

Domestic Violence Prevention and Response in Viet Nam

Lessons Learned from the Intervention Model in Phu Tho and Ben Tre provinces



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Foreword

The United Nations in Viet Nam is strongly committed to preventing and addressing gender-based violence in partnership with the Government of Viet Nam, mass organizations, and civil society organizations. During its Seventh Country Programme of Assistance to Viet Nam (2006-2010), UNFPA collaborated with the Swiss Agency for Development and Cooperation (SDC) to support the Government to promote gender equality and to address gender-based violence through policy dialogue, advocacy, communication, technical assistance, health sector and community based interventions.

This review aims at drawing lessons learned from an assessment of the strengths, weaknesses, achievements, and challenges of the UNFPA-SDC supported interventions at the policy and programme levels in Phu Tho and Ben Tre provinces. UNFPA would like to introduce these lessons learned to policy makers, programme managers, and others who are concerned with putting in place a functioning prevention and response system to end gender-based violence in Viet Nam in the most appropriate and effective way. UNFPA and UN partners will further collaborate with the Government of Vietnam to apply these lessons on addressing gender-based violence in the new One Plan (2012-2016).

UNFPA would like to thank Ms. Sarah De Hovre and Dr. Vu Manh Loi, consultants, for their efforts in conducting this review and summarizing the lessons learned. We are grateful to the Project Management Boards in Phu Tho and Ben Tre provinces for their cooperation, facilitation and support. We also acknowledge contributions from the Department of Maternal and Child Health (Ministry of Health), Department of Family (Ministry of Culture, Sports and Tourism), General Office of Population and Family Planning, Viet Nam Women's Union, Youth Union, and Farmers' Union. Lastly, we would like to thank all the leaders, officers and community groups in Ben Tre and Phu Tho provinces for their participation in the review and for sharing their views on the pilot intervention model.



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Executive Summary

Gender-based violence (GBV) is a major public health and human rights issue. Worldwide, at least one in every three women has been beaten, coerced into sex or abused in her lifetime¹. In Viet Nam, similar numbers have been revealed in the 2010 National Survey on Domestic Violence against Women.

UNFPA Viet Nam began addressing violence against women in 2004, in collaboration with the Government of Viet Nam. These efforts were expanded in the Seventh Country Program 2006-2010, when UNFPA joined hands with the Swiss Agency for Development Cooperation (SDC) to pilot a comprehensive intervention model to prevent and respond to domestic violence in Phu Tho and Ben Tre provinces.

The purpose of this Lessons Learned Paper is to identify the strengths and weaknesses of the piloted intervention model, to analyze whether the model, or components of the model, can be replicated nationwide. These lessons learned provide a strategic direction on GBV/DV response in Viet Nam, including information that will help them in developing an intervention model that suits the needs of the Vietnamese society, culture and political and administrative structures.

The first section of the paper provides an introduction to GBV and DV worldwide and in Viet Nam, including definitions, available data, and legal and policy framework. The second section describes the piloted intervention model, with its four interventions: (1) Advocacy and capacity building, targeted at leaders and professionals; (2) Awareness raising and IEC, targeted at general population; (3) Health sector response to survivors of GBV/DV; (4) Community response to GBV/DV. This section also identifies lessons learned for each of these interventions. The final section makes recommendations on appropriate steps that are needed for the full implementation of the Law on Domestic Violence Prevention to ensure prevention of GBV/DV in Viet Nam and to ensure the availability of a full range of adequate services for survivors.

¹ 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, Geneva, 2005.

Abbreviations and acronyms

BCC	Behavioral Change Communication
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
DMCH	Department of Maternal and Child Health Care (in MOH)
DOCST	Department of Culture, Sports and Tourism
DV	Domestic Violence
DVP	Domestic Violence Prevention
DVPC	Domestic Violence Prevention and Control
FF	Fatherland Front
FP	Family Planning
GBV	Gender-based Violence
GE	Gender Equality
GOPFP	General Office for Population and Family Planning (in MOH)
HHD	Hanoi Health Department
HMIS	Health Management Information System (from MOH)
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
M&E	Monitoring and Evaluation
MOCST	Ministry of Culture, Sport, and Tourism
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
NCPFC	National Committee for Population, Family and Children
PD	Population and Development
PFPD	Population and Family Planning Department
PPC	Provincial Peoples Committee
RH	Reproductive Health
SDC	Swiss Agency for Development and Cooperation
SH	Sexual Health
SRH	Sexual and Reproductive Health
TOT	Training of Trainers
UN	United Nations
UNFPA	United Nations Population Fund
VFU	Vietnam Farmers' Union
VYU	Vietnam Youth Union
VWU	Vietnam Women's Union

1. INTRODUCTION

1.1. International commitment to address gender-based violence

Gender-based violence (GBV) is a universal issue and possibly the most widespread and socially tolerated violation of human rights. It includes all forms of physical, psychological and economic violence. The essential feature of GBV is that it emanates from the unequal power relations between people based on the existing norms, social structures and roles that influence men's and women's lives. While GBV can affect both males and females, it is carried out predominantly against women and girls.

Globally, GBV has been recognized as a major public health priority with legal, social, cultural, economic and psychological dimensions, which needs the attention of all governments, in line with their commitments to achieving the Millennium Development Goals (MDGs) and to realizing the fundamental human rights set forth by international conventions.

Since the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women, the elimination of violence against women has become an important part of the United Nations (UN) efforts around the world. The United Nations Population Fund (UNFPA) in particular has taken a prominent role within the UN system in furthering gender equality (GE), empowering women and preventing GBV. UNFPA's action is guided by the rationale that the prevention of GBV is closely linked with the improvement of women's reproductive health, in particular, and their status in society, overall.

1.2. Gender-based violence, violence against women or domestic violence: which is it?

The UNFPA focus remains on tackling violence against women and girls, since it is they who are overwhelmingly affected. Women and adolescent girls are not only at higher risk for GBV, they also suffer exacerbated consequences as compared with what men endure. As a result of gender discrimination and their lower socio-economic status, women have fewer options and resources to avoid or escape abusive situations and to seek justice. They also suffer sexual and reproductive health (SRH) consequences, including forced and unwanted pregnancies, unsafe abortions and resulting deaths, traumatic fistula, and sexually transmitted infections and HIV. UNFPA efforts focus on eliminating forms of violence against women and girls that are especially relevant to its mandate of programming on SRH issues, such as domestic and sexual violence and harmful practices².

The UN Declaration on the Elimination of Violence Against Women (1993) provides the following definition for violence against women: "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"³. This includes violence within the family, also called domestic violence (DV).

² UNFPA. Strategy and Framework for Action to Addressing Gender-based Violence 2008-2011. New York, 2008.

³ UN Economic and Social Council. Report of the Working Group on Violence against Women, E/CN.6WG.2/1992/11.3. Vienna, 1992.

In Viet Nam, the adoption of the Law on Gender Equality and the Law on Domestic Violence Prevention and Control (DVPC), in 2006 and 2007 respectively, has created a solid legal framework and an enabling environment to combat violence against women. After the adoption of these laws, various decrees, circulars, strategies and plans of action have been developed to guide their implementation. Since the legal framework in Viet Nam is strongly focused on addressing DV, rather than GBV in general, the UNFPA country office is supporting the Government to address DV but continues to advocate moving beyond DV to address other forms of GBV.

The Law on DVPC defines DV as: “Purposeful acts of certain family members that cause or may possibly cause physical, mental or economic injuries to other family members.” DV thus encompasses various forms of violence perpetrated by a family member against another family member and includes violence against women, men, children and older people.

However, in reality the most common type of DV is violence against women committed by their husband or partner. *Therefore, if not otherwise specified, DV in this paper refers to DV against women.*

Data from the National Study on Domestic Violence against Women in Viet Nam, conducted by the General Statistical Office (GSO) in 2010, show 58% of ever-married women experienced any form of physical, sexual, or emotional violence at some time in their life; 32% experienced physical violence; 5% experienced were beaten during pregnancy.⁴ More than 60% of respondents who experienced partner abuse reported that the violence had affected their health and 26% of women who ever had been physically or sexually abused reported having been injured because of the violence.

