GENDER-BASED VIOLENCE

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PROGRAMMING REVIEW

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Preface

Since the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995, prevention of violence against women has become a significant part of the United Nations Population Fund (UNFPA) mandate, guided by the rationale that prevention of violence against women is closely linked with improvements to women's reproductive health and their status in society.

UNFPA in its Seventh Country Programme of Assistance to Viet Nam (2006-2010) supports the Government of Viet Nam to improve the quality and utilization of gender-sensitive reproductive health (RH) information and services, including sexual health(SH) and family planning (FP). UNFPA also provides support to specific central and provincial institutions in their efforts to promote gender equality and prevent violence against women or gender based violence (GBV). To this end, a qualitative review was undertaken in 2006 to indentify successful GBV programming in Viet Nam, the challenges faced, and future areas of proposed action.

We would like to thank Ms. Kathy Taylor, MPH, a gender specialist and Prof. Vu Manh Loi, PhD for their efforts in conducting the review. We also acknowledge contributions from the Central Women's Union, the Viet Nam Commission

for Population, the Family and Children (VCPFC), the Duc Giang Hospital, the Tu Du Hospital Family Planning Unit, the Ford Foundation, the International Cooperation for Development and Solidarity (CIDSE), Oxfam Great Britain, the Population Council, Research Centre for Gender and Development (RGCAD), Centre for Applied Studies in Gender and Adolescence (CSAGA), Centre for Reproductive and Family Health (RaFH), Counselling Centre for Psychology, Education, Love, Marriage and Family (LMF) and Binh Phuoc Provincial Comission for Population Family and Children.

This report is intended to inform policy makers, programme managers and concerned agencies about the design and implementation of GBV related programmes /projects crucial for achieving the objectives of the Millennium Development Goals (MDG) and the International Conference on Population and Development in Viet Nam.

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UNFPA Representative in Viet Nam

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
BCC	Behavior Change Communication
CEDAW	Convention for the Elimination of all Forms of Discrimination Against Women
CIDSE	International Cooperation for Development and Solidarity
CP 7	Country Programme 7
CSAGA	Centre for Applied Studies in Gender and Adolescence
DV	Domestic Violence
EU	European Union
FP	Family Planning
FU	Farmer's Union
GBV	Gender-based violence
GDP	Gross Domestic Product
HCMC	Ho Chi Minh City
HFC	Husband and Father Clubs
HHD	Hanoi Health Department
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
INGO	International Non-governmental Organization
IPV	Intimate Partner Violence

LMF	Counselling Centre for Psychology, Love, Marriage and Family
LNGO	Local Non-governmental Organization
MIS	Management Information System
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalids and Social Affairs
MPI	Ministry of Planning and Investment
NCFAW	National Committee for the Advancement of Women
NPA	National Plan of Action
PDVAW	Prevention of Domestic Violence Against Women
PWU	Provincial Women's Union
RaFH	Centre for Reproductive and Family Health
RH	Reproductive Health
RHIYA	Reproductive Health Initiative for Youth in Asia
SRH	Sexual and Reproductive Health
SDC	Swiss Agency for Development and Cooperation
STI	Sexually Transmitted Infection
UN	United Nations
UNFPA	United Nations Population Fund
USA	United States of America
USD	United States Dollar
VCPFC	Viet Nam Commission for Population, Family and Children
VU	Veteran's Union
VWU	Viet Nam Women's Union
WHO	World Health Organization
WMC	Wife and Mother Clubs
YU	Youth Union

Executive summary

Violence against women, also known as gender-based violence (GBV), is a major public health and human rights problem. Worldwide, at least one in every three women has been beaten, coerced into sex or abused in her lifetime[1]. The effect of violence on a woman's mental health and well-being is severe. There are also negative effects on children and families, and economic costs. In recent years the international community has begun to acknowledge the seriousness and magnitude of the problem, and to take action.

In 2004, UNFPA Viet Nam began addressing violence against women, in collaboration with Government of Viet Nam working at the national level and in Thai Binh and Phu Tho provinces, and the city of Ha Noi. When UNFPA began its Seventh Country Program, 2006-2010, in partnership with the Government of Viet Nam it continued to expand its work on GBV.

The purpose of this review is to identify those successful programmes which address and prevent GBV in Viet Nam, plus the challenges, and future areas of action. This information

[1] Heise, L., Ellsberg, M., Gottemoeller, M., *Population Reports: Ending Violence Against Women*, Volume 27, No. 4, 1999, Garcia-Moreno C., Jansen HAFM, Watts C, Ellsberg M, Heise L, *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses,* World Health Organization, 2005

will be used by UNFPA to develop recommendations for a model to address GBV in its programming in Phu Tho and Ben Tre provinces, and for advocacy with its partners who are involved in the current development of the Law on Domestic Violence Prevention and Control.

The first section of this paper provides an introduction to GBV worldwide, the types of violence, their magnitude and consequences. It also provides a basic introduction to the situation of GBV in Viet Nam. The second section describes the methodology used in the review (literature review, field visits, sites selected, and respondents interviewed).

In the third section of the paper, the findings are divided into three different levels that must build synergistically on one another in order to address GBV comprehensively. This section discusses the national policy level in order to review the policy environment needed to support the prevention and reduction of GBV. It further reviews relevant individual sectors (health, justice, and education) where policies, protocols, and programs should be in place in order to provide services directly and to document cases sufficiently. The final section reviews programming at the community level to highlight how grassroots initiatives can prevent and decrease tolerance of violence, support victims, and address the needs of perpetrators.

In the conclusion, the review provides recommendations on appropriate ways to prevent and address GBV in Viet Nam.

1 Introduction to gender-based violence

Violence against women, also known as gender-based violence (GBV), is a major public health and human rights problem worldwide. The effects of violence on a woman's mental and physical health can be severe. Throughout the world, women are abused, beaten or coerced, or forced into having sex everyday. In recent years the international community has begun to acknowledge the seriousness and magnitude of the problem, and to take action.

1.1 Definition of gender-based violence

The United Nations Declaration on the Elimination of Violence Against Women, adopted by the UN General Assembly in 1993, defines Gender-based violence as:

"Any act of gender-based violence that results in or is likely to result in physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life."

Gender-based violence is further described in the Population Report: Ending Violence Against Women (1999):

"It is often known as 'gender based' violence because it evolves in part from women's subordinate status in society. Many cultures have beliefs, norms, and social institutions that legitimize, and therefore perpetuate, violence against women. The same acts that would be punished if directed at an employer, a neighbor or an acquaintance often go unchallenged when men direct them at women, especially within the family."[2]

[2] Heise, L., Ellsberg, M., Gottemoeller, M., *Population Reports: Ending Violence Against Women,* Volume 27, No. 4, 1999

1.2. Forms of gender-based violence

Throughout their life cycle, women and girls may experience different forms of GBV from pre-birth and infancy (such as sex selective abortions or female infanticide), throughout childhood and adolescence, their reproductive years and as elderly women. Lori Heise reviewed data on different types of violence against women and developed an overview of violence throughout a woman's lifecycle[3] (see Box 1 below).

Box 1. Gender-based violence throughout the life cycle

Phase	*Type of violence present*
Prenatal	Sex-selective abortion (China, India, Republic of Korea); battering during pregnancy with emotional and physical effects on women, effects on birth outcome; coerced pregnancy (example: mass rape in war).
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care for girl infants.
Childhood	Child marriage, genital mutilation, sexual abuse by family members and strangers, differential access to food and medical care, child prostitution.
Adolescence	Dating and courtship violence (acid-throwing in Bangladesh, date rape in the United States), economically coerced sex (African schoolgirls having to take up with "sugar daddies" to afford school fees), sexual abuse in the workplace, rape, sexual harassment, forced prostitution, trafficking in women.

