pregnancy were reported in the same period (Population Council 2002). At the time, clinics and hospitals did not routinely screen clients for GBV. When health care providers did identify cases of GBV, there was no obligation to record the violence, give advice to survivors, or routinely notify the police or commune officials. There were no standard service protocols or guidelines for providers who wanted to give specialized care to GBV victims, and no referral networks for services after the women were discharged.

[4] Respect is the U.K. membership association for domestic violence perpetrator programs and associated support services: www.respect.uk.net/

HDH managers decided to address GBV. In 2002, with technical assistance from the Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents and the Population Council, and financial support from the Ford Foundation, HDH piloted the Improving Health Care Response to Gender-based Violence project. HDH played a central role in developing guidelines and provided project management, supervision, and technical support to the hospitals involved. At this time, neither the Gender Equality Law nor the LDVPC had been approved, though both became law during the course of the project.

HDH staff visited GBV service sites in Thailand and the United States and adapted approaches used there to develop an appropriate model for Vietnam. The first phase was implemented from 2002 to 2004 in DGGH and two health centers serving large populations in the outer suburbs of Hanoi. HDH chose these sites assuming that in-house accidents in the catchment areas near the hospital was higher than in urban catchment areas, the work would be easier to implement in less congested suburban hospitals and communities, and the hospital directors were committed to implementing the project. In phase II (2005–2009), the model was also implemented at Dong Anh General Hospital (DAGH), in suburban Hanoi, and additional health centers.

> ***"Before they [health care staff] just cared about the symptoms and therapeutic methods. Now they ask questions to find out relations between symptoms and violence. If a woman came frequently to the hospital for gynecological treatment or for an abortion, health staff would ask if she had been sexually coerced. Before, they would consider the phenomenon as a normal thing."***
> ***–Doctor, Dong Anh General Hospital***

Service Delivery Model

A major project goal was to establish routine screening of female patients for GBV and to shift providers' perspective so that they would see screening not as a project activity but as part of their daily routine and professional duty. HDH assumed that making screening routine would make the practice sustainable after the project period (though this proved not to be the case).

The project model had three components: screening, referrals, and community outreach and support.

Integrating GBV screening into health services: All medical and nursing staff in emergency rooms, obstetrics/gynecology and surgery departments, maternal and child health and family planning, mobile teams, and other professional staff and managers were trained in basic knowledge about GBV, consequences of violence, recognizing GBV, talking to clients, working with survivors, and collaborating with the community to support GBV survivors. Staff were trained to use a short, three-question screening tool asking clients whether they have experienced physical, emotional, or sexual violence, or rape. The training also discussed the issues that underlie GBV in Vietnam, including gender, the unequal power between men and women, the pressure of gender roles, and the causes of GBV.

All female clients over age 15 in hospital emergency rooms, treatment departments, or general examination departments were to be screened for GBV. Females under age 15 would be screened

only if they had signs or symptoms of physical or sexual violence. Women who experienced GBV would receive emergency treatment, if needed, and a referral to the Women's Counseling Center for Health or also, during phase II, to the Dong Anh Counseling Center.

Free counseling services: Two trained nurses worked full-time at DGGH's counseling center, which is on the third floor of the hospital building. In DAGH (phase II), a medical doctor who is also an HIV counselor in the Voluntary Counseling and Testing Center, was the primary GBV counselor at the Dong Anh Counseling Center, which is located in a separate building on the hospital grounds. To avoid stigma and protect clients' privacy, the names of the counseling centers do not mention GBV.

Both centers receive GBV referrals from the hospitals, mass organizations, and the police, and receive walk-in clients from the community who hear about the service through mass media or friends. Counseling centers keep detailed case reports on each survivor and take photos of a woman's injuries in case she decides to press charges. The counselors provide one-on-one counseling and refer women to other services including reproductive health, the counseling hotline or shelter in Hanoi, and community-based organizations that provide support (e.g., the Women's Union). Women who come on their own to the counseling centers may be referred to the hospital if medical care and treatment services are needed. Women are encouraged to return to the counseling centers any time for social support or referrals to other resources and services.

In phase II, counselors started advising women who experienced sexual violence and those whose partners refused to use a condom to visit the Voluntary Counseling and Testing Center for HIV testing and counseling (HTC). The HIV and sexually transmitted infection (STI) services are easy to access and free, subsidized by an HIV prevention project underway at the hospitals. However, counselors said that many women were reluctant to test for HIV; only 282 women accepted referrals to the voluntary counseling and testing site at DGGH and only 15 at DAGH (fewer than 10 percent at each facility).