1.3. GBV/DV prevention and response

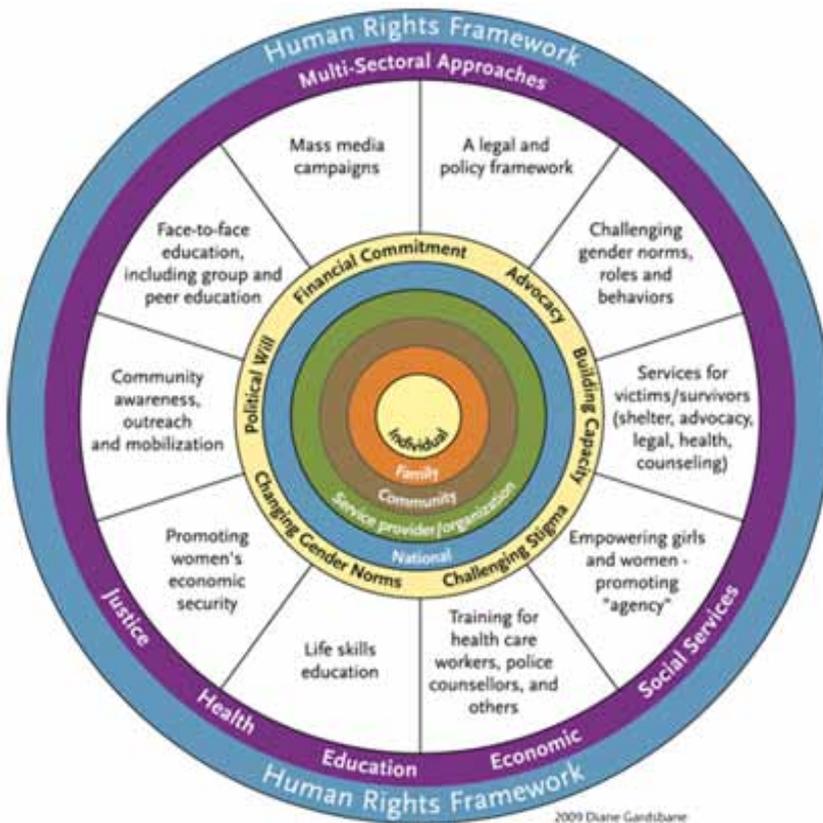
International literature and experience highlight that ending GBV/DV requires action at multiple levels and participation of multiple sectors. An effective response is characterized by the need for a coordinated response at local levels by implementers and at higher levels for policy, funding, M&E and accountability. The GBV intervention model on the next page presents a comprehensive approach to preventing and addressing GBV⁵. The key component of such an approach is the coordination mechanism through which the many initiatives, strategies and activities are coordinated so that an integrated approach can be implemented, monitored, evaluated and funded.

In Viet Nam, several initiatives have been taken to take action at multiple levels and to involve multiple sectors in preventing and addressing different forms of GBV and DV. According to a mapping done in 2009 by the Gender Action Partnership (GAP), approximately 40 organizations are providing GBV/DV related services and interventions, which are funded by various international donors and organizations. Many of these initiatives are implemented as small scale pilot projects⁶.

⁴ GSO, UN. Results of the National Study on Domestic Violence against Women in Viet Nam 2010. Hanoi, 2010.

⁵ United Nations Viet Nam. *Gender-based Violence: Issue Paper*. Hanoi, 2010.

⁶ United Nations Viet Nam. *Gender-based Violence: Issue Paper*. Hanoi, 2010.



1.4. UNFPA-SDC project

UNFPA and the Swiss Agency for Development Cooperation (SDC) decided to join hands to assist the Government in its fight against DV as part of Viet Nam's larger population and RH programmes. The ultimate goal of their joint project was to contribute to improving the quality of life of the Vietnamese people through (a) improved quality of and access to RH services, and (b) improved implementation of policies and programmes related to population and development, RH and gender mainstreaming. The project objectives were twofold: (1) to strengthen DV prevention mechanisms towards women, in order to improve the quality of social, health, legal and protection services for survivors, and (2) to increase knowledge and change attitudes and behavior of men and women towards GE and DV.

The UNFPA-SDC project ran from October 2006 to December 2011. It was implemented by the MOH GOPFP, VWU, VFU and some other key partners at central level and at provincial, district and commune levels in Phu Tho and Ben Tre Provinces. Initially 2 districts and 12 communes were selected for promoting GE and preventing DV against women through a comprehensive intervention model. Gradually the number of communes increased and by the end of the project, the intervention model had been piloted in a total of 48 communes.

Although the UNFPA-SDC project focuses primarily on DV, certain elements of the project are also relevant for other types of GBV. Therefore, this is reflected in this paper as GBV/DV.

1.5. Methodology and purpose of this paper

This Lessons Learned Paper was developed in two phases⁷. In a first phase, a rapid assessment study was carried out through a combination of different methods: (a) an analysis and review of key documents, (b) focus group discussions⁸ at commune and district level, and (c) in-depth interviews⁹ at commune, district and central level. The study led to a 46-page review identifying the strengths and weaknesses, achievements and challenges of the interventions at the policy and programme level. In a second phase, the review was summarized and complemented with the findings from the most recent final reports and evaluations of the project.¹⁰

Policymakers need successful and evidence-based models of programming in order to make adequate policy, strategy, programme and budgetary decisions with regard to the development and provision of services for survivors of GBV/DV. These lessons learned provide a strategic direction on GBV/DV response in Viet Nam, including information that will help them in developing an intervention model that suits the needs of the Vietnamese society, culture and political and administrative structures.



DV information provided to the community

⁷ Respectively November-December 2009 and December 2011.

⁸ Focus group discussions were held with: (1) DVP Steering Committees, (2) DVP Advisory Committees in district hospitals, and (3) FU and WU group leaders who integrated DVP messages into their club/group activities.

⁹ At commune and district level, interviews were held with: (1) Project Management Board staff, (2) counselors and directors at district hospitals, (3) Chairpersons and Vice Chairpersons of DVP Steering Committees, (4) Heads of Commune Health Centers. At central level, interviews were held with (1) MOCST Family Department, (2) GOPFP/MOH, (3) MOH RH Department, and (4) VWU, VYU and VFU

¹⁰ All documents reviewed are listed in the Annex.

2. COMPREHENSIVE INTERVENTION MODEL

The intervention model consists of a combination of four interventions:

- (1) Advocacy and capacity building, targeted at leaders and professionals¹¹
- (2) Awareness raising and IEC, targeted at general population¹²
- (3) Health sector response to survivors of GBV/DV¹³
- (4) Community response to GBV/DV¹⁴

The UNFPA-SDC project applied a comprehensive intervention model that focused on different groups of **beneficiaries**, including individual men and women, people in the community, health and other service providers, mass media, community leaders and policymakers.

The intervention model is focusing on **primary and secondary** prevention strategies¹⁵, which respectively aim to prevent violence before it occurs and aim to provide an immediate response to violence. Investment to stop GBV/DV before it occurs will protect and promote the well-being and development of individuals, families, communities and societies.

While the advocacy, capacity-building, awareness raising and IEC activities were carried out at **both central and lower levels**, the network and services created to respond to GBV/DV were only established at the village, commune and district levels, where individual cases of GBV/DV occur and can actually be responded to.

Overarching these concrete actions, a very important aspect of the project is the **mainstreaming strategy**, which consists of integrating GE and GBV/DV prevention initiatives into existing SRH, FP and population policies, programmes and activities, which are the core of UNFPA's mandate. The flowchart on the next page gives an overview of the structure of the intervention model.

¹¹ As stated in project outputs 1, 2 and 6.