[3] Heise L., Pitanguy, J. & Germain, A. *Violence Against Women: The Hidden Health Burden*, World Bank Discussion Papers, 1994

Reproductive age	Abuse of women by intimate male partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities.
Elderly	Abuse of widows, elder abuse (in the United States of America, the only country where these data are now available, elder abuse mostly affects women).

1.3 Definition of domestic violence or intimate partner violence

One particular form of GBV is violence between intimate partners. In international literature, Domestic Violence (DV) and Intimate Partner Violence (IPV) are synonymous concepts[4]. DV/IPV is violence carried out by one person in a relationship against another. This can occur among married or unmarried couples, separated or divorced couples. The most common form of DV/IPV is men using violence against their female partners[5]. DV/IPV can take various forms:

- Physical violence, such as slapping, hitting, kicking, beating.
- Psychological violence, such as intimidation, constant humiliation and belittling.
- Sexual violence, such as forced intercourse, and other forms of sexual coercion.

[4] Krug, E G., Dahlberg, L.L., Mercey, JA, Zwi, AB, Lozano, R., (eds). *World Report on Violence Chapter 4 Violence by Intimate Partners,* World Health Organization: Geneva, 2002

[5] Heise, L., Ellsberg, M., Gottemoeller, M., *Population Reports: Ending Violence Against Women,* Volume 27, No. 4, 1999

- Controlling behaviour, such as isolating a person from family and friends, monitoring their movements and restricting access to information, services, and resources[6].

In Viet Nam, however, the term "domestic violence" has a somewhat different meaning. It is used to refer to all kinds of violence that one family member causes to another family member(s) regardless of sex, age, or relationship to the victim(s). The most recent draft of the Law on Domestic Violence Prevention and Control defines domestic violence in Article 3 as "any intentional action by a family member to cause damage or potentially cause damage in terms of physical, spiritual, and economic damages to another family member" including the following actions:

1. Beating, maltreatment, or other intentional actions that damage the health and life [of other family members].
2. Forcing to work excessively.
3. Forced sex or other actions and violations of sexual life [of others in the family].
4. Verbal abuse or other intentional actions that damage the reputation, personality and prestige [of other members].
5. Forcing child marriage, marriage, or divorce or preventing voluntary marriage.
6. Isolating, discriminating, harassing or constantly exerting psychological pressure that causes serious consequences.
7. Preventing others from exercising legitimate rights in relationships between grandfather, grandmother and

[6] Krug, E G., Dahlberg, L.L., Mercey, JA, Zwi, AB, Lozano, R., (eds), *World Report on Violence Chapter 4 Violence by Intimate Partners,* World Health Organization: Geneva, 2002

grandchildren, between father, mother and children, between wife and husband, and between siblings.

8. Taking or intentionally causing damage to personal property of other members in the family or common property of family members.

9. Illegal actions forcing other family members to leave home.

10. Other domestic violence acts as stipulated under the law [7].

Although this review recognizes that women are sometimes perpetrators of violence against their male partners, evidence suggests that the majority of violence cases are against women. For the purpose of this paper, the focus will be only on violence against women perpetrated by men.

1.4 Impact of gender-based violence

1.4.1 Impact on health

GBV can result in many negative consequences for women's physical health, such as physical injury, gastrointestinal disorders, disability, and chronic pain. It also has severe consequences on women's mental health, such as depression, anxiety, substance abuse, and post traumatic stress disorder. It can also have fatal outcomes such as AIDS-related death, maternal mortality, homicide and suicide[8].

[7] Draft Domestic Violence Law reviewed at the Vietnam National Congress Meeting in Hanoi October-November 2006

[8] Krug, E G., Dahlberg, L.L., Mercey, JA, Zwi, AB, Lozano, R., (eds), *World Report on Violence Chapter 4 Violence by Intimate Partners,* World Health Organization: Geneva, 2002

1.4.2 Impact on sexual and reproductive health

Women who live with violent partners have a very difficult time asserting their sexual and reproductive rights. Violence can lead to many sexual and reproductive health problems, such as gynecological disorders, infertility, pelvic inflammatory disease, sexual dysfunction, STIs, HIV/AIDS, unsafe abortion, unwanted pregnancy and maternal mortality. Violence during pregnancy has been associated with miscarriage, late entry into prenatal care, still birth, premature labour and birth, fetal injury and low birth weight[9].

1.4.3 Impact on children

GBV also has devastating effects on families and children. Children who witness violence within the family have higher risks of emotional and behaviour problems, and physical health complaints[10]. Research also shows that children who witness violence often display many of the same behavioural and psychological disturbances as children who are abused[11]. Boys who witness violence in the family are also at a higher risk for using violence themselves as adults[12].

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[9] ibid

[10] Mc Closkey LA, Figueredo AJ, Koss MP, *The Effects of Systemic Family Violence on Children's Mental Health. Child Development,* 66:1239-1261, 1995, Edelson JL, Children's Witnessing of Adult Domestic Violence. *Journal of Interpersonal Violence.,* 14:839-870, 1999, Jounriles EN, Murphy CM, O'Leary KD, Interspousal Aggression, Marital Discord, and Child Problems. *Journal of Consulting and Clinical Psychology*, 57:453-455, 1989

[11] *Edelson JL, Children's Witnessing of Adult Domestic Violence. Journal of Interpersonal Violence.,* 14:839-870, 1999, Jaffe PG, Wolfe DA, Wilson SK. Children of Battered Women. Thousand Oaks, CA, Sage, 1990

[12] Krug, E G., Dahlberg, L.L., Mercey, JA, Zwi, AB, Lozano, R., (eds), *World Report on Violence Chapter 4 Violence by Intimate Partners,* World Health Organization: Geneva, 2002

1.4.4 Economic impact

Economic consequences of GBV for individuals and society are very high. For the victims and their families, in addition to health care costs for treatment of injuries and psychological disorders associated with GBV, there are also opportunity costs in terms of time required for treatment and legal activities that could be better used by the victims and their families to generate income. A study in Latin America in 1996-1997 estimated that health care costs of GBV (not including other costs) were 1.9% of the GDP in Brazil, 5% in Colombia, 4.3% in El Salvador, 1.3% in Mexico, 1.5% in Peru, and 0.3% in Venezuela[13]. GBV can also have lasting consequences in terms of a reduction in victims' productivity. For society, GBV requires enormous resources for public services such as police and courts, social support, child protection services, and treatment for perpetrators. In the United States, for example, it is estimated that the annual national budget allocated for the enforcement of the 1994 Act on Prevention of Domestic Violence against Women amounts to 1.6 billion USD[14].

1.5 Prevalence of gender-based violence worldwide

GBV occurs in all countries and societies, and within all social, economic, religious and cultural groups. In population-based surveys from 48 countries around the world, 10-69% of women report experiencing some type of physical violence by an intimate partner in their lifetime[15]. The World Health

[13] ibid

[14] Risk factors for domestic violence among women, USA. Reproductive Health Matters, Vol. 8, No. 16, November 2000

[15] ibid

Organization (WHO) Multi-country Study on Women's Health and Domestic Violence Against Women, carried out in 10 countries, found that 13-61% of women suffered physical violence from a partner[16]. Prevalence rates of sexual violence ranged from 6-59%. In the majority of sites, 30-50% of women who had experienced violence reported both physical and sexual violence. Most acts of physical violence constituted on-going abuse. In each site, more than half of women who experienced violence over the previous 12 months experienced it more than once.

Violence during pregnancy is also a serious issue. Population-based surveys in Canada, Chile, Egypt and Nicaragua show that 6-15% of women have been physically or sexually abused during pregnancy[17]. The WHO Multi-country study also found that rates of violence during pregnancy ranged from 1-28% with the majority exceeding 5%[18].