Community outreach and support: The Population Council trained hospital and counseling center staff as master trainers. These trainers visited communities monthly to provide communication sessions on GBV and gender equality to members of mass organizations, like the Farmers' Union and Students' Union, or interested community members. In phase II, "Clubs for Family Happiness" were established for female survivors in several communes, and members of the Women's Union were invited to participate in helping to decrease stigma. In some communes, community members established two different clubs—one for survivors of violence, and one for GBV prevention volunteers. Both clubs provided information on GBV and referrals to counseling centers and trusted addresses. The project provided transportation funds and helped the volunteer clubs provide support to GBV survivors and intervene when violence occurred in their communities. The survivors' club introduced dancing, drama, games, painting, and puppets to help women express their emotions and discuss solutions. Gradually, management of the clubs shifted from project staff to club members, who continued to organize performances in their communities. These clubs provide a safe environment for women to share their problems, support each other, learn how to solve family conflicts, and make safety plans.

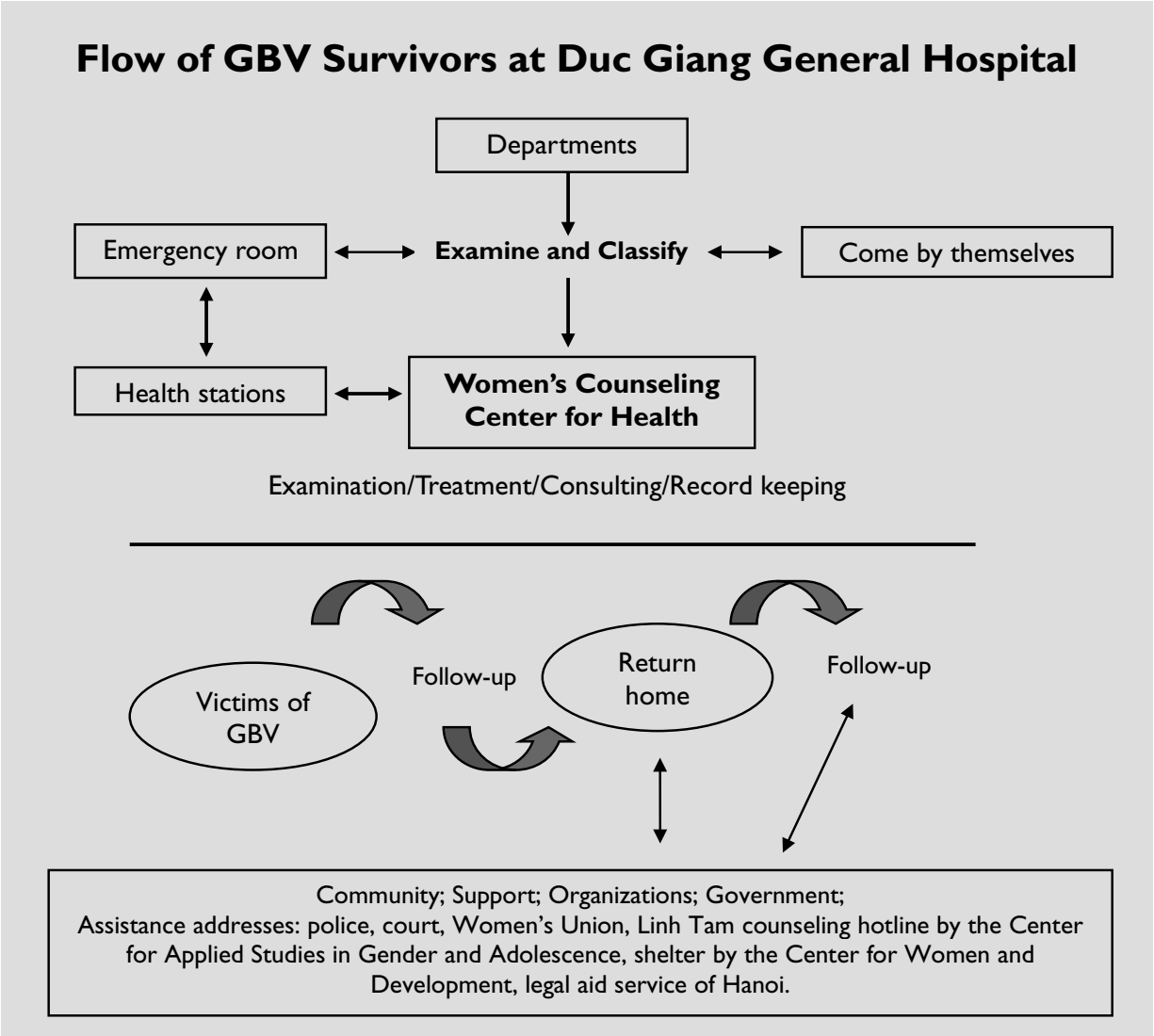
Figure 1 is a diagram of the hospital- and community-based service model, adapted from the government manual (Population Council 2002).