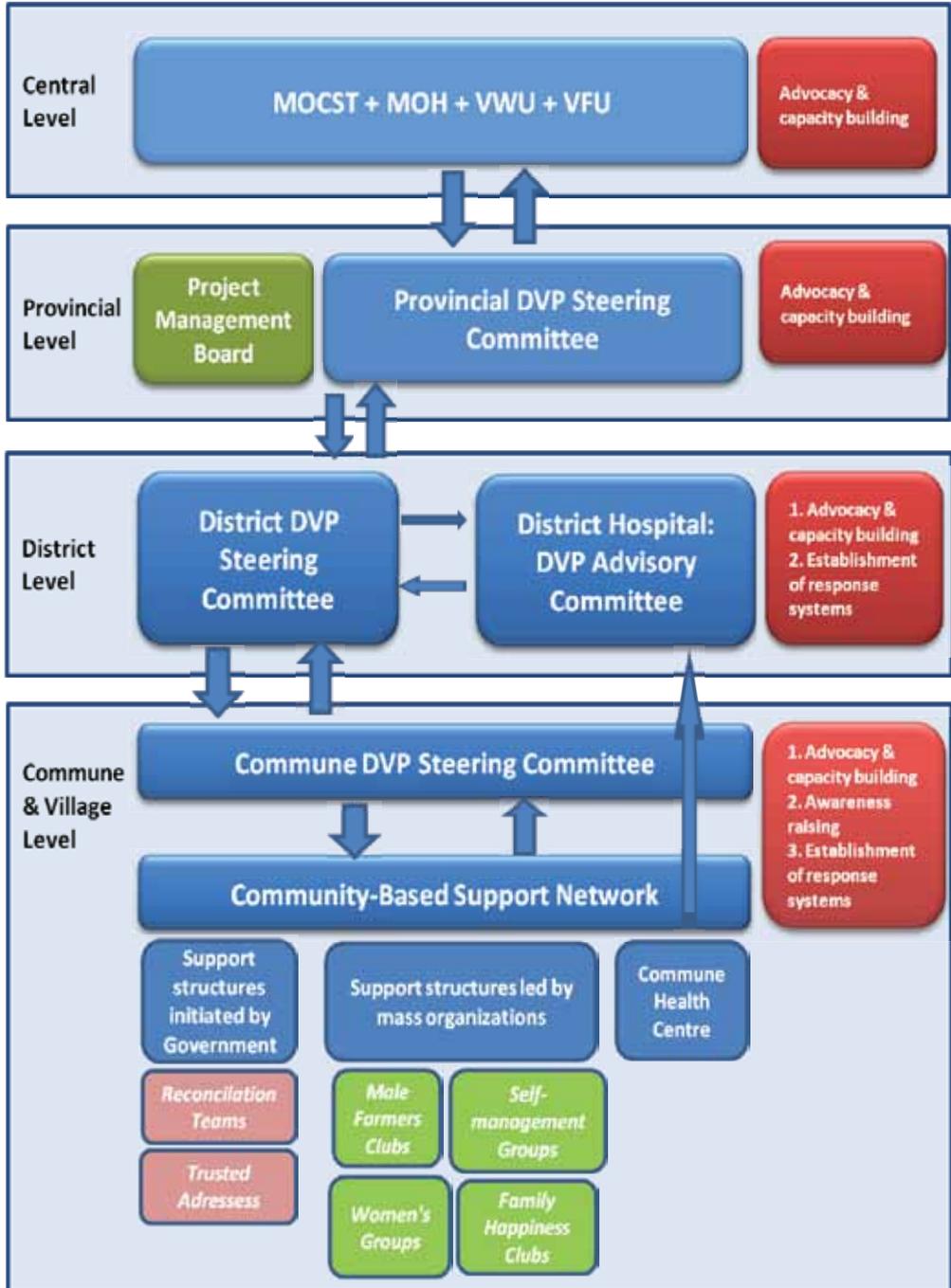
¹² As stated in project outputs 4 and 5.

¹³ As stated in project output 3.

¹⁴ As stated in project output 4.

¹⁵ From a public health perspective, prevention strategies can be classified into 3 types: Primary prevention aims to prevent violence before it occurs, e.g. community awareness campaigns. Secondary prevention focuses on the more immediate responses to violence, e.g. treatment of physical and reproductive health needs. Tertiary prevention focuses on long-term care in the wake of violence, e.g. rehabilitation and long-term counseling.- Source: World Health Organization.

Figure 1: Overview of the structure of the intervention model



2.1. Advocacy and capacity building, targeted at leaders and professionals

Capacity building serves as the foundation for the successful implementation of the intervention model. In general, local authorities, health care providers, police officers, legal professionals and members of mass organizations have limited knowledge about GE and GBV/DV. They also lack gender-sensitive attitudes and skills to work with GBV/DV survivors. Therefore, all professionals and community volunteers who are in contact with families and survivors of GBV/DV need to be trained adequately.

During the project, about 2,800 people attended trainings and workshops to raise awareness and improve their skills related to GE and GBV/DV. The capacity building activities were targeting different sectors and focusing on the audience's particular needs, such as: legal knowledge, counseling, communication, coordination, monitoring and evaluation, integration of activities in local socio-economic and cultural events, and/or data collection and reporting. In the future, other topics need to be added, such as masculinities, male problems, healthy life styles, sexuality, RH and life skills. To enhance and sustain national capacity, a Training of Trainers was organized at provincial level to build a group of core trainers, who then conducted capacity building activities for other service providers.

⇒ Result of intervention

Capacity building for professionals and community volunteers has contributed to improve the knowledge about GBV/DV of the key concerned staff at the provincial, district and commune levels and to strengthen their capacity to deal with individual GBV/DV cases.

At the central level, long-term advocacy has contributed to the political commitment that led to the adoption of the Laws on GE and DVPC and subsequently to the development of required decrees, circulars, strategies and plans of action¹⁶.

National Legal and policy framework for domestic violence prevention and control		
Laws	Policies	Strategy documents
<ul style="list-style-type: none"> • Viet Nam Constitution, 1992 • Civil Code, 1995 • Law on Marriage and Family, 2000 • Penal Code, 2003 • Civil Procedure Code, 2004 • Law on Gender Equality, 2006 • Law on Domestic Violence Prevention and Control, 2007 • Population Ordinance 03/2003/PL-UBTVH11 	<ul style="list-style-type: none"> • MOCST Directive No. 16/2008/CT-TTG (guides collaboration of each ministry that has responsibility for the Law on DVPC) • MOCST Decree No.08/2009/ND-CP (guides the implementation of a number of articles of the Law on DVPC) • MOH Circular No.16/2009/TT-BYT-2009 (guides the admission and provision of health care and reporting on patients who are victims of DV at health facilities) • MOCST Circular No.02/2010/TTBVHTTDL-2010 (provides detailed regulations on procedures relating to counseling facilities, services, and professionals) • MOF-MOCST Circular No.143/2011/TTLT/BTC-BVHTTDL (guidance for management and use of state budget for DVPC) 	<ul style="list-style-type: none"> • MOCST Plan of Action on DVPC 2008-2015 • National Family Strategy 2005-2010 • Viet Nam Family Strategy until 2020, with a vision to 2030

¹⁶ Complete list of legal and policy documents in Annex 1.

The implementation at lower levels is progressing slowly, not necessarily because of a lack of commitment, but for three key reasons identified during the project evaluation: (1) most documents have been issued recently and have not yet reached all local government officials; (2) resources to bring the new policies into action have not yet been secured; and (3) most importantly, there is limited awareness and knowledge about GE and GBV/DV among the local leaders. Although their impact may not be visible yet, these documents provide a solid policy and legal ground for new initiatives and serve as an impetus to facilitate progress in the prevention of GBV/DV at grassroots level, giving local authorities more legitimacy to intervene in DV cases.