1.6 Prevalence of gender-based violence in Viet Nam

There is a lack of reliable evidence and research on GBV in Viet Nam. To date there have only been qualitative research and small-scale quantitative studies on GBV in the country. Although the national prevalence of GBV is not yet known,

[16] Garcia-Moreno C., Jansen HAFM, Watts C, Ellsberg M, Heise L, *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses,* World Health Organization, 2005

[17] Krug, E G., Dahlberg, L.L., Mercey, JA, Zwi, AB, Lozano, R., (eds), *World Report on Violence Chapter 4 Violence by Intimate Partners,* World Health Organization: Geneva, 2002

[18] Garcia-Moreno C., Jansen HAFM, Watts C, Ellsberg M, Heise L, *WHO multi-country study on women's health and domestic violence against women: Summary report of initial results on prevalence, health outcomes and women's responses,* World Health Organization, 2005

existing research shows that it is a problem[19]. A study carried out in 1999 in six communes in Ha Noi, Hue, and HCMC with a sample of 600 married women showed that physical violence occurred in 16% of these families, including 10% of economically better-off families and 25% of economically worse-off families while sexual violence (forced sex) occurred in 18% of economically better-off families and in 25% of economically worse-off families[20]. A 2006 study among 2000 married respondents in eight provinces/cities showed that 2% of participants reported physical violence, 25% reported emotional violence in their families, and 30% reported forced sex[21]. These prevalence rates are likely to be under-reported because respondents are reluctant to talk to other people about violence in their families due to fear and shame, or their adherence to traditional values.

Cultural attitudes, norms, and behaviours pose an obstacle to understanding GBV in Viet Nam. The term "violence" in Vietnamese, "bao luc" is a very strong term and people are reluctant to use it to label their family members, unless the abuses cause very serious consequences such as physical injury. In everyday life, then, many other forms of violence, such as verbal abuse, slapping, or coerced or forced sex against a

[19] Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, Jennifer Clement (1999) *Gender-based Violence: The Case of Viet Nam, World Bank:* Ha Noi and Phan Thi Thu Hien,(2004) *Sexual Coercion within Marriage: A qualitative Study of a Rural Area in Quang Tri Province,* Masters Thesis, University of Amsterdam, Netherlands

[20] Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, Jennifer Clement, *Gender-based Violence: The Case of Viet Nam,* World Bank: Hanoi 1999

[21] *The proposal for the project of development of Domestic Violence Law* (document No. 2330 TTr/UBXH) sent to the National Assembly by the Committee for Social Affairs of the National Assembly dated 30 August 2006.

wife's will are often not considered as violence[22].

There is thus a strong need for a national, population-based survey to understand the full extent of GBV in Viet Nam. Regardless of the exact prevalence, GBV continues to be a problem because there is no comprehensive framework to prevent and manage it.

1.7 Efforts to combat gender-based violence in Viet Nam

In response to recent increasing awareness of GBV in Viet Nam, a number of intervention efforts have been designed and implemented by government agencies, local non-governmental organizations (LNGOs), and international non-governmental organizations (INGOs). These interventions appear to have had positive impacts among project beneficiaries. However, similar to studies about GBV, interventions to combat this issue are generally small in scale (scattered among different isolated locations), narrow in scope (mostly addressing only physical violence), and usually experimental in nature.

[22] Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, Jennifer Clement, *Gender-based Violence: The Case of Viet Nam,* World Bank: Ha Noi, 1999 and Phan Thi Thu Hien, *Sexual Coercion within Marriage: A Qualitative Study of a Rural Area in Quang Tri Province,* Masters Thesis, University of Amsterdam: Netherlands, 2004

2 The review

A team of two consultants, one international and one national, conducted a review of theoretical and practical lessons of GBV and DV interventions to develop recommendations for a comprehensive model to address the issue in Viet Nam, to be used by UNFPA and for recommendations to its partners.

Consultants carried out the review in two phases. The first consisted of a literature review of GBV and DV projects implemented from 2001 to 2006. Documents were reviewed in both English and Vietnamese. The second phase involved field visits to Ninh Binh, Thai Binh, and Binh Phuoc provinces, and Ha Noi and Ho Chi Minh City carrying out in-depth interviews and small group meetings with project beneficiaries, project/ program staff, INGOs, and LNGOs. The results of this review are summarized in this paper.

During the research process, programming was reviewed on both DV and GBV. However, the section on policy level focuses only on DV because UNFPA is using paper for advocacy with its partners involved developing the Law on Domestic Violence Prevention and Control.

The other sections of the paper focus on GBV because there is a need to develop programming to address the issue throughout the life cycle, in addition to addressing DV.

The paper uses the term DV occasionally in these other sections when describing projects that focus on the issue to ensure accurate portrayal of their programming.

3 Introduction to Findings from the review

In order to address and prevent GBV effectively in Viet Nam, a multi-level, multi-sectoral approach must be developed to create synergy among the different actors. This approach should include action at three levels:

- National policy level
- Relevant public sector level, such as health, justice, and education
- Community level

The following sections highlight results from the review at each of these levels to show Viet Nam's current position relative to each area.

4 Findings: National policy level

At the policy and law making level, the Vietnamese government has been strong in creating legislation that guarantees women's rights. Viet Nam ratified the Convention for the Elimination of all Forms of Discrimination against Women (CEDAW) in 1981 and committed to the Cairo International Conference on Population and Development Plan of Action in 1994 and the Beijing World Conference on Women Platform of Action in 1995.

Prevention and methods to address violence are also included in several different legal documents, laws and national strategies:

- Vietnam Constitution 1992
- Law on Marriage and Family 2000
- Penal Code 2003
- Civil Code 2005
- National Strategy for the Advancement of Women till 2010
- National Plans of Action for the Advancement of Women by 2005 and 2006-2010
- National Family Strategy 2005-2010
- National Program of Action on Childhood 2001-2010
- National Plan of Action Against the Crime of Trafficking Children 2004-2010

In addition, several policy documents include references to DV. The Comprehensive Poverty Reduction and Growth Strategy of Viet Nam (CPRGS, 2002) states that DV, trafficking in women, and gender inequality hinder development and contribute to poverty. The Viet Nam Development Goals and

Targets adapted nationally from the Millennium Development Goals also address the need to prevent and reduce vulnerability to DV.

Although the last five years have seen a high commitment at the Governmental level to develop polices and laws on DV, there is still a large discrepancy in the way that laws and policies are implemented at the local level. There is also an important lack of understanding among the general public about DV and GBV and the rights women are entitled to under Vietnamese law.

Until now, Viet Nam has not designated one central agency to act as the coordinating body to address DV or GBV throughout the sectors and has not developed a National Plan of Action (NPA) to prevent and address DV or GBV. In other countries the development of an NPA on gender-based violence has moved the issue forward and provided the necessary political support. In Viet Nam, DV and GBV tend to be viewed as a "women's issue" and are often designated as the work of the Women's Union. This has the effect of marginalizing an important issue, that should be placed at a higher level, creating partnership among the education, health, justice, and other social sectors.

In recognition of the need to prevent and address DV more adequately in Viet Nam, the National Assembly included the drafting of the Law on Domestic Violence Prevention and Control in its 2006 Law Development Program.

This is a crucial step in the fight to prevent and reduce DV in Viet Nam. The new law is intended to raise the issue to a high

level of public awareness and address DV on a large scale. It shows the government's commitment to addressing DV while improving women's rights and gender equality in the country.

However, it is not enough simply to have a law. The decree for the implementation of the law is extremely important to ensure that it is adequately funded, that guidelines are clearly developed. It is also crucial that political support is maintained.

5

Findings: Sectoral level

Addressing GBV requires a synergistic approach among the different sectors to prevent violence and to address the needs of victims and perpetrators. Each sector requires specific capacity building, protocols need to be developed and implemented, and information must be shared across the sectors. This section shares findings from three sectors:

- Health
- Justice
- Education

5.1 Health sector

The health sector is a key entry point for identifying and treating victims of violence and for providing information on GBV prevention. Research has shown that women who are victims of violence have more health problems and use health services more often than women who do not[23]. Another study identified that few women disclose to health providers that they are victims of violence, even when they are seeking treatment for violence-related injuries[24]. Health providers rarely ask women if they are victims of violence, and if they do, they often do not properly document the case or know where to refer women.