Results

A 2005 assessment by the Population Council and HDH indicated significant positive changes in providers' awareness and attitudes regarding gender equality and factors contributing to violence during phase I (Mai 2006). Findings also indicated more proactive screening, assessment, and documentation of GBV cases, and improved support to GBV survivors. The training strengthened providers' counseling skills and improved their ability to interact with GBV survivors.

The evaluation showed that as the services became known in the catchment areas, DGGH and the Women's Counseling Center for Health were overwhelmed with clients. However, doctors maintained that they were too busy and often failed to screen every female client, conduct follow-up care with GBV clients, and fully document cases of GBV. The responsibility for screening shifted to

Figure 1. Hospital- and community-based service model



nursing staff; in some cases, women were asked to fill out the forms themselves because of providers' heavy workload. As a result of this shift, the number of women being adequately screened declined.

The evaluation also identified problems in the community component stemming from insufficient collaboration by HDH. In phase II (2005–2009), HDH increased communication and outreach activities to local commune authorities and provided gender equity and GBV training to authorities to increase their support for GBV community outreach activities. The project added communication sessions for men (mostly male farmers through the Farmers' Union) and adolescents in schools, and organized several large social events to strengthen outreach to the community.

Outside funding and technical assistance ended in September 2009. Maintaining GBV screening services at DGGH and DAGH and community referrals and outreach activities are now the responsibility of the respective hospitals, commune authorities, and HDH. In 2010, the Ministry of Health endorsed the project model for all health facilities in Vietnam.

What Worked Well

Expanding providers' awareness of GBV: By the project's end, providers' perceptions of GBV had changed; they saw violence as not only a purely medical issue, but also a social and public health issue (Budiharsana and Tung 2009). This change was due in part to culturally appropriate training and monitoring tools, periodic retraining, and consistent support from HDH and hospital management, but also to the discussions of gender and inequality that were included in the training. Many staff members said that the GBV project transformed their lives.

> ***"Before, most clients of the counseling centers were referred by hospitals. Now many clients are introduced by ex-clients. They were given my phone number and called me to ask for counseling. Before clients came to us only when their situations were serious. Now they come to us even when nothing is serious yet, and they are more eager to ask for counseling and information."***
>
> ***–Counselor, Dong Anh General Hospital***

Increasing community awareness of GBV: Community awareness about counseling services increased significantly during phase II. During phase I, about half (383, or 48 percent) of the 797 clients visiting the the Women's Counseling Center for Health were either referred by other organizations or came on their own. In phase II, only 460 (12 percent) of the 3,982 clients seen at the Women's Counseling Center for Health were referred by DGGH clinics (Budiharsana and Tung 2009). At DAGH, between January 2007 and May 2009, less than half (146) of the 363 women who visited the counseling center were hospital referrals; the majority (217, or 60 percent) were referred by other organizations or came on their own.[5] This suggests that the GBV services met a significant need within the community and that word was spread within the community allowing women to access these services without having to go through the hospital.

[5] Ratio before 2007 is unknown.

Training expertise: Local HDH master trainers took over all of the project-related training. Key staff and counselors provided training and technical assistance to projects undertaken by local Women's or Farmers' Unions in the adjacent communes.

Model for domestic violence law: The project's most far-reaching outcome occurred in mid-2009. In a first step for implementing the 2007 law on domestic violence, the Ministry of Health used the project model to develop a circular (guidance) that requires all Vietnamese hospitals to integrate screening for GBV into health check-ups (Circular No. 16/2009/TT-BYT). The guidance mandates that project training materials and screening tools be used countrywide. This guidance represents a true, policy-based commitment by the health sector to address GBV.

Challenges

The Improving Health Care Response to Gender-based Violence project experienced many challenges. It was able to address some of those challenges because an assessment was built in and HDH committed full-time staff, albeit funded by the project, for supervision, support, and monitoring. Many of the challenges relate to structural issues that could not be addressed without a concomitant strategy for multi-sectoral policy advocacy.