The commitment of political leaders at provincial, district and commune level was a determining factor for the successful implementation of the UNFPA-SDC project. Preventing and addressing DV requires coordinated efforts of different sectors and organizations, which can only be done with the active participation and support of the top leaders at each administrative level. Political commitment is essential (1) to ensure favorable resource allocation, (2) to generate effective inter-sectoral coordination and collaboration, and (3) to contribute to the process of changing mentalities and behaviors among the population.

⇒ Challenges

Correct interpretation of an increase in reported DV cases – International experiences show that successful DV prevention and intervention initiatives, with public awareness campaigns and capacity building efforts, increase the number of reported DV cases, without a corresponding increase in the actual number of DV incidents. This is a sign of increased awareness among the public in general, and women in particular, as well as a better enforcement of the law by police and justice authorities. Hence, the increased number of reported DV cases in the piloted areas should be interpreted as an indicator of the success of the intervention model and as a positive impact of the project. This is especially true in the context of Viet Nam where it is only the beginning stage of combating century-long traditions of tolerating violence in the family. Before the project, people took for granted that a man would “teach” his wife with violence. Since the start of the project however, people in general, but especially women, have become increasingly aware that DV is a violation of the law and deserves public condemnation.

However, during the focus-group discussions and in-depth interviews¹⁷ conducted with local officials, some have expressed their concern that the increased numbers of reported DV cases may have a negative impact on their reputation as the number of “cultured families” in their area risks to decrease. They are worried that a successful DVP project (i.e. with a high-profile debate, large public campaigns and an increased number of cases) may indicate that local families are not meeting the requirements of cultural families. Logically speaking, the two concepts – preventing and addressing DV on the one hand and promoting cultural families on the other – stand at opposite extremes. Thus, the real risk exists that ill-informed local officials may hide incidences of DV to “keep face”. Therefore, it would be useful to carry out an analysis of the cultural families’ campaign to see if and how this affects the local leaders’ willingness to address certain issues.

Availability of resources – To ensure the availability of resources, the Ministry of Finance (MOF) issued two circulars¹⁸ that require the provincial authorities to include a budget line in their annual financial plan for the implementation of the Laws on GE and DVPC. However, both circulars

¹⁷ These focus-group discussions and in-depth interviews were carried out in November-December 2009 as part of the rapid assessment study mentioned in Section “1.5. Methodology and purpose”.

¹⁸ MOF Circular No.191/2009/TT-BTC and Joint MOF-MOCST Circular No.143/2011/TTLT/BTC-BVHTTDL. See above for full title.

were adopted at the end of the year, in October 2009 and 2011 respectively, when most provinces had already completed their annual budget plans for the following year. Thus, the impact of these circulars cannot yet be evaluated. Even when political commitment exists, it may be challenging to allocate sufficient resources to GBV/DV prevention, especially in resource-poor areas where leaders are under constant pressure to prioritize stronger economic development over social development.

Apart from state budget, other sources of funding are available and need to be examined. In one of the piloted areas, the leaders of the district hospital mobilized funds from a private business company to cover hospital fees for the victims who did not have medical insurance. This practice of involving private companies can be considered in other places.

LESSONS LEARNED

Advocacy and capacity building, targeted at leaders and professionals

- **Capacity building** serves as the foundation for the successful implementation of the intervention model.
- **Trained professionals and service providers** contribute to changing attitudes and behavior among the population and are essential to provide adequate services.
- **Political commitment** of central, provincial, district, and commune leaders is a critical and determining factor.
- **Continuous advocacy** is necessary to build, strengthen and sustain this political commitment.
- Lessons learned from community based initiatives can **feed into policy advocacy efforts at provincial and central level.**
- The **increased number of GBV/DV cases** is a positive indicator of the success of the intervention model. Future advocacy messages towards political leaders need to take this into account and highlight that an increase in reported GBV/DV cases is a sign of increased awareness level among the public in general, women in particular, and law enforcement authorities.
- Adequate and sufficient **resources** need to be allocated in short and long-term.

2.2. Awareness raising, IEC and BCC activities, targeted at general population

Sample **IEC and BCC materials** were developed at central level and subsequently adapted at local level for distribution in the piloted areas. Massive communication campaigns were carried out at all levels by local authorities, mass organizations and mass media. GE and GBV/DV related information has been gradually disseminated via various means of communication, including: TV, radio, local loudspeaker systems, newspapers, panels, flyers, leaflets, brochures, local art shows, theater and role plays, cultural mobile teams and direct communication fora.

The **diverse range of communication** channels and formats used during the campaign has helped to increase the awareness of local leaders and people alike. This diversity is important to catch the interest of people, especially when the target audience varies in terms of age, gender, education, livelihood, availability of time, and access to communication channels. The communication efforts were also targeting **men**, as it is essential to engage them in changing gender norms, social attitudes and behavior and in becoming positive role models for their sons and male family members.

Participation of **highest level leaders and influential people** (such as retired intellectuals, village heads, active members of the WU and FU, or religious leaders) in communication events has facilitated positive changes in people's attitudes and behaviors. Their mobilization is an effective way to draw the attention of the general population. Through their charisma they carry great power of persuasion and can play a critical role in leading processes of behavioral change.

⇒ Result of intervention

At the start of the project, the awareness of local residents regarding GE, GBV/DV, and available support services was very limited. On the one hand, many women did not realize that they were suffering DV and rarely sought help from outsiders. On the other, many men did not know that their actions were against the law. They simply carry on the century-old traditions of male domination within the family domain that allow men to “teach” their wives and children, even with violence.

The communication efforts have led to an **increased awareness and knowledge** among people about GE, DV, the law and people's rights. At the provincial, district and commune level, the project contributed to a change in the mindset of leaders, mass organizations, local government officials and people, who used to consider DV as a private family affair. They now understand that DV is a seriously detrimental behavior that needs to be halted. In the piloted areas women now appear to be more active in seeking help from local authorities, counseling rooms, and health care facilities.

⇒ Challenges

Quality of IEC materials – The content of some IEC materials need to be revised based on the comments gathered during the project evaluation¹⁹ and the rapid assessment study²⁰. In particular, materials need to link the issue of GBV/DV with other relevant issues such as GE, RH, FP, and/or HIV/AIDS, in order to provide people with a comprehensive view. In addition, materials need to move

¹⁹ For more details, consult following documents: (1) UNFPA and SDC. Project Evaluation Report. Mainstreaming Prevention of Domestic Violence towards women in Vietnam's Population and Reproductive Health Programmes; (2) UNFPA and SDC. Final Project Report from November 2006 to December 2010: Mainstreaming prevention of Domestic Violence towards women in Vietnam's Population and Reproductive Health Programmes.

²⁰ This is the rapid assessment study mentioned in Section “1.5. Methodology and purpose”.

beyond physical violence and include more information on other forms of violence, such as verbal, economic, and sexual violence. With so many good materials available, it would be useful to create an online **database** of good IEC materials, not only from this project but also from other projects, which can be downloaded from internet and/or ordered from the central MOCST.

Role of the media – The media has an important role to play in changing the mindsets of people. During the project, selected media practitioners and journalists participated in a training to learn how to report on issues of GE and cases of GBV/DV in a gender-sensitive and human rights based approach. As a result, cases of GBV/DV have received increasing interest in the media, but often the articles highlight cases of extreme physical violence and cases brought to court. In the future, media practitioners need more training on GE and GBV/DV, not only to increase the number of articles published, but most importantly, to ensure that the content of the articles is gender-sensitive and guarantees the confidentiality for the concerned family.

LESSONS LEARNED

Advocacy and capacity building, targeted at leaders and professionals

- Public awareness raising, IEC and BCC is necessary on a **regular** basis, using **diverse** methods and **integrated** into other initiatives/messages.
- Thanks to awareness raising and IEC efforts, **women have become more active** in seeking help from local authorities, counseling rooms and health care facilities.
- Working with **men and boys** as partners contributes to promoting GE and preventing GBV/DV.
- **Media** have an important role to play in changing mentalities and therefore need adequate training to show gender-sensitivity when reporting on GBV/DV.
- All **IEC materials** developed for this project²¹ are available and can be used in other areas or for nationwide replication. An online database would make it easy to share.