In the last five years two small-scale projects were developed in the health sector that include screening clients for GBV.

[23] Krug, E G., Dahlberg, L.L., Mercey, JA, Zwi, AB, Lozano, R., (eds), *World Report on Violence Chapter 4 Violence by Intimate Partners,* World Health Organization: Geneva, 2002

[24] Rosales Ortiz J, Loaiza E, Primante D, Barberena A, Blandon Sequeira L, Ellsberg M, *Nicaraguan demographic and health survey,* National Institute of Statistics and Census: Managua, Nicaragua, 1999

Consultants carried out two site visits to review these projects at:

- Tu Du Hospital, HCMC: Integrating GBV screening into abortion services
- Duc Giang Hospital in Gia Lam district, Ha Noi: Improving the Health Care Response to Gender-based violence, by providing GBV screening to all patients

5.1.1 Tu Du Hospital Family Planning Unit

The Family Planning (FP) Unit at Tu Du Hospital provides GBV screening in its abortion counselling services. In 2001, Ipas began supporting a project to train the FP Unit on a Comprehensive Abortion Care model. One key element of the model is to provide high quality counselling to abortion clients. This counselling includes 10 steps, one of which is to screen for GBV. Although the counsellors have not received extensive training on GBV, it is noteworthy that it is included as one aspect of abortion counselling. Based on interactions with clients the FP Unit realized it is necessary to train all counsellors to screen for GBV, to provide support and referral information for victims.

The FP Unit also has a clear procedure for referring victims to four counselling centres in HCMC. They provide clients with phone numbers and addresses of these centres. But they do not have phone numbers for other types of services, such as legal assistance, does not collect any data on GBV cases, nor provides follow-up on cases.

5.1.2 Duc Giang General Hospital and Gia Lam Women's Centres for Counselling and Health Care[25]

With the technical support of the Hanoi Health Department (HHD), Population Council, and Center for Applied Studies in Gender and Adolescence (CSAGA), the project "Improving Health Care Response to GBV" began implementation in June 2002. The project focuses on:

- Comprehensively screening clients for GBV at Duc Giang Hospital[26] and Gia Lam District Medical Center.
- Providing GBV counselling through the Gia Lam Women's Center for Counselling and Health Care (based at the hospital).
- Organizing community based activities (IEC/BCC, clubs for victims of violence, counselling for families through Reconciliation Committees) in two wards.

Through the project, all health staff of Duc Giang Hospital and two health centers for Ngoc Thuy and Long Bien wards were trained on GBV. The training provided knowledge on GBV, and of the laws that address GBV, counselling skills, and skills to work with victims, such as screening, evaluating and documenting, providing emotional support and referrals to counselling centres and other support services. Advanced training courses were organized in the second year.

This is the first model in the Vietnamese health sector that systematically carries out GBV screening, treatment, and

[25] A more detailed description of the Gia Lam Women's Center for Counseling and Health Care will be provided in the community-based model section.

[26] Duc Giang Hospital was formerly known as Gia Lam General Hospital

referrals to other sectors. Procedures were developed by the project for screening and documentation of cases. A form is used to collect numbers of cases, types of violence, treatment provided, referrals to the in-house counselling centres and to other social and legal services. The hospital and counselling centre work together with local authorities, mass organizations, police, and the courts in order to deal effectively with cases using a multi-sectoral approach.

An external evaluation by the Population Council in 2005 found favourable results[27]. First, there were positive changes in attitudes and awareness among health providers, staff of mass organizations, and local authorities involved. Second, health providers screen clients more actively, with 46% identifying GBV victims. Third, health providers report providing emotional support in a non-judgmental way and referring victims to counselling and support services. Finally, there is closer collaboration between the health sector and other organizations and sectors.

These two projects provide a good example of the strengths and challenges in addressing GBV in the health sector. They also highlight the fact that there are few places in Viet Nam where GBV is addressed systematically through the health system. This review, and additional research by the Centre for Reproductive and Family Health (RaFH) in 2000, shows that there is much to be done in the health sector[28].

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[27] Le Thi Phuong Mai, *Evaluation of the Effectiveness of the Project "Domestic Violence in Rural Communities: Adapting Counseling Guidelines":* Comparison between Pre and Post Tests, Population Council, Hanoi, March 2005 (draft)

[28] Report *"Domestic Violence Against Women: Attitudes and Practices of Health Care Staff for Victims of Domestic Violence Against Women",* RaFH, September 2000.

Key lessons found in these site visits that can be applied to the larger health sector:

A need to develop health policies on GBV

At Duc Giang and Tu Du Hospitals, there is no official policy, nor at the Ministry of Health (MOH), mandating that health providers screen clients for GBV and provide referrals. This is currently done based on their own sense of 'responsibility'.

Need to develop norms and protocols on GBV

The HHD, in partnership with CSAGA and the Population Council, developed protocols for screening at Duc Giang Hospital. The Tu Du Hospital FP Unit also developed a basic screening protocol for abortion counselling. But there are no nationwide norms and protocols for screening, providing services and referrals, nor for registering cases, hence there is no standardized way to treat and document victims.

Need to train health personnel

All health personnel have been trained at Duc Giang Hospital and all abortion counsellors have been trained in Tu Du on GBV screening and referral. At both sites, staff said they wanted more training to improve their skills in detecting violence and providing high quality counseling. Staff also felt that not all health providers had changed their attitudes sufficiently regarding gender equality and needed further sensitization. At the national level, health providers will require high quality training and also refresher courses to improve their skills and maintain commitment. This must be integrated into medical school curricula as well.

Need to integrate GBV into the existing health management information system (HMIS)

At present, data collection on GBV cases is weak in these sites and throughout Viet Nam. Tu Du FP Unit refers clients for counselling services, but does not record the number of cases identified. Duc Giang Hospital would also like to integrate its GBV statistics into its regular HMIS. There is no standardized data collection system for GBV in the health sector. Therefore, it is impossible to estimate the number of women who come through the health sector suffering violence, and how many of them have received adequate services.

5.2 Legal sector [29]

The legal sector can play a substantial role in prevention of GBV through the following ways:

- Prosecuting those who perpetrate GBV related crimes
- Raising awareness that GBV is a crime (legal literacy)
- Strengthening women's rights in marriage, divorce, child custody, and property
- Increasing women's access to the legal system
- Increasing the number and types of interventions to protect victims
- Improving treatment of victims by law enforcement[30]

[29] Findings from the legal sector mainly come from secondary data. The review did not find sufficient information in the literature review on GBV programming in the legal sector to require field visits.

[30] National Research Council, *Advancing the Federal Research Agenda on Violence against Women,* National Academy Press: Washington DC, 1998

5.2.1 The Criminal Code and the Marriage and Family Law

Viet Nam Criminal Code, Marriage and Family Law, and other legal regulations prohibit the use of violence regardless of whether it is a man or woman using it against another man or woman. The Laws can be interpreted to mean that violence in general, and GBV in particular, are prohibited, but it does not specifically address violence against women.

These existing laws therefore do not provide adequate protection against GBV and DV. In the Criminal Code, for example, a violence case is only prosecuted if the victim's physical injury is estimated to damage more than 10% of the victim's health and if the victim files charges[31]. There is no difference if the victim is a man or a woman. When applying this to a case of GBV, this means that if a woman is injured as the result of a violent act by her husband, the husband is prosecuted only if (1) the woman's injury is determined to cause more than 10% loss of health and (2) if she files charges. But in reality, very few cases are actually criminally prosecuted. This is likely due to women's fear and shame at speaking out about GBV and their inability to support themselves and their children in case the husband is incarcerated or in case of divorce.