Limited response to GBV across sectors: Outside the health sector, referrals for GBV clients are limited. Police respond to conflicts resulting in serious physical violence but not to cases involving mental violence or sexual coercion. Because civil laws only recognize serious physical harm as a crime, there is little motivation for police to respond to complaints that do not result in short-term disability or visible injury. Hospitals, commune health clinics, and police have not established a joint mechanism to document GBV cases in the event that a woman decides to press charges. The education sector is the least involved in GBV issues, and is not linked to any of the community-based activities that the project supported.

Limited impact on HIV prevention: There was little opportunity to amend the training to include content on how GBV increases women's vulnerability to HIV and other STIs. The model does not include routine referral to services for STIs and HTC for GBV clients; only women whom counselors considered at risk for HIV were referred to the HIV testing center—mostly women who had experienced sexual violence. Women were not screened on other risk factors such as being sex workers or people who inject drugs. As a result, very few women received HTC at DGGH. At the Dong Anh Counseling Center, the staff trained for GBV counseling were HTC counselors, so the proportion of women receiving HTC was greater than at DGGH. Missed opportunities to provide HTC were due in part to the nature of project funding: the project was funded as a GBV project, not a GBV *and* HIV project, so HTC was not integrated into the training or services. This omission is especially troubling because data collected during the project showed that many women were subject to multiple forms of GBV (see Table 1).

Economic constraints: Economic restructuring by the Government of Vietnam has reduced central funding to public sector health services, which are increasingly under pressure to charge fees to cover the majority of costs for salaries, operating expenses, and service provision. GBV services at DGGH and DAGH are free, and providers are not compensated through hospital operating budgets or by Ministry of Health subsidies to the hospitals. When the incentives provided by the project ended, anecdotal reports from project staff indicate that the number of women being screened decreased,

TABLE 1. REPORTED GBV CASES IN PROJECT PHASES I (2002–2004) AND II (2005–2009)*

Duc Giang	Phase I (n = 797)	Phase II (n = 3,982)
Physical violence	529	979
Emotional violence	502	944
Sexual violence	35	183
Economic deprivation	56	142
Dong Anh		**Phase II (n = 363)**
Physical violence		145
Emotional violence		344
Sexual violence		15
Economic deprivation		22

*Women may have reported more than one type of violence. Data provided by the Hanoi Department of Health.

and given the economic pressures on hospitals and health care providers, the number of women screened could further diminish.

The Ministry of Health circular mandates GBV screening but does not specify how screening will be funded, and costs for counseling, referrals, and community outreach and events to raise awareness about GBV are not included in the guidance. It is possible that hospital administrations may use their own budget to reimburse staff for GBV screening and counseling. However, the quality and level of GBV services could vary widely across Vietnam, depending on the extent to which hospital administrators prioritize GBV services. DGGH and DAGH administrators indicate that they are committed to continuing the services, but maintaining the level of services depends on a funding mechanism from the Ministry of Health.

Staffing: HDH, which has administrative management responsibility for hospital and clinic funding, has been unable to fully fund the level of services and staff positions supported by the Ford Foundation, which HDH estimated would cost an additional U.S.$5,000 per year per hospital beyond the current staffing commitment. As of July 2010, DGGH still retained one of the two full-time counselors and was committed to paying the counselor's salary for at least the next year, but was unable to cover community outreach activities or long-term recurrent costs for the Women's Counseling Center for Health. In Dong Anh, GBV services were combined with the HTC site to compensate for a lost staff position in the GBV clinic; outreach activities were curtailed. Fortunately, a few community-based activities initiated through the project may continue through local Women's Union or Farmers' Union budgets.

Future funding: For want of approximately $5,000 per year per hospital, it is difficult to predict the extent to which GBV screening, counseling, referrals, and community outreach will continue

> ***"After 8 years involved in this project, I found my own awareness on GBV has significantly changed. We struggled hard to change our opinions and then I found humanitarian equality in the intervention on GBV. I would feel very sorry if this project model could not find resources to continue. After all the efforts we took to write down our experiences and lessons learned into these protocols and manuals, I feel it would be a big waste not to use them further in health services."***
>
> ***–Vice Director of Duc Giang General Hospital***

at both hospitals. Addressing GBV represents a long-term effort to change cultural and community norms. The best outcome would be that the Ministry of Health circular represents the first step in implementing existing legislation on GBV and gender equity, and that additional guidance on funding, staffing, and training will be forthcoming.