²¹ Complete list of IEC materials in Annex 3.

2.3. Health sector response to survivors of GBV/DV

The response within the health care system consists of:

- (1) Screening all female patients aged 15 years and above to identify victims of DV;
- (2) Providing treatment and support for women who experience DV;
- (3) Referring women to other services, as needed; and
- (4) Collecting data and recording cases of DV.

At district level, each hospital established an **Advisory Committee** composed of hospital leaders of the relevant departments (i.e. surgery, emergency, examination and obstetrics) with the responsibility to steer and monitor the DV prevention initiatives. The Advisory Committees, which meet on a regular (often monthly) basis, developed a protocol “Hospital Regulation on Health Workers’ Response to GBV/DV”; which includes procedures for screening, identification, support and recording of GBV/DV cases.

Each hospital set up a **counseling room**, which is exclusively used for dealing with cases of GBV/DV. Women are referred to the counseling room from other departments within the hospital, commune health centers, or DVP Steering Committees, but they can also come directly without referral. The counselors are health staff from other departments, who usually work part-time in the counseling room and part-time in their department. Some take on the duties of the counseling room on top of their regular job.

At the **counseling room**, patients are informed about GBV/DV, the applicable laws, their legal rights, and support services available to them and their children, and receive health-related information on RH, FP, and HIV/AIDS. They are further referred to non-health departments, such as police, justice or DVP Steering Committees at district or commune level to receive additional support if needed. As such, the counseling room plays a role of connecting the health sector with the community response system.

At commune level, the commune health centers were instructed to carry out screening and recording procedures for GBV/DV using the forms developed at district level.

The **screening and recording system** is based on two forms. The first form is to be used for screening all women, aged 15 and above, who visit the health centre or hospital to gather general information (such as name, date, marital status, reason of visit, and whether she has ever been a victim of DV, child abuse or rape). The second form is to be used to gather more specific information about the violence if the answer to any of the violence questions on the first form was positive.

The **data collection and recording system** is linked to the community sector response (i.e. counseling rooms and commune health centers report data to the DVP Steering Committees at district and commune levels respectively) and to the MOH Health Management Information System (i.e. an online software for collecting DV data was developed after the issuance of MOH Circular No.16 and piloted in the project districts and communes, with promising results).

During the project, about 500 health professionals were trained. All staff from the selected district hospitals and commune health centers attended one or more **training** sessions, which related to different topics, such as gender-sensitivity, GE, GBV/DV, legal issues related to DV and skills for screening, counseling and recording GBV/DV cases in accordance with the MOH Circular No.16 /2009/TT-BYT. To

enhance and sustain national capacity, a Training of Trainers was organized at provincial level to build a group of core trainers, who then conducted capacity building activities for other health care providers.

⇒ Result of intervention

Screening female patients has become an important mechanism to detect cases of GBV/DV. For instance, from September 2009 to December 2010, Doan Hung District Hospital screened 13,042 female patients aged 15 years and above, and identified 155 DV survivors.

Creating a separate **counseling room** for GBV/DV counseling has had a positive impact on providing support to survivors. For instance, from September 2009 to December 2010, the counseling room at Doan Hung District Hospital provided 196 counseling sessions, of which 107 sessions were for patients referred from other hospital departments, 26 sessions for patients referred from commune health centers, and 63 sessions for patients visiting on their own initiative. After a first visit, patients tend to return for further counseling.

There have been significant changes in **health providers' attitudes** toward GE and GBV/DV, who are now more active in screening for, and identifying, GBV/DV cases not only for physical violence but also for psychological violence. They have contributed to breaking the silence around GBV/DV.

⇒ Challenges

Screening – Health professionals have complained that the screening process is complex, time-consuming and that it is difficult to ensure privacy. This shows that more training and awareness raising is needed for health professionals and leaders to ensure that hospitals follow the protocol and allocate staff to work full time for the counseling room.

Referral mechanism – When a health professional wants to refer the victim to legal services or shelter, often the health professional doesn't have the information or the service is not yet available in the commune/district. It is necessary to establish and institutionalize a formal referral mechanism, with an updated list of available services in the area.

Implementation of MOH Circular – The issuance of MOH Circular 16/2009/TT-BYT was an important government move and has created an increased effort in all health facilities to start keeping records of DV cases and to report them to provincial health departments. However, the implementation of the circular needs additional guidance to solve a few problems. First, the Circular requires expenses of medical consultation and treatment for DV victims who have a health insurance to be reimbursed by their health insurance²². According to the health insurance procedures, victims would need a certificate issued by the People's Committee to request payment by their health insurance. However, such a proof can never be issued on time. The procedure is too complicated and can delay immediate treatment and care for DV victims. Second, the Circular requires health facilities to provide temporary shelter to victims of DV²³. In reality, this is very complicated as commune health centers do not have sufficient space or resources to provide victims with a room and food, and most importantly, cannot guarantee the safety of the woman and the health workers.

²² Circular, Article 7.

²³ Circular, Article 6.

Secondary prevention versus primary and tertiary prevention²⁴ – Currently the health sector’s involvement has focused solely on secondary prevention, namely providing immediate responses to violence through treatment of physical and reproductive health needs and treatment of acute psychological problems. However, in the future it would be necessary to involve the health sector in primary prevention initiatives before the violence occurs (e.g. integrating GBV content in primary health care programme to promote community awareness and prevent GBV) and in tertiary prevention initiatives for the long-term care (e.g. mental health care and rehabilitation).

LESSONS LEARNED

Health sector response to survivors of GBV/DV

- Health care services are usually the **first entry-point** for victims of GBV/DV. As such, it is very important for health care service providers to be able to provide appropriate support to survivors.
- **Screening** is an important mechanism to detect cases of GBV/DV.
- **Hospital-based counseling rooms** for survivors of GBV/DV provide a safe place for women to talk about their problems and receive adequate support.
- To ensure the quality and sustainability of the services, the hospital-based counseling rooms require the allocation of a **full-time health professional**.
- The **protocols, procedures and training modules** developed for screening, monitoring and recording cases are readily available and can be used in other areas and/or for replication nationwide.
- While health care services often focus on secondary prevention²⁵, they should also participate in **primary and tertiary prevention**.
- It is necessary to establish and institutionalize **a formal referral mechanism** to other services, such as social, economic and legal support.
- Implementation of the **MOH Circular No.16** requires more detailed guidance and supervision from central level

²⁴ See page 8 and footnote 15 for definitions.

²⁵ See page 8 and footnote 15 for definitions.

2.4. Community response to GBV/DV

The community response consists of

- (1) Organizing public awareness raising, IEC and BCC activities;
- (2) Providing support for women who experience DV;
- (3) Referring women to other services, as needed;
- (4) Taking measures towards perpetrators; and
- (5) Collecting data and recording cases of DV.

In each selected district and commune, a **DVP Steering Committee** was established as multi-agency coordination mechanism to ensure collaboration between the community and relevant sectors. The committees are composed of approximately 20 members, i.e.: (1) the Vice Chairman of the People's Committee acts as Head of the DVP Steering Committee, (2) the representative from the Population and Family Planning Department acts as Vice Head, (3) leaders of related sectors, such as health, police, justice, population, culture and education, and (4) leaders of mass organizations, i.e. VWU, VFU and VYU. The committees meet on a regular basis. A "Working Regulation" spells out functions and tasks, in accordance with each sector's responsibilities set forth by the Law on DVPC.

To carry out the DV prevention initiatives, the piloted intervention model relies on the existing **government-led support structures and networks** at community level, namely the **community clubs/groups** run by the local People's Committee, FF, WU, FU and PFPD (such as self-management groups, inter-family groups, happy family clubs, men's clubs), where women and men meet on a regular basis to be informed about new laws, regulations, and policies on a variety of topics. Where community clubs/groups were not available, new ones were established.