5.2.2 Lack of legal knowledge and literacy

There is also a gap between the theoretical provisions of the relevant laws and their implementation in practice. Different

[31] In Vietnam damage to a women's health is measured as part of the legal process. Government regulation No. 12/TTLB provides guidelines to quantify the percent of damage to woman's health. This assessment can only be done by the Council for estimation of Health Damage at provincial and central levels.

barriers have been identified that prevent justice for victims of GBV and DV. These include the public's lack of legal knowledge and education on GBV, weak implementation by the legal system, and cultural biases among legal and police staff, who prefer to maintain 'family unity' over women's safety[32].

Legal literacy among the general population is poor as well, and as a result victims are unable to claim their rights. Attempts have been made to increase legal knowledge of the general population and in many provinces a Council for Legal Education and Information has been developed. In each commune throughout Viet Nam, a bookshelf for legal documents has been created in the commune center for legal education and information[33]. These activities are aimed only at general legal issues, however, and GBV is not the focus. There is no report available about the effectiveness of these activities on raising the legal awareness of the population.

When interviewing project beneficiaries in rural areas of Ninh Binh and Thai Binh provinces several women said that prior to the project activities they did not know they were legally protected from violence. One woman stated that by learning about her rights she finally decided to leave her husband and to seek a divorce after living with violence for more than ten years. Two former male perpetrators also stated they did not have knowledge about gender equality and women's rights until the Prevention of Domestic Violence against Women (PDVAW) Board in Ninh Binh province counselled them,

[32] Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, Jennifer Clement, *Gender-based Violence: The Case of Viet Nam,* World Bank: Ha Noi, 1999

[33] See Circular 05/1999/TTLT-TC-TP 28 January 1999 on *Guideline for Implementation of Project to Set Up Legal Documents Bookshelf in Communes,* Wards, and Towns.

further demonstrating the dire need for public legal awareness of gender equality and GBV.

5.2.3 Poor coordination and lack of clear guidelines on how to handle GBV cases

Since divorce and criminal prosecution are considered last resorts for cases of violence in Vietnam, coordination between the legal sector and community level networks has been weak. In areas where GBV or DV projects are established, improved coordination between the legal sector and the community has been recognized by project implementers interviewed as a key component of preventing and addressing violence. For example, police officers have been added to Reconciliation Committees and Prevention of Domestic Violence Against Women (PDVAW) Boards. This has given credibility to these teams in the eyes of the community and now cases that merit legal action are documented more appropriately. In the project coordinated by HHD, CSAGA and Population Council, "Improving Health Care Response to GBV" in Gia Lam district, 10 perpetrators were imprisoned due to the coordination between the project and the legal sector.

Many cases of violence, however, remain unresolved, where legal mechanisms fail to protect women and their families and deal inadequately with perpetrators. Two cases of women and their families experiencing repetitive violence without sufficient protection or resolution were studied in Gia Lam, Ha Noi. One woman abused by her husband had taken refuge

in her parent's house, and the other woman continues to be abused by her ex-husband. Both victims and their families live in fear because the perpetrators have threatened them over a long period of time. Local authorities and mass organizations, such as the WU, have been involved in reconciliation repeatedly but without success. According to the victims and their parents, the local authorities and mass organizations either do not know what to do, cannot come on time, or have lost enthusiasm to intervene in on-going abuse. There is no legal mechanism to protect the family from harassment. Under existing law, the perpetrators' harassments have not reached the point where they can be arrested. Difficulty acquiring legal documentation of the incidents contributes to the problem and the victims do not know how to hold local authorities and mass organizations accountable.

These cases demonstrate that the future Law on Domestic Violence Prevention and Control is urgently needed to serve as a guideline for local authorities and mass organizations to protect victims and their families. These cases also show the frequent confusion over the roles and responsibilities within the local authorities (People's Committee), mass organizations, and legal sector, and a lack of legal literacy and skills to deal with perpetrators of violence.

5.2.4 Divorce due to violence

Women who are victims of GBV may also seek divorce through the Marriage and Family Law. However, reconciliation is the culturally preferred solution and divorce is sought

when women can no longer tolerate violence. Before the court grants divorce, reconciliation is legally required. "Reconciliation" is a type of counselling done by Reconciliation Committees set up in every commune to prevent families from "hasty" or "unnecessary" divorce. Many couples ultimately, change their minds during the course of reconciliation and do not divorce.

The rate of divorce due to DV has been significant in Vietnam in recent years. According to a report by the People's Court summarizing eight years of implementation of the Marriage and Family Law, divorce cases where DV was cited as a principle cause account for 32% of all cases in Hanoi, 31% in Hai Phong and 10% in Ho Chi Minh City[34]. A recent report by the People's Supreme Court found that "nearly half of divorce cases (46%) were due to DV"[35]. This is most likely due to women's greater ability to support themselves and their children economically than in the past, women's greater understanding of their rights, and a decrease in the stigma of divorce in some areas of the country.

5.3 Education sector

Young people are a key group to work with to prevent GBV because they are still forming their values and beliefs and can be positively influenced towards treating men and

[34] See *Proposal for Development of the Law for Prevention and Fight Domestic Violence,* Document No. 1613 BC/UBXH, Committee for Social Affairs, XI National Congress, 23 August 2005.

[35] People's Supreme Court, *Report on Reviewing Legal Documents Concerning Domestic Violence by People's Court and Assessment of Domestic Violence Through Court Cases of Criminal, Civil, Marriage and the Family Cases,* Hanoi 25 September 2006; report presented in the workshop organized by the Committee for Social Affairs of the National Assembly on 28 September 2006 in Hanoi.

women with equal respect and to reject the use violence. In Viet Nam, youth under age 25 currently make up 47% of the population and are the largest population segment[36]. Therefore, there is vast potential to work with this group through the education sector.

Currently, GBV is not directly addressed and gender equality is not sufficiently addressed in any curriculum in the education sector. However, several projects that are working with youth in adolescent reproductive health implicitly touch upon gender equality issues. From 2001 to 2005 UNFPA supported the Ministry of Education and Training (MOET) to implement Adolescent Reproductive Health (ARH) Education in the upper-secondary school system and to integrate ARH into the education program of central-level Pedagogical Colleges on a pilot basis. One of the topics covered in the curriculum developed and piloted was gender equality including rights and equal participation of boys and girls in the family, school and society. But the curriculum did not specifically cover GBV.

Within and outside the school system, UNFPA and the European Union (EU) have also supported the Reproductive Health Initiative for Youth in Asia (RHIYA). This project developed a comprehensive strategy to work with youth both in and out of school. It is implemented by the Youth Union (YU) and therefore does not fall directly under the education sector, but does include certain peer education activities in schools throughout the country. One of the five

[36] GSO 2005: Survey on Population Change and Family Planning 1 April 2005: Major Results, available on website (downloaded 7 October 2006): http://www.gso.gov.vn/default.aspx?tabid=407&idmid=4&ItemID=4488

main components of the RHIYA Behavior Change Communication (BCC) strategy focuses on sexual abuse. This is a strong move forward to address the topic, although still sensitive in Vietnam. Unfortunately, it does not cover other forms of GBV, such as physical and emotional violence, or sexual harassment.

6 Findings: Community level

In the last five to eight years several organizations have begun community-based GBV or DV projects in Viet Nam. They have reached a point where they can share lessons learned thus far from their successes and challenges. In this review, several community-based projects were visited and consultations were also held with key leaders of implementing organizations.

Consultants visited the following projects and organizations:

- Centre for Reproductive and Family Health (RaFH), Prevention of Domestic Violence Against Women, Ninh Binh province
- Counselling Center for Psychology, Education, Love, Marriage and Family (LMF), Ho Chi Minh City
- UNFPA/Swiss Agency for Development and Cooperation (SDC) supported project, "Mainstreaming Gender Equality in the Family in UNFPA Population and Reproductive Health Program", Thai Binh province
- Vietnam Commission for Population, Family and Children (VCPFC), "Sustainable Development of the Family and Prevention of Domestic Violence", Binh Phuoc province

Though programming was unique at each site, this review found several similar components in many community-based models that appear key to preventing and addressing GBV.