Recommendations

Link HIV and GBV in service provision: Hospitals should integrate routine referral for HTC into their GBV counseling and referral services. This will require a long-term strategy to ensure that budgets are available at all levels for integrated HTC and GBV services, and that staff receive sufficient training to provide good services. In the case of Vietnam, the government has not adopted a provider-initiated testing and counseling strategy in primary health settings,[6] so GBV counselors may not be allowed to test for HIV. Until such a strategy is implemented, GBV counselors should receive training on the link between HIV and GBV and on pre- and post-test counseling, and should provide referrals to HTC sites (as well as sites for STI and reproductive health services) within the hospital or in the community.

Establish a broad advocacy base: Donors and foundations should consider funding advocacy training for HDH, nongovernmental organizations, and local government staff countrywide to expand the base of knowledge and strengthen advocacy on GBV. This will increase the capacity and popular support for developing long-term, multi-sectoral strategies for addressing GBV. The Ministry of Health circular is a promising indicator of the government's commitment to reducing GBV, but this support is only one of many steps that must be taken before the social and cultural factors that influence GBV begin to change. The Vietnamese political system does not accommodate citizen-based advocacy groups, but committed government officials can and do influence ministry policy choices and funding decisions at the provincial, municipal, and commune levels.

Vietnam has made enviable progress on the third goal of the Millennium Challenge[7] by reducing poverty and increasing girls' level of access to education, but it will fall short on increasing gender equality if efforts to address GBV remain limited. With proper strategic planning and advocacy skills, HDH leaders and their nongovernmental organization partners are in an excellent position to promote GBV as a public health *and* development issue with decision makers at all levels of government.

Include males in efforts to reduce GBV: Deeply held beliefs about gender roles and relations underlie GBV. Interventions that address gender roles and expectations for men and women are necessary to break the cycle of violence. Future GBV programs must include activities to reach men and boys to begin changing norms that perpetrate gender inequality and GBV.

Integrate GBV screening across services: Ministries of health, the U.S. President's Emergency Plan for AIDS Relief, and other donors should support programs to incorporate GBV screening and referral into all of their clinic-based services; in addition, community-based services should be able to provide referrals to GBV services. Women and men who are at risk for HIV may be at higher risk

[6] The U.S. Centers for Disease Control and Prevention (CDC) HTC guidelines will be revised in 2012. CDC is providing technical assistance to the government of Vietnam on inclusion of both couples testing and counseling and provider-initiated testing and counseling. Currently, provider-initiated testing and counseling is limited to tuberculosis, prevention of mother-to-child transmission of HIV, and STI settings in Vietnam (funded through the U.S. President's Emergency Plan for AIDS Relief).

[7] "Promote gender equality and empower women by eliminating gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015" (United Nations 2010, 20).

for GBV, and current HIV programs are not reaching some of the most vulnerable—male and female sex workers, women who inject drugs, and partners of men who inject drugs. Research on how to motivate doctors and nurses to screen for GBV without payment would help inform program interventions and identify what kinds of non-monetary incentives would sustain their engagement to provide compassionate and competent care.

Incorporate quality assurance: Integrating a GBV approach should include a quality assurance process to ensure quality counseling. This could include annual refresher training for health care providers and counselors to maintain skills in how best to interact with GBV survivors, and developing a small cadre of health workers who only screen and care for patients (children and adults) who experience trauma, rape, and GBV.

Foster donor-government collaboration: Donor collaboration with the government on providing GBV services should be based more on a "partnership framework" approach where the local government begins to take on the cost of continuing the services at some early point in the project so that by the end of the project period the entire cost is sustained by the local health department/public sector budget. In Hanoi, there was hope that the government would continue to support the services which, according to HDH estimates, is U.S.$5,000 per year per hospital to maintain the pre-2010 level of services annually.

Future Programming

Government policies that support gender equality and address domestic violence reflect hard-won gains by advocates working on behalf of survivors. However, the commitment to implement these policies—through dedicated funding for training, implementation, and monitoring—remains elusive.

Further, there needs to be a broader effort to look at GBV throughout society. While social norms are changing, there are still very few options for GBV survivors to find safe places and the counseling and support they need. GBV remains predominantly a woman's issue, though men and boys also experience violence. Future GBV projects and services need to work from the planning stages to strengthen the capacity of mass organizations like the Women's Union and Student's Union, as well as individual community members and families to understand and challenge the gender norms that perpetuate GBV.