All members of the DVP Steering Committees and community clubs/groups attended one or more **training** sessions on following topics: gender-sensitivity, GE, GBV/DV, laws and policies relating to DV, skills for identifying and counseling survivors, problem solving and communication skills, as well as skills on how to implement, monitor and lead DVP programmes/activities. To enhance and sustain national capacity, the training sessions were organized in two steps, with a Training of Trainers at provincial level to build a group of core trainers, followed by trainings at lower level.

The piloted intervention model has relied very much on the network of the **health and population sector** because it has a well-organized network of trained and experienced staff at commune and village levels, such as "Population Cadres" and "Village Population Coordinators".

Throughout the project's lifecycle, the legal and policy framework for DV prevention evolved and on request of the MOCST, other government-initiated support structures were introduced to participate in the piloted intervention model, namely the **trusted addresses and the reconciliation teams**.

Trusted addresses are organized by the VWU. These private homes, where women can go in case of violence, form safe havens for survivors who cannot seek support from their families, relatives or friends. Families who are willing to help and hold high reputation in the community can register as a trusted address. Reconciliation teams are part of the MOJ system²⁶. These teams work as the

²⁶ Reconciliation teams were set up according to the Ordinance 09/PL-UBTVQH10/1998 in villages and urban community settings in order to mediate ("reconcile") in conflicts and disputes in residential areas. They are also used in cases of family disputes according to the Marriage and Family Law (2000). Team members include representatives of the People's Committee and mass organizations, as well as the head of the village, hamlet or township where the family lives.

local arm of the MOJ to “guide, assist and persuade” individuals to reach agreement relating to minor disputes. They also provide assistance in the form of mediation and counseling to the families and women who suffer from violence.

⇒ Result of intervention

Awareness raising and IEC activities have been integrated into the structure and meetings of the community groups/clubs: relevant topics, such as the Law on GE, the Law on DVPC, rights of women, how to recognize DV, or how to get support from local authorities, are presented by the group/club organizer and issues are discussed.

The community clubs/groups are a good entry-point to disseminate information on GBV/DV. While it is relatively easy to integrate sessions on GE and GBV/DV women’s clubs/groups, the project has also been successful in integrating such sessions in male clubs/groups, in particular those led by the FU. Experience from this project shows that club/group leaders can learn new skills and approaches to involve men in initiatives relating to GE and GBV/DV prevention.

The project evaluation²⁷ includes the number of meetings held on the issue of GBV/DV, as well as the number of participating men and women. Even though it cannot be measured from these indicators how many people will actually change their behavior after attending these meetings, the mere fact of their participation to learn about GBV/DV should be considered as a success by itself and a trigger for future change.

There are indications that the communication activities through the community groups/clubs have had a visible impact. At village level, mass organizations and community clubs/groups have started to raise their voice when cases of DV become apparent in the community. Women suffering from DV actively seek help from the local DVP Steering Committees. Perpetrators have been called to account for their behavior in village meetings or self-management group meetings.

In addition to communication activities, the community clubs/groups have also been involved in **dealing with individual DV cases**. In general, identified victims or perpetrators have been reluctant to talk about their problems in the groups. However, the self-management groups have been successful in dealing with individual cases of DV and referred the women to local authorities or health facilities if needed.

When informed about a DV case in their commune, members of the **DVP Steering Committees** contact the woman to offer support. All DV cases handled in the hospital-based counseling rooms are discussed in the DVP Steering Committee meetings. While most individual DV cases are dealt with at commune level, sometimes individual cases are brought to the DPV Steering Committees at district level to find ways for improved support to survivors.

⇒ Challenges

Referral system – The initial objective of the intervention model was to encourage referrals from one service to the other. While the referral of victims from commune to district health service works well, the referral of victims from health services to other services, such as police, justice, or social services, and vice versa is not yet functioning. The project evaluation²⁸ shows that the individual organizations lack

²⁷ For more details, consult following documents: (1) UNFPA and SDC. Project Evaluation Report. Mainstreaming Prevention of Domestic Violence towards women in Vietnam’s Population and Reproductive Health Programmes; (2) UNFPA and SDC. Final Project Report from November 2006 to December 2010: Mainstreaming prevention of Domestic Violence towards women in Vietnam’s Population and Reproductive Health Programmes.

²⁸ Ibid

sufficient information about other available services. As a first entry point for many victims of GBV/DV, the hospital-based counseling room should play a central role in the referral system.

In an efficient referral system each service provider (i.e. legal aid, health worker, police officer, justice officer, People's Committee, WU, shelter, and others) should form a strong link in the whole chain of support, where victims are referred from one sector to the other. Such a system can be established quite easily by providing regularly updated lists of available services, with addresses and phone numbers. In addition, a hotline number would be helpful to provide information and guidance to victims and families suffering from GBV/DV.

Role of trusted addresses – While the trusted addresses are highly valued by women as a place where they can hide from the violence for a few hours with a shoulder to cry on, some issues have been raised. First, in cases where the woman needs a place to stay for a few days, there are questions about feasibility, costs as well as safety of the women and the host family. Second, there are no criteria for applied to identify a trusted address and the owners have not been trained to provide protection, counseling or professional support. Therefore, members of trusted addresses in the piloted areas have received a first-aid kit and attended training on the concepts of GE and DV/GBV. But the system needs to be evaluated.

Role of reconciliation teams – While mediation can be a good system to solve neighborhood conflicts or land disputes, some issues arise when it comes to DV cases. First, the members of these teams are community volunteers who have not been trained in counseling and provide advice based solely on their personal knowledge and life experience. As a result, the teams often advise women to keep silent and stay with their husband. Second, reconciliation does not address the root causes of GBV/DV. As the name suggests, reconciliation teams focus on persuading both sides to make compromises as a means of promoting family harmony. By doing so, the process simply reinforces traditional gender inequality. Third, there are no established criteria to decide whether reconciliation is appropriate, no guidance on reconciliatory process in DV cases and no system for monitoring individual cases after reconciliation. As a first step to respond to these issues, the reconciliation teams in the piloted areas have received special training in gender-sensitive reconciliation skills, concepts of GE and GBV/DV, and legal aspects.

Measures against perpetrators – Some members of the DVP Steering Committee have the authority to take appropriate measures against perpetrators. For instance, the **Law on DVPC** provides the opportunity for the Chairperson of the People's Committee to issue "forbidden contact orders". However, in practice this has not yet been implemented. **Decree 110** provides a list of administrative measures that can be taken against perpetrators of DV. However, these sanctions are not all as effective: monetary fines, for example, sometimes have a counterproductive effect because survivors end up paying the fines for their violent husbands. People's Committees may need additional guidance from central level to issue "forbidden contact orders" and other measures, such as compulsory social and community work, which may have more impact.

Collecting data and recording cases of DV – The intervention model relies on the **DVP Steering Committee** as a central body to coordinate the data collection and consolidate all data from commune and district levels, collected through the health sector and community response. In practice, many challenges arise. Data can easily be missed out or double-counted. Each sector has a different data collection system, which makes it difficult to consolidate and/or compare the data on DV cases. There is no comprehensive list of indicators or unified set of data for monitoring the prevalence rate of GBV/DV, the number of victims receiving social protection and legal assistance, the number of

DV cases handled by the police and courts, etc. There is no systematic approach to collect, monitor, and report GBV/DV data from the commune level all the way to the central level.

There is a need for a unified, harmonized data collection mechanism from community to central level, with a centralized coordinating agency (ideally the MOCST) to bring all data together and supervise a joint M&E framework. As internet has become easily accessible at commune and village level, a web-based data management programme would be more convenient for data entry and management.

Knowledge management for DVP Steering Committees – Although the DVP Steering Committees have been set up in the same way at district and commune level in the piloted areas, how well a DVP Steering Committee functions, depends on personal commitment and capacity of the chair. Staff turnover and change of leaders also impact the results. In those situations, a good handover is important to make sure all capacity and knowledge is not lost. While staff turnover and change of leaders cannot be prevented, the intervention model needs to create a strategy or mechanism for capacity and knowledge management.