6.1 Key components to develop models to address GBV

6.1.1 Raising awareness and gaining support of local leaders

In each project visited, staff were highly conscious of raising awareness among local leaders to gain support. In the RaFH

project, local authorities were trained in gender equality and DV. The training influenced several other positive changes for gender equality in the community, such as creation of quotas for women in local government positions and providing land to single women over age 35, previously reserved only for men.

6.1.2 Creating multi-sectoral boards or committees to address GBV

At each project site, a multi-sectoral board or committee was developed to manage and implement GBV or DV projects. These generally included the head or vice-head of the People's Committee, mass organizations, police, health sector, and village heads. By bringing together the different sectors, participants regularly communicated on GBV or DV cases and improved assistance to victims and perpetrators. This raised the issue to a higher level of priority at project sites since GBV or DV was no longer viewed as just a "women's issue", cases were handled by the team and each person contributed their different expertise according to the case.

6.2 Key components for GBV prevention

6.2.1 IEC/BCC to raise awareness, knowledge and prevent and/or change gender inequitable and violent behavior

GBV is a relatively new topic being discussed and addressed openly in Viet Nam. Only in the last five years has there been a substantial opening in public discourse this. There is still a great deal to be done to raise public awareness of gender equality, women's rights, laws and GBV. In all site visits to community-based models as well as in almost all of the projects in the literature review, IEC/BCC activities were identified as a cornerstone of GBV or DV prevention.

Each project employed several methods of IEC/BCC to raise community awareness. Leaflets, posters, and booklets on gender equality, GBV prevention, women's rights and laws were disseminated. Loudspeakers, local radio, TV, newspaper articles and community talks were also used to share information at the grassroots level. Clubs were formed to create a space for the community to discuss gender equality, women's rights, GBV, laws, SRH, and also integrated other topics, such as agricultural techniques and poverty alleviation to maintain community interest.

These multiple forms of IEC/BCC were effective in raising awareness of local communities and creating greater public space for women to speak out as victims and seek help where they had previously been ashamed. At each field visit, interviewees still reported stigma for both victims and perpetrators, but there appears to be an improved capacity to discuss the matter and find support within the community.

6.2.2 Integrating GBV into the agenda of mass organizations and socio-economic activities of the community

Another key to success of the projects was the integration of GBV or DV into the agenda of all mass organizations and other development activities in the community. In the RaFH and UNFPA projects, DV was integrated into mass organizations' regular meetings and talks, such as at the WU, Farmer's Union (FU), and YU. In the VCPFC project, DV information was integrated with agricultural trainings (extension training, integrated pest management, and other production trainings). This created greater awareness among the entire community by reaching out to more people through multiple channels to

receive repeated message. This also allows for greater possibilities to reach men, who may not attend club meetings and often believe that WU activities are not open or interesting to them.

6.3 Key components to address GBV in the community

In order to address GBV at the community level effectively, there is a need for strong support and counselling models for victims and perpetrators, and for enforcement of laws. Several low-cost, culturally sensitive models have been developed and piloted at the local level to address GBV and DV. It is still early, however, to see strong results addressing and reducing GBV or DV from the few models available. These models have been implemented for five to eight years and will require long-term investment before significant decreases in GVB can be measured. The following points below are promising components identified for community-based models.

6.3.1 Clubs/support groups for victims of violence and perpetrators

As mentioned, most clubs invite victims, perpetrators and other community members to participate in support groups. Some victims and perpetrators feel confident enough to speak out, but in many cases they do not. For example during the RaFH project, victims and perpetrators were too embarrassed to share their stories and requested separate meetings. In response RaFH began holding separate "seminars" for them but did not publicly announce the beneficiary group. Female victims

appreciated being able to speak about their problems and receive support from the group. Some perpetrators stated that they appreciated the chance to learn more about DV and gender equality and self-reported that they used less violence. These support groups are not held regularly, despite their potential to provide more support for victims, to reinforce new knowledge, and reduce violence. Other projects, such as UNFPA/SDC, invited perpetrators to meetings hoping to integrate them into the group, but did not provide meetings strictly for them.

The HHD-CSAGA-Population Council project developed "Clubs for Family Happiness" for female victims of violence, but also invited members of the WU to attend to decrease stigma. These clubs created a safe environment for women to share their problems, support each other, learn how to solve family conflicts, and make safety plans.

6.3.2 Counselling through community-based teams/ Reconciliation Committees

At the community level in Viet Nam there are Reconciliation Committees that try to assist families where GBV or DV occurs. These committees usually consist of members from local authorities and mass organizations such as the WU and FU. They usually become involved only in serious cases of violence since families often try to hide evidence due to fear and/or shame. In general, they are not trained in counselling skills or legal knowledge[37].

[37] Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, Jennifer Clement, *Gender-based Violence: The Case of Viet Nam,* World Bank: Ha Noi, 1999

Due to the existence of Reconciliation Committees and their close relationship with the grassroots community, several projects decided to improve effectiveness by building capacity in counselling and legal literacy. Each project decided to build on existing Reconciliation Committees in a slightly different way. For example, some changed the name but essentially they became a stronger version of existing committees.

At the RaFH project, the project staff led the development of Prevention of Domestic Violence Against Women (PDVAW) Boards at the commune level. These included the head of the People's Committee as the head of the Board, police, health workers, and mass organization representatives (WU, FU, YU).

At the village level the project staff developed "Intervention Teams" which do the majority of the direct counseling. These teams consisted of village heads, representatives of hamlets, WU, and other mass organizations.

One prior weakness of the Reconciliation Committees was their lack of legal power to enforce laws that would encourage men to stop using violence. At the village level, the head of the village also functioned as the local police representative. Adding the police has given the PDVAW Board and Intervention Teams greater strength and credibility within the community to intervene in cases and apply legal measures as a last, but necessary resort. This has led to more respect for the teams, knowledge among the community that DV is not acceptable, and that there are repercussions if it cannot be resolved. The VCPFC and UNFPA/SDC community based

models also have added police or heads of villages that function as local police to their Counselling Teams. In the VCPFC project in Binh Phuoc, a task force was established at the commune level by the commune police chief with the VCPFC commune officer as the vice-head.

6.3.3 Counselling rooms, counselling centres and hotlines

In the RaFH project, twenty counselling rooms were developed in project communes. The PDVAW Board staff these counseling rooms in rotation. They are unique because they are developed in rural areas, whereas most counselling centres exist in large cities. RaFH staff and PDVAW board members mentioned that they have a hard time motivating people to attend the counselling centres since they are located at the commune level. At the moment, the most pressing needs for counselling at the village seem to be met by village level Intervention Teams since they know the community better. Many people either do not have time to go the counselling centres, or are reluctant to speak with people they do not know.

In HCMC, the LMF Counselling Centre has ten years experience in providing counselling services that cover a range of information on DV, legal advice, psychology, biology/puberty, SRH, HIV/AIDS, and family relationships. Through awareness raising, such as broadcasting documentaries on national TV and distributing IEC materials, they were able to raise awareness of DV in communities substantially and create demand for counselling services. The centre is staffed by counsellors and professionals knowledgeable on each of these topics. Clients can receive face-to-face counselling or call their hotline. The centre is well known after ten years throughout HCMC, provides twenty-four hour service, and

receives two hundred calls per day. Through their counselling experiences, the centre has realized that DV is inextricably linked to legal issues. Therefore, they always have a lawyer work with their other staff to provide necessary legal information that clients need.

The Gia Lam Women's Centre for Counselling and Health Care was developed in 2002 to provide counselling services to GBV victims from the community and to complement the GBV screening services provided by Duc Giang Hospital. The centre is supervised by HHD and works in close contact with hospital through daily meetings. It is located on the hospital premises and receives referrals from the hospital, mass organizations, the police, and court, and walk-in clients from the community who hear about it through mass media or friends. Since it's opening in 2002, the centre has served more than 2400 clients. In some severe cases, counsellors also make home visits as a team with the WU, People's Committee and police. The senior counsellor in charge of the center stated that many women know about the centre and they provide services also to women from neighbouring districts and provinces.