The training supported through the project had a profound impact on many providers and government partners because it provided opportunities to think critically, for the first time, about gender equality, gender norms, and GBV. Programs should ensure that such training, along with information and guidance for providers, communities, and those experiencing violence, is supported in future projects. ■

RESOURCES

Center for Creative Initiatives in Health and Population, Hanoi, Vietnam: http://ccihp.org/

Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents, Hanoi, Vietnam: www.csaga.org.vn/

REFERENCES

Budiharsana M.P., and M.Q. Tung. 2009. *Final Project Evaluation Report: Improving the Health Care Response to Gender-based Violence – Phase II*. Hanoi: Population Council. Available at www.popcouncil.org/pdfs/2009RH_HealthCareRespGBVVietnam.pdf (accessed January 2011)

Center for Studies and Applied Sciences in Gender, Family, Women and Adolescents. Interview with the Director. July 7, 2010.

Gardsbane, D., V. Song Ha, K. Taylor, and K. Chanthavysouk. 2010. *Gender-Based Violence: Issue Paper*. Hanoi: United Nations.

Huong, H.M. 2008. Vietnamese Legislation on Combating Domestic Violence. *Social Sciences Information Review* 2(4). Available at www.vjol.info/index.php/ssirev/article/viewFile/2685/2680 (accessed October 2010)

Jonzon, R., N.D. Vung, K.C. Ringsberg, and G. Krantz. 2007. Violence Against Women in Intimate Relationships: Explanations and Suggestions for Interventions as Perceived by Healthcare Workers, Local Leaders, and Trusted Community Members in a Northern District of Vietnam. *Scandinavian Journal of Public Health* 35(6):640–647.

Mai, L.T.P. 2006. *The Role of Health Providers in Assessment and Treatment of Gender Based Violence: Evidence from an Intervention in Hanoi, Vietnam*. Unpublished paper.

Ministry of Health. 2009. *Viet Nam HIV Estimates and Projections 2007–2012*. Hanoi, Vietnam: Family Health International.

Nguyen, T.D. 2006. Prevalence of Male Intimate Partner Abuse in Vietnam. *Violence Against Women* 12(8):732–739.

Population Council. 2002. *Project on Improving the Health Care Response to Gender-based Violence: Training for Heath Providers on Gender-Based Violence. Training Manual*. Hanoi, Vietnam: Population Council (accessed January 2011)

Socialist Republic of Vietnam. 1998. Ordinance on the Organization and Activities of Reconciliation at the Grassroots. Available at http://moj.gov.vn/vbpq/en/Lists/Vn%20bn%20php%20lut/View_Detail.aspx?ItemID=1238 (accessed June 2011)

United Nations. 2010. *The Millennium Development Goals Report*. New York: United Nations. Available at http://mdgs.un.org/unsd/mdg/Resources/Static/Products/Progress2010/MDG_Report_2010_En.pdf (accessed January 2011)

UN Population Fund. 2007. *Gender-based Violence Programming Review*. Available at http://vietnam.unfpa.org/public/lang/en/pid/5268 (accessed September 2010)

Vu, M.L., T.H. Vu, H.M. Nguyen, and J. Clement. 1999. *Gender-based Violence: The Case of Vietnam*. The World Bank Policy Research Report on Gender and Development. Washington, DC: World Bank.

ACKNOWLEDGMENTS

The authors would like to express their deepest gratitude to staff at the Hanoi Department of Health and at the Duc Giang and Dong Anh General Hospitals involved in the Improving Health Care Response to Gender-based Violence project for generously sharing their experiences and enthusiasm for integrating a GBV response into their clinic services. The authors thank the Center for Creative Initiatives in Health and Population for their invaluable insights, expert collaboration, and extensive logistical support. The authors express their sincere thanks to the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) team in Vietnam for allowing them to conduct this case study. Thanks also to the PEPFAR Gender Technical Working Group for their support and careful review of this case study.

RECOMMENDED CITATION

Spratt, Kai, and Thi Thu Trang. 2012. *Public Sector Response to Gender-based Violence in Vietnam.* Case Study Series. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1.

Please visit www.AIDSTAR-One.com for additional AIDSTAR-One case studies and other HIV- and AIDS-related resources.

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

AIDSTAR-One's Case Studies provide insight into innovative HIV programs and approaches around the world. These engaging case studies are designed for HIV program planners and implementers, documenting the steps from idea to intervention and from research to practice.

Please sign up at www.AIDSTAR-One.com to receive notification of HIV-related resources, including additional case studies focused on emerging issues in HIV prevention, treatment, testing and counseling, care and support, gender integration and more.