Limited involvement of some sectors – The piloted intervention model mainly focuses on strengthening the community and health sector responses to GBV/DV. Thus, participation from other stakeholders has been limited. However, in order to create an enabling environment for GBV/DV prevention, it is essential to include all relevant mass organizations and government sectors: i.e. health, police, justice, education, and culture. Participation of all is needed because GBV/DV prevention cannot be carried out effectively by any one single sector.

Since the MOCST has been appointed as state management agency for the Law on DVPC, there is an opportunity for the **culture sector** to play a stronger role²⁹ in the piloted intervention model. At provincial and local level, the DOCST needs human resources in general and DVP specialists in particular. For example, at commune level the “Culture and Social Affairs Cadres” are responsible for all the aspects of social life, which leaves them little time for DVP. The DOCST should consider focusing on its coordinating role at provincial and district level.

Active involvement of **police and justice** in DVP is important to develop a safety and protection net for the survivors and their families. For instance, their participation in meetings of the DVP Steering Committees is necessary to have a better oversight, to increase collaboration and to coordinate the support provided by different sectors. In practice, many police officers do not take DV seriously, which results in victims being reluctant to report cases or call for the police. Thus, capacity building for police is essential to change their attitudes and handling of DV cases. It is also necessary to work with the MOJ to provide training to legal aid centers and to lobby for providing free services to survivors of GBV/DV.

The participation of the **education sector** has not been strong. Within the context of changing structures and power relations in families, with children and adolescents of today making more decisions regarding many aspects of their personal life³⁰, more IEC and BCC efforts are needed to transform young people’s understanding through a school based approach.

²⁹ The main reason for the limited role of the MOCST is the reorganization of the National Committee for Population, Family and Children (NCPFC) and the redistribution of its responsibilities between MOH GOPFP and MOCST, which occurred in 2007 when the UNFPA-SDC project had already started. Since the reorganization occurred during the project’s implementation, most project activities remained under the lead of the former NCPFC officials with the MOH GOPFP.

³⁰ Ministry of Culture, Sports and Tourism, General Statistics Office, UNICEF, Institute for Family and Gender Studies. Results of Nationwide Survey on the Family in Viet Nam 2006. Hanoi, 2008.

Coordination of inter-agency collaboration – In addition to the participation of all relevant sectors, one of the critical factors for a successful initiative against DV is good coordination among all stakeholders. Indeed, effective action to prevent and address GBV/DV requires synchronized activities by different actors.

The piloted intervention model was designed to have a coordination mechanism with DVP Steering Committees at district and commune levels. In the piloted areas, coordination of responses to GBV/DV was stronger at **district level**, which is partially due to the fact that many activities were carried out in and around the district hospital-based counseling rooms. At the **provincial** level, the authorities lack resources and have competing priorities, while at the **commune** level, financial and human resources are limited. In addition, coordination between WU, FU, and PFPD at local level is challenging because these organizations work independently from one another. As a result, they report individually to the DVP Steering Committee. Without inter-agency information sharing, it is difficult for the coordinator to trace activities and effectively coordinate.

In 2010, as a result of policy advocacy to better implement the Law on DVPC, Phu Tho and Ben Tre provinces also established DVP Steering Committees at provincial level. The main purpose of this extra level is to integrate the guidance and instructions from central level to lower levels. The same coordination mechanism could be reviewed and adapted to the central level, in which the MOCST would take the leading role, according to its mandate as state management agency for the Law on DVPC.

Ownership and role of MOCST – The Law on DVPC, in which the MOCST was appointed as State Management Agency, came into effect one year after the start of the project. As such, the MOCST was not involved in the project design and implementation from the beginning. Therefore, it is necessary to further advocate and build capacity for MOCST at all levels to be able to own the piloted intervention model. While project implementation can be done by other stakeholders, MOCST and DOCST staff should oversee coordination, monitoring and evaluation processes.

LESSONS LEARNED

Community response to GBV/DV

- Relying on the **existing social support structures** led by local authorities and mass organizations is key to the success of the intervention model, for it presents many advantages: (1) less duplication of efforts, (2) efficient use of available resources, (3) less competition between organizations/authorities, and (4) more sustainability.
- Involving **all government sectors and mass organizations** at local level ensures effective implementation and wide reach of the intervention model.
- **DVP Steering Committees** at district and commune levels, led by the People's Committee, are a first step towards successful inter-agency coordination and collaboration. This structure can be used in other areas and for replication nationwide with clear mechanism and guidance from the central level to commune level. A knowledge and capacity management strategy needs to be developed to ensure continuity and prevent loss of knowledge and capacity with staff turnover.
- More guidance is necessary to ensure an efficient **referral system**, where each service provider forms a strong link in the whole chain of support. Ideally, the referral system should be institutionalized.
- A unified and systematic approach to **collect, monitor and report data** on GBV/DV is necessary. A unified and user-friendly system for data collection, recording and verification, needs to be established, including training for those who have to use the system.
- The **role of MOCST** at all levels needs to be strengthened, not only to implement and monitor the Law on DVPC, but also with regard to all aspects of preventing and addressing GBV/DV.
- The system of **trusted addresses** is valued by women, but requires the establishment of criteria and training for the owners to guarantee safety of the women and their children.
- The **reconciliation teams** need training and clear guidelines on how to proceed with reconciliation in cases of DV. Their role needs to be reviewed and adapted in the context of a changing society, changing family relations and the specific complexities of DV.
- **People's Committees** need additional guidance from the MOJ at central level with regard to the issuance of "forbidden contact orders" and other administrative measures against perpetrators.
- At the grassroots level, relying on the **network of the health and population sectors** is the best option because of their well-organized networks of experienced staff at the commune and village levels.
- Awareness raising and capacity building for **police and justice** officials is essential to create a safety and protection net for survivors, their children and families.
- The intervention model needs to expand and involve **other sectors**, such as police, justice and education.

2.5. Mainstreaming Strategy

Overarching the above-mentioned interventions, a very important aspect of the model is the **mainstreaming strategy**, which consists of integrating GE and GBV/DV prevention initiatives into existing SRH, FP and population policies, programmes and activities, which are the core of UNFPA's mandate.

The mainstreaming and integration of GE and GBV/DV prevention in existing structures, activities and initiatives was done in different ways at different levels, such as: (a) establishing and operating a health sector response system in current health facilities, (b) establishing and operating a community response system in the existing support structures of local government and mass organizations, (c) adding a section on GBV/DV into the National Standard Guidelines on RH and into training curricula for health workers, (d) creating GBV/DV indicators for the MOH HMIS, and (e) integrating GE and GBV/DV messages in different IEC and BCC activities.

⇒ Result of intervention

Integrating GE and GBV/DV prevention into SRH, FP and PD related policies, strategies and programmes at central level had a positive impact on the achievement of UNFPA-SDC project outcomes at grassroots level. For example: (1) gender is fully mainstreamed in the Population and SRH Strategy; (2) health workers have been trained to screen female patients in all health departments, rather than the usual maternal health department, which has led to identifying new victims.

Integration of GBV/DV prevention in the socio-economic activities of the mass organizations (such as WU's micro-credit activities or FU's provision of agricultural services) has led to an increased interest in the topic. Relying on existing structures and activities has two additional advantages: (1) the financial support is limited; and (2) the intervention is more likely to be sustainable.

The success of the mainstreaming strategy is also illustrated by the integration of the Laws on GE and DVPC into the strategies and action plans of different national project partners (such as Family Strategy; Socio-Economic Development Strategy; Plans of Action for GE of MOH, MOCST, MOET, MOLISA; Plans of Action for Law on DVPC of WU and FU). These documents being approved by the national authorities ensure the coverage nationwide and increase the level of sustainability of projects such as the UNFPA-SDC project.

⇒ Challenges

Additional efforts and capacity-building – An integration/mainstreaming approach requires special skills and motivation. In particular, it calls for more training of mass organization leaders and leaders of agencies at all levels, and more importantly, training on knowledge regarding both substantial topics (such as RH, FP, GE, GBV/DV) and communication skills for the community groups/clubs facilitators.