The counselling staff feels the centre is successful but they still encounter barriers to their work, including:

- Traditional norms remain strong and many women don't realize they suffer from GBV.
- Many women only consider physical violence to be GBV and do not understand that sexual and psychological violence are also violence.
- It is difficult to assist victims of violence living outside the project implementation area because local authorities

have limited understanding and capacity to deal with violence.

- Stronger coordination with mass organizations is needed to assist clients who repeatedly return and need higher levels of support (such as trusted addresses for victims and assisting the children of victims of violence with school tuition).

6.3.4 Trusted addresses

In each site visited, all interviewees noted the need for a safe place or "trusted address" to accommodate women in extreme cases to ensure their safety. The UNFPA project was the only site visited that provided a community based "trusted address" for women. These "trusted addresses" belong to members of the Counselling Teams and other influential members of the community. Victims of violence may go and stay there until they decide to return home. In most cases, the woman stays there for a short period and during that time the Counselling Team meets with the husband and assesses the situation, and attempts to address the violence.

Due to the current lack of funds to develop GBV shelters at the community level and the strong desire of women to remain in the community, this model appears to work based on strong social cohesion and a willingness to assist others. It appears that, due to Vietnamese cultural values associated with "losing face" and not airing one's problems in public, some perpetrators dare not enter or harass the inhabitants of the "trusted address", since project activities raise community awareness and the prospect of arrest.

There are still unanswered questions for cases of repetitive violence where the trusted address may not prove a deterrent. For example, it is unclear where a victim will go if she cannot stay at the trusted address for a long period due to a severe case of unresolved violence. The question also is whether a woman will suffer more violence when she goes home as a "punishment" for going to the trusted address? This model should be further piloted to understand its feasibility. However, it appears to have potential within the Vietnamese context.

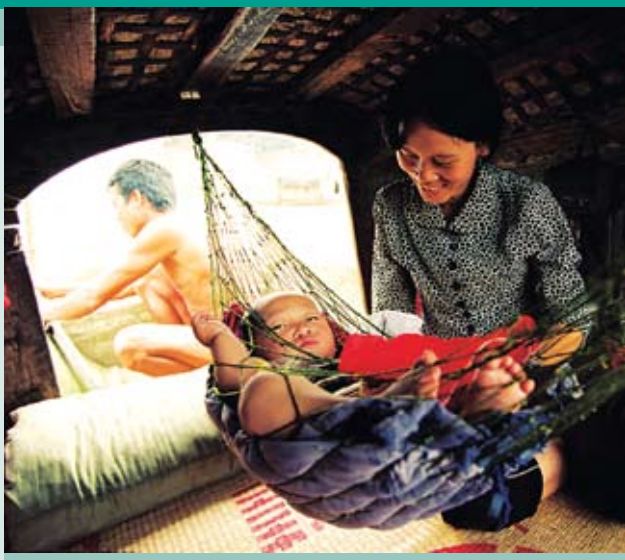
6.3.5 Access to referral services from other sectors

A key component of community-based models of GBV is making sure that women receive appropriate referral services to other sectors to address their needs. In many cases women may need health, legal, economic and social services. Staff in these sectors need to be trained to provide support services to victims and also be in regular contact with each other to follow up on GBV cases.

As observed in site visits, the strength of the referrals varied within the different projects. The health and legal sectors tended to be involved to some degree, though the health sector requested more training be provided in a few sites. The education sector was the least involved and lacked links to the community-based projects visited except for the UNFPA/EC supported RHIYA project in HCMC. Activities focusing on HIV and DV prevention through the YU in the RaFH project represented the only connection seen with youth in rural areas. The education sector should be asked to join GBV prevention committees and participate in community and school-based activities.

Victims of violence also require social and economic support. At the community level it appears that emotional support for women beyond the Reconciliation Committees is often provided by the WU. The WU at the commune and village levels report they regularly visit victims of violence and try to support them as needed whether through counselling, inviting them to attend WU meetings, or providing economic support through microcredit loans and other means.

7 Discussion



7.1 Strengths

Over the last five years there have been many positive changes with regard to preventing and addressing GBV in Viet Nam. Efforts on the part of the Government, mass organizations, the UN system, LNGOs, INGOs, and donors have shown results.

During this period, advocacy efforts have placed the issue on the policy agenda of the government. Talk of GBV is no longer taboo and the subject is no longer denied in public. The Government of Vietnam is moving forward to take action and is developing the Law on Domestic Violence Prevention and Control. For this, the Government is seeking input from the national and international community in the development and showing a strong commitment to implementation.

Throughout the country the awareness of women speaking out and seeking justice through the court system or filing for divorce is also increasing. This is a positive sign. Higher rates of court cases and divorce associated with GBV do not necessarily mean that violence is increasing; it could signify that women are no longer afraid to speak out when victimized and are claiming their rights to security and autonomy.

Pilot projects implemented throughout the country in the last five to eight years are now producing results and in a position to share lessons learned. Community-based models have been developed to prevent and address GBV. Several projects have been successful in raising community awareness and changing attitudes that reject and no longer quietly tolerate violence. Stigma appears to be decreasing in project areas against women speaking out and requesting help.

These models also show success in creating multi-sectoral teams to provide counselling to victims and perpetrators in their attempts to reduce GBV. Victims appreciate counselling, clubs, and other supportive forums. Some perpetrators self-report that they have reduced or stopped using violence after receiving counselling and attending meetings or clubs.

Within the health sector, certain lessons are apparent from the two pilot models to screen, treat and refer clients to services in the community. The HHD - Population Council - CSAGA project in Gia Lam, Ha Noi, is a strong model for providing timely medical and referral services to clients and also for ensuring data collection and follow-up.

7.2 Future challenges

GBV is a major human rights and public health problem that cannot be solved quickly. There are still many steps that need to be taken to prevent and address the issue effectively in Viet Nam.

7.2.1 National policy level

There exist many positive laws and polices, but their enforcement needs to be strengthened. After the Law on Domestic Violence Prevention and Control is passed, strong political support and funding for the implementation of the law must be sustained in order to prevent and address GBV in the long run. Knowledge and awareness among leaders will also need to be further improved.

7.3 Sectoral level

There are still many gaps at the sector level. Since there is no law or guiding framework to address GBV, multi-sectoral collaboration remains weak. Data and information are not routinely collected or shared across ministries. Protocols and guidelines for addressing GBV cases are also lacking in all sectors. Knowledge and awareness within each sector will need to be strengthened to address these key issues.

7.3.1 Health sector

Within the health sector there is a lack of protocols for screening, treatment and referral. There is no systematic data collection or data management system. Though providers routinely encounter victims of violence, many do not know how to work with them in a sensitive manner and do not know where to refer them. In the review, all providers who had not received training, but had GBV or DV projects in their communities, requested training so they could participate more actively in the prevention and treatment of GBV.

7.3.2 Legal sector

Currently there are still gaps in the enforcement of existing laws related to GBV, such as in the Marriage and Family Law. It remains difficult to collect sufficient information for criminal court cases due to women's shame or fear and lack of income to support themselves if the husband is incarcerated[38]. There are also cultural biases among legal officers and police, who prefer to maintain family unity over the safety of victims, and among women themselves, who lack knowledge of their legal rights.

[38] Vu Manh Loi, Vu Tuan Huy, Nguyen Huu Minh, Jennifer Clement, *Gender-based Violence: The Case of Viet Nam,* World Bank: Ha Noi, 1999

There is also poor data collection on who the perpetrators are in GBV cases (husband, parent-in-law, children, boyfriends). Data is not shared among different sectors. Reconciliation Committees lack skills to deal with counselling victims and perpetrators on GBV since they have not been formally trained.

7.3.3 Education sector

In the education sector there is a significant lack of attention to GBV with insufficient coverage of gender equality in the curriculum. At the moment, the MOET curriculum on ARH only covers basic gender equality discussions. There is no subject area related to GBV. The UNFPA -EC RHIYA project covers the topic of sexual abuse but does not cover physical or psychological violence. Youth are at a key time in their lives to change their behaviour while still forming their opinions and values. This opportunity to change gender roles and perspective within society and prevent GBV should not be missed.

7.4 Community level

At the community level, particularly in places where there have been no projects, there is still shame and secrecy associated with GBV. It is viewed as a "family affair". In interviews, men and women still mention Confucian norms where women should always obey either their father, husband or eldest son (after the husband's death) and it is acceptable for a man to use violence to "teach his wife" if he feels she has done something wrong. Therefore, there is still much work to be done to raise public awareness of women's rights and promote gender quality to reduce violence.

In GBV community models, there is also a need to engage men, youth and older generations more actively. More reports at project sites still show the majority of participants in activities are married women, usually members of the WU. Activities should be targeted to involve youth since they are of key importance and represent the largest population segment in Viet Nam.

There is also a need to continue to work harder to engage men in GBV prevention and reduction. Activities for men should be targeted through the Farmer's Union to increase participation. GBV should be integrated into different agricultural trainings and other meetings in order to maintain interest and participation.

It is also important to work with older family members since they hold positions of prestige in the community and family. This can be done through working with the Elderly Association, Veteran's Association, or Women's Union. Respondents mentioned some cases where parents-in-law encouraged the use of violence to "teach the wife". Yet other respondents also mentioned cases where parents-in-law functioned as important role models in the community to encourage stopping violence.

8 Recommendations for the development of a model to prevent and address GBV

8.1 National Policy Level

In order to address GBV systematically there needs to be strong guidance at the national level. There is currently strong interest in addressing GBV and existing legislation and signed conventions that promote gender equality in Viet Nam. But more remains to be done in order to effectively mobilize national support and implementation.

Following are recommendations for the national and policy level:

- Lobby for the completion and approval of the Law on Domestic Violence Prevention and Control. The law must have strong decrees guiding the implementation and monitoring as well as sufficient funds. A state management agency (SMA) should be in charge of the monitoring process.
- Create a national network to end GBV. This network would consist of concerned mass organizations, the National Committee for the Advancement of Women (NCFAW), LNGOS, INGOs, UN, and research institutions to move forward GBV policies, research, and work as a watchdog to monitor implementation of existing and new laws and international conventions (such as the Law on Domestic Violence and Control, Marriage and Family Law, and CEDAW) and to coordinate national level advocacy.
- Develop decrees and circulars specifying the role of each sector (health, justice, education) to address GBV

to ensure ministerial support and the development of clear guidelines for implementation.

- Link GBV with socio-economic development plans and activities at the national level.
- Develop a national BCC strategy and a sustained long-term national campaign that is linked to BCC at the local level in order to actively reduce gender inequality and GBV.

8.2 Sectoral level

8.2.1 Health sector

- Develop policies and protocols to improve the health care response to GBV. These would include protocols to detect, treat, register and refer all victims of violence encountered in the health system.
- MOH should integrate GBV prevention and management into the National Reproductive Health Strategy by 2011and require all SRH providers to screen and counsel clients on GBV.
- Collect standardized data on GBV victims as well as services and referrals provided for integration into the existing health management information system.
- Provide specialized services to victims of GBV (counselling and support groups).
- Strengthen coordination between the health sector, mass organizations, NGOs and other sectors to ensure high-quality referrals.
- Ensure adequate coverage in medical curricula (doctors,

nurses, psychologists, etc.) on GBV screening, detection, and treatment.

- Provide health care providers with on-the-job training on GBV and regular follow-up and training to ensure long-term commitment and improvement in addressing GBV through the health sector. At the commune level, train all health workers on GBV.
- Ensure adequate time for health care providers to screen, treat, and refer, and properly document cases of GBV, as well as follow up with patients after discharge.

8.2.2 Justice sector (police and judiciary)

- Develop clear policies and protocols to handle GBV cases for police, court officials, forensic doctors and other professionals involved.
- Develop national protocols and systematic training for Reconciliation Committees.
- Sensitize and train police, court officials, and other justice system professionals on gender equality and how to handle GBV cases appropriately (rather than "preserving the family" or blaming the women).
- Train local advocates from Reconciliation Committees or community networks on GBV legal literacy and have them accompany women to the court if needed to help navigate the legal system and provide moral support.
- Strengthen coordination among prosecutors, police, and the court system in handling GBV cases.
- Strengthen coordination between community level networks preventing and addressing GBV and the legal sector.

- Develop a clear data collection system that disaggregates data by specific type of GBV and identifies the perpetrator (husband, uncle, mother-in-law, boyfriend).

8.2.3 Education sector

- Develop age-appropriate curricula that teach children and youth about gender equality, human rights, SRH, HIV/AIDS, and life skills so that children develop gender equitable attitudes and behaviours.
- Develop school-based GBV prevention programs such as peer education and theater groups.
- Pilot confidential, school-based counselling desks where young people can discuss any issue (family conflicts, puberty, SRH/HIV/AIDS, GBV, etc.) and provide referral services.

8.2.4 Multi-sectoral initiatives

- Develop a cross-sectoral information collection and sharing system (MOH, law enforcement, court system). Guidelines and protection of confidential data must be ensured in order to protect women's safety.
- Develop multi-sectoral plans to address GBV with the State Management Agency facilitating coordination and monitoring the implementation and progress of the law.
- Integrate gender equality and GBV prevention into local socio-economic development plans.

8.3 Community level

8.3.1 Prevention of gender-based violence

- Raise awareness and train local leaders and media to gain political will and support for GBV initiatives (People's Committee, mass organizations, local ministry departments, police, and court representatives).
- Develop community networks to prevent, detect, address, and make referrals for victims of violence and perpetrators (i.e. VCPFC, LNGOs, police, health sector, WU, YU, FU, VU, village leaders, and respected community members).
- Implement BCC activities and campaigns at the community level to raise awareness of gender equality, change norms of masculinity, and decrease tolerance of violence, as follows:

1. Target men and male adolescents to change norms of masculinity and gender equality through working with unions (FU, VU, trade unions) where when men are likely to attend meetings. Include men who have stopped using violence as group leaders. Carry out local campaigns against violence focusing on male youth.
2. Develop GBV prevention/gender equality groups (for women and couples). Include men who have stopped using violence as group leaders and positive role models or couples where GBV was once present.
3. Raise awareness of youth on GBV, SRH, HIV/AIDS and life skills through programming with YU and other community forums.

4. Use existing population/FP collaborators to disseminate information about gender equality and GBV in their talks and personal visits.
5. Work with older men and women in the community through the Elderly Association or Veteran's Union (VU) using their position of respect and status to positively influence family members and the community on gender equality and preventing and addressing DV.

8.3.2 Provide comprehensive services to GBV victims and male perpetrators

- Provide counselling for men, women, and couples through specifically trained Prevention of Domestic Violence Against Women/Reconciliation Committees that are also linked to local networks. Provide support groups for victims of violence in the community. (This can also be at the health centre depending on the situation.)
- Provide hotlines for victims of violence and information on violence prevention and family relationships to the general public in cities where people have access to telephones.
- Further pilot and assess the provision of temporary refuge for women at "trusted addresses".
- Pilot the Centre for Women and Development, the first shelter for victims of GBV in Vietnam and assess the feasibility for replication in urban settings.
- Provide legal aid services for women through Provincial Legal Aid Committees, LNGOs or mass organizations and free filing of paperwork at court for poor women.
- Provide local advocates who are victims of violence

to assist victims and attend any legal proceedings with them.

- Develop community regulations and deterrents to GBV and enforce them at the community level to ensure perpetrators meet with Reconciliation Committees and police for counselling and sign an agreement not to use violence, and are monitored by the Reconciliation Committee.