LESSONS LEARNED

Mainstreaming strategy

- The strategy of **mainstreaming GE and GBV/DV prevention** into existing structures and initiatives is cost-effective and sustainable.
- Integrating GE and GBV/DV prevention into other **IEC and BCC messages** allows reaching a broader audience and leads to an increased interest in the topic.
- **Specific training** on how to mainstream GE & GBV/DV prevention is necessary for leaders of local authorities and mass organizations.

3. CONCLUSION AND RECOMMENDATIONS

Overall, the intervention model piloted through the UNFPA-SDC project in 2 districts and 48 communes in Phu Tho and Ben Tre provinces from 2006 to 2011 has been a successful experience, with increased awareness and knowledge among the public, increased political commitment to GE and GBV/DV prevention, available support services for survivors, their children and families.

A number of aspects of the intervention model can easily be replicated in other provinces, taking into account some revisions or adaptations to address the lessons learned. However, an enormous amount of time and resources will be needed to reach the scale required to cover the entire country, especially with regard to the training and capacity building of all the professionals and community volunteers involved.

The following recommendations are based on the lessons learned from the implementation and evaluation of the piloted intervention model:

3.1. Advocacy and capacity-building, targeted at leaders and professionals

1. Ensure government ownership and **political commitment** of leaders at all levels in all sectors through **advocacy** and awareness raising.
2. Ensure **enforcement of the Laws on GE and DVPC** and related legal and policy documents at local level through **capacity-building** of all the local authorities, professionals and community volunteers involved in DVP. Where good training materials are available, consider institutionalizing the trainings in curricula.
3. Expand the intervention model to involve **other sectors**, such as police, justice and education. Collaborate with other UN agencies and international organizations that have already developed training and IEC materials for these sectors.
4. **Support the MOCST** to effectively take on its role of state management agency for DVPC. This will require training to strengthen its capacities for coordination and monitoring at all levels to effectively prevent and address GBV/DV and to implement the Law on DVPC. It would also be necessary to create an enforceable information-sharing mechanism between the MOCST and other partners, regardless of who has the leading role in implementing the activities.
5. Continue the strategy of **mainstreaming GE and GBV/DV prevention** into upcoming other policy documents to generate cross-sectoral responsibility for GBV/DV prevention.
6. Carry out a **cost-benefit analysis** of this intervention model in the piloted areas. An economic evaluation will identify the resources needed to replicate or expand the intervention model and will assess the costs and benefits to help determine if the benefits outweigh its costs.
7. Advocate for adequate **state budget allocation** at national and sub-national levels to further promote GE, prevent GBV/DV, and provide treatment, protection, justice and support services to survivors of GBV/DV.

8. Consider carrying out an analysis of the campaign for **“cultural families”** to identify how this affects the local leaders’ willingness to address certain issues and the reliability of data. This is relevant not only for GBV/DV, but for all other social issues. Consider revising the campaign to reflect the reality of changing family structures and social norms in Viet Nam.

3.2. Awareness raising, IEC and BCC activities, targeted at general population

9. Develop a long-term **national BCC strategy** to raise awareness and change traditional gender-inequitable norms and attitudes of the population. Include men and boys as partners to promote GE and prevent GBV/DV.
10. Develop an online **database** of good IEC materials, not only from this project but also from other projects, which can be downloaded from internet and/or ordered from the central MOCST.
11. **Empower women** to address violence in their lives through life skills training, self-help groups, education, job training, legal support and financial support.
12. Adopt the strategy of **mainstreaming GE and GBV/DV prevention** into other IEC and BCC activities to reach a broader audience and make the link with other health, family and social development issues.

3.3. Health sector response to survivors of GBV/DV

13. Advocate for a more active **involvement of the MOH** in the implementation of Circular No.16 at local level, including adequate financial and human resources and commitment at all levels.
14. Establish a supervision and monitoring mechanism to ensure that the **screening** of female patients is done adequately following the principles set by the protocol (i.e. privacy, confidentiality, safety).
15. Organize regular **training** for health care providers about how to **screen**, how to sensitively provide treatment to survivors, as well as skills and knowledge about how to work with other sectors, such as police, justice and social sector, to address GBV/DV holistically.
16. Integrate the GBV/DV-related **data collection, monitoring and reporting** system into the overall HMIS supported by MOH.

3.4. Community response to GBV/DV

17. Broaden the scope of the intervention model to include **all forms of GBV/DV**, in particular DV against children, men, older people and disabled people, as mentioned in the Law on DVPC.
18. Ensure that a **minimum comprehensive intervention package** of GBV/DV prevention, care, treatment, protection and support is available and that these services are accessible and affordable for every person.

19. Carry out an analysis of the concept, purpose, process and outcomes of **trusted addresses** and **reconciliation teams** as a means to deal with DV cases. Their role needs to be reviewed and adapted in the context of a changing society, changing family relations and the specific complexities of DV. To improve the quality of their intervention, it is necessary to develop criteria, procedures and guidance for counseling in cases of DV.
20. Strengthen and institutionalize the **referral system** to ensure that all partners involved in the intervention model form a strong link in the whole chain of support. A regularly updated list of contacts needs to be developed and distributed, containing addresses and phone numbers of the available services for GBV/DV survivors. As a first entry point for many survivors, the hospital-based counseling room should play a central role in the referral system.
21. Strengthen and integrate the processes of **data collection, recording and verification** into a central, unified system managed by MOCST. This will also require training for those who have to use the system.



Discussion on DVPC at a residential meeting in Binh Dai district, Ben Tre province

ANNEX A. References

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A.2. Reference materials

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ANNEX B. IEC materials developed for the UNFPA-SDC project

B.1. For professionals

1. A communication document entitled “Core messages on Domestic Violence Prevention”
2. A flipchart on GBV
3. Manual of gender mainstreaming in Population and Reproductive Health (for trainees)
4. Training material on gender mainstreaming in Population and Reproductive Health (for trainers)
5. Factsheet on GE and integration of GE in Population and Reproductive Health programmes
6. Booklet on GE and GBV/DV in Population and Reproductive Health programmes
7. Two sets of TOT training materials on DV prevention (for trainers and trainees)
8. Manual on operation of community clubs/groups on DVP (for communication officers)
9. Monitoring tool on DV prevention activities (for non health staff)
10. VFU’s POA for implementation of DVPC Law
11. VFU’s monitoring tool for implementation of DVPC Law
12. GE and DVP - A reference material
13. A booklet “What Women Should Know about the DVPC Law” (for VWU officials)
14. Manual on implementation of DVPC Law (for VWU staff)
15. VWU’s Plan Of Action on implementation of DVPC Law
16. Guidelines on setting up a Trusted Address in community
17. VYU’s Plan Of Action for implementation of DVPC Law
18. Training Materials on GE and DVP for youth
19. GBV Programme Review
20. Needs Assessment in Phu Tho and Ben Tre
21. SDC End Project Evaluation
22. One set of two training materials for health workers
23. Monitoring tool on DV prevention activities (for health sector)
24. An extra-curriculum guidebook (for teachers)

B.2. For general population

1. Two flyers on GE in reproductive health for young people and for men
2. A booklet “Men Can Build Family Happiness”
3. Questions and Answers on DVPC Law
4. Some things one needs to know on GE in family
5. Leaflets “You are not alone, we are always at your side” and “Stopping Domestic Violence”
6. Two posters “DVP is community responsibility” and “Do not keep silence”
7. Painting Series on DVP for use of group/club meetings
8. Two Posters “Prevention of DV is responsible of the whole society” and “4 types of Domestic Violence”
9. Leaflets on DV prevention

In... cuốn khổ 17 x 25 cm tại CÔNG TY CỔ PHẦN IN LA BÀN

Đăng ký GPXB số:....

In xong và nộp lưu chiểu Quý IV năm 2